Humber Health Partnership

GROUP BOARDS IN COMMON - PUBLIC

GROUP BOARDS IN COMMON - PUBLIC

13 February 2025

09:00 GMT Europe/London

Boardroom, Hull Royal Infirmary

AGENDA

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

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

Agenda - HUTH NLaG Boards in Common Meeting - February 2025 - Public.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

AGENDA

A meeting of the Trust Boards-in-Common (meeting held in Public) to be held on Thursday, 13 February 2025 at 9.00 am to 1.15 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** Amanda Stanford, Group Chief Nurse	Verbal	Discussion / Assurance	
1.4	**Declarations of Interest** Sean Lyons, Group Chair	BIC(25)001 Attached	Assurance	
1.5	**Minutes of the Meeting held on Thursday, 12 December 2024** Sean Lyons, Group Chair	BIC(25)002 Attached	Approval	
1.6	**Matters Arising** Sean Lyons, Group Chair	Verbal	Discussion / Assurance	
1.7	**Action Tracker** - **Public** Sean Lyons, Group Chair	BIC(25)003 Attached	Assurance	
1.8	**Group Chief Executive's Briefing** Jonathan Lofthouse, Group Chief Executive	BIC(25)004 Attached	Assurance	**09:25**
2.	**GROUP DEVELOPMENT**			
2.1	**Humber Acute Services Review – Update on Planned Changes** Ivan McConnell, Group Chief Strategy & Partnerships Officer	BIC(25)006 Attached	Information	**10:00**
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)007 Attached	Assurance	**10:10**
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)008 Attached	Assurance	**10:25**
BREAK – 10:35 – 10:50				

3.1.2	**Maternity & Perinatal Updates:**			**10:50**
	Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH Amanda Stanford, Group Chief Nurse & Yvonne McGrath, Group Midwifery Director	BIC(25)009 Attached	Assurance	
	Maternity Incentive Scheme – NLaG & HUTH Amanda Stanford, Group Chief Nurse & Yvonne McGrath, Group Midwifery Director	BIC(25)010 Attached	Approval	
3.2	**Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(25)014 Attached	Assurance	**11:25**
3.3	**Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge** Tony Curry & Julie Beilby, Non-Executive Directors Committee Chairs	BIC(25)015 Attached	Assurance	**11:40**
3.3.1	**Freedom to Speak Up Guardian (FTSUG) Report – Quarter Three** Liz Houchin & Fran Moverley, FTSUGs	BIC(25)016 Attached	Assurance	**11:55**
3.3.2	**People Strategy – 2025 - 28** Simon Nearney, Group Chief People Officer	BIC(25)017 Attached	Approval	**12:05**
3.4	**Capital & Major Projects Committees-in-Common Highlight Report & Board Challenge** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(25)018 Attached	Assurance	**12:15**
3.5	**Audit, Risk & Governance Committees-in-Common Highlight Report & Board Challenge** Jane Hawkard & Simon Parkes, Non-Executive Directors Committee Chairs	BIC(25)019 Attached	Assurance	**12:25**
3.6	**Charitable Funds Highlight Report** Jane Hawkard, Non-Executive Director	BIC(25)020 Attached	Assurance / Approval	**12:35**
3.7	**Health Tree Foundation Trustees' Highlight Report** Gill Ponder, Non-Executive Director	BIC(25)042 Attached	Assurance	**12:40**
4.	**GOVERNANCE & ASSURANCE**			
4.1	**Board Assurance Framework & Strategic Risk Register – NLaG and HUTH** David Sharif, Group Director of Assurance	BIC(25)021 Attached	Assurance	**12:45**
4.2	**Trust Board Reporting Framework** David Sharif, Group Director of Assurance	BIC(25)022 Attached	Approval	**12:50**
5.	**OTHER ITEMS FOR APPROVAL**			
5.1	**Audit, Risk & Governance Committees-in-Common Terms of Reference – NLaG & HUTH** David Sharif, Group Director of Assurance	BIC(25)023 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		**13:00**

8.	**QUESTIONS FROM THE PUBLIC AND GOVERNORS**			
8.1	**Questions from the Public and Governors** Sean Lyons, Group Chair	Verbal	Discussion	**13:05**
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	
10.	**DATE OF THE NEXT MEETING**			
10.1	**The next meeting of the Boards-in-Common will be held on Thursday, 10 April 2025 at 9.00 am**			

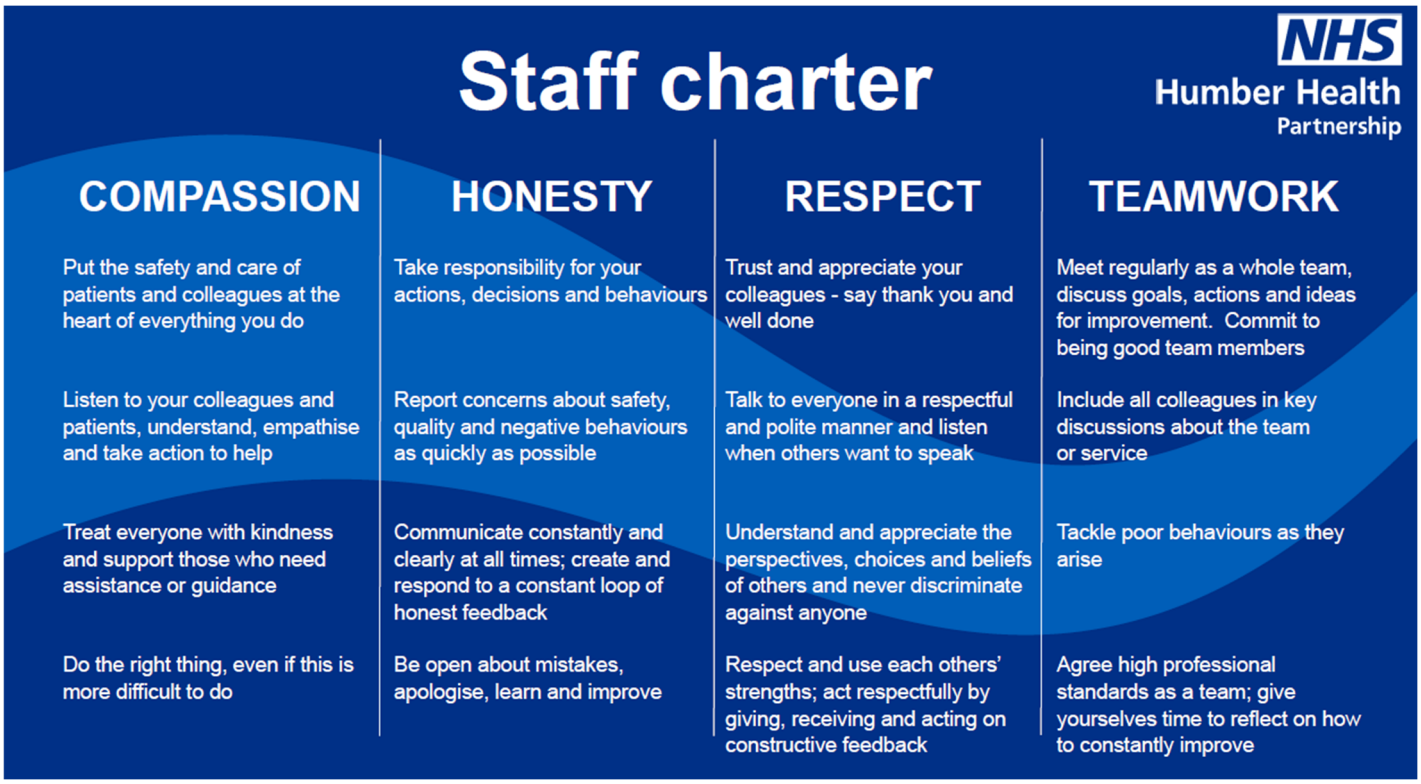
KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
6.1	**Quality & Safety Committees-in-Common**	
6.1.1	**Quality & Safety Committees-in-Common Minutes – October, November & December 2024** Sue Liburd & Dr David Sulch, Non-Executive Directors Committee Chairs	BIC(25)024 Attached
6.2	**Performance, Estates & Finance Committees-in-Common**	
6.2.1	**Finance, Estates & Performance Committees-in-Common Minutes – November & December 2024** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(25)025 Attached
6.3	**Workforce, Education & Culture Committees-in-Common**	
6.3.1	**Workforce, Education & Culture Committee-in-Common Minutes – November 2024** Tony Curry & Julie Beilby, Non-Executive Directors Committee Chairs	BIC(25)026 Attached
6.4	**Capital & Major Projects Committees-in-Common**	
6.4.1	**Capital & Major Projects Committees-in-Common Minutes – November 2024** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(25)027 Attached
6.5	**Audit, Risk & Governance Committees-in-Common**	
6.5.1	**Audit, Risk & Governance Committees-in-Common Minutes – October 2024** Jane Hawkard & Simon Parkes, Non-Executive Directors Committee Chairs	BIC(25)028 Attached
6.5.2	**Results of Audit, Risk & Governance Committees-in-Common Annual Self-Assessment Exercise 2025** Jane Hawkard & Simon Parkes, Non-Executive Directors Committee Chairs	BIC(25)029 Attached
6.6	**Other**	
6.6.1	**Integrated Performance Report – NLaG and HUTH** Ivan McConnell, Group Chief Strategy & Partnerships Officer	BIC(25)030 Attached
6.6.2	**Documents Signed Under Seal** Jonathan Lofthouse, Group Chief Executive	BIC(25)031 Attached
6.6.3	**Trust Boards & Committees Meeting Cycle – 2025 & 2026** David Sharif, Group Director of Assurance	BIC(25)032 Attached

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

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



1.2 - STAFF CHARTER AND VALUES

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

Staff Charter and Values.pdf

Staff charter

NHS
Humber Health Partnership

COMPASSION

Put the safety and care of patients and colleagues at the heart of everything you do

Listen to your colleagues and patients, understand, empathise and take action to help

Treat everyone with kindness and support those who need assistance or guidance

Do the right thing, even if this is more difficult to do

HONESTY

Take responsibility for your actions, decisions and behaviours

Report concerns about safety, quality and negative behaviours as quickly as possible

Communicate constantly and clearly at all times; create and respond to a constant loop of honest feedback

Be open about mistakes, apologise, learn and improve

RESPECT

Trust and appreciate your colleagues - say thank you and well done

Talk to everyone in a respectful and polite manner and listen when others want to speak

Understand and appreciate the perspectives, choices and beliefs of others and never discriminate against anyone

Respect and use each others' strengths; act respectfully by giving, receiving and acting on constructive feedback

TEAMWORK

Meet regularly as a whole team, discuss goals, actions and ideas for improvement. Commit to being good team members

Include all colleagues in key discussions about the team or service

Tackle poor behaviours as they arise

Agree high professional standards as a team; give yourselves time to reflect on how to constantly improve

1.3 - PATIENT STORY

Amanda Stanford, Group Chief Nurse

1.4 - DECLARATIONS OF INTEREST

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

BIC(25)001 - Declarations of Interest.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)001

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**13 February 2025**
Director Lead	Sean Lyons, Group Chair
Contact Officer / Author	David Sharif, Group Director of Assurance
Title of Report	Declarations of Interest
Executive Summary	Non-Executive Directors, Executive Directors and other Directors Declaration of Interest
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:

Executive Directors and Other Directors Register of Interests At both the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals NHS Trust (HUTH)	
Name and position	**Interests**
Amanda Stanford, Group Chief Nurse	None.
Andy Haywood, Group Chief Digital Information Officer	Previous employer was a digital health consultancy that could potentially bid for services within the Trust. Procurement steps in place to remove Andy from any decision making and to ensure full transparency.
Aswathi Shanker, South Bank Managing Director	None.
Clive Walsh, Interim Site Chief Executive – North	CRW Consulting Ltd – Sole Director. Spouse works for Birmingham Community Trust.
David Sharif, Group Director of Assurance	None.
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.
Neil Rogers, North Bank Managing Director	Director of own limited company – Neil Rogers Healthcare Management Solutions Ltd which is currently dormant.
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.
Tom Myers, Group Director of Estates & Facilities	None.

Non-Executive Directors at NLAG Register of Interests	
Name and position	**Interests**
Gillian Ponder, Non-Executive Director and Senior Independent Director	None.
Julie Beilby, Non-Executive Director	None.
Linda Jackson, Vice Chair/Non-Executive Director	Associate Non-Executive Director at HUTH. Family members working at NLAG and HUTH.
Sean Lyons, Group Chair at both NLAG and HUTH	Family member is a Registered Adult Nurse at The Rotherham NHS Foundation Trust.
Simon Parkes, Non-Executive Director	Director of Lincoln Science and Innovation Park (Unremunerated). Lay Canon and Chair of the Finance Committee of Lincoln Cathedral. Deputy Vice Chancellor and Chief Operating Officer of the University of Lincoln.
Susan Liburd, Non-Executive Director	Managing Director and Principal Consultant of Sage Blue. Director and Trustee of British West India Regiments Heritage Trust CIC.
Murray Macdonald, Associate Non-Executive Director	NED at East Midlands Ambulance NHS Trust from January 2024 Independent Committee Member Yorkshire Housing from September 2024 Trustee Manby Scout Group - 2009 Vice Chair at HUTH

Non-Executive Directors at HUTH Register of Interests	
Name and position	**Interests**
Dr Ashok Pathak, Associate Non-Executive Director	Works as a medical expert for Medical Appeals Tribunals. Family members are surgeons at St James Hospital, Leeds.
Dr David Sulch, Non-Executive Director	Medicolegal reports on patients in the fields of stroke, geriatric or general medicine (split roughly 80:20 between defendant and claimant work). I have reported on the care of patients treated at HUTH and NLaG previously but do not do so now. 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).
Linda Jackson, Associate Non-Executive Director	Vice Chair/Non-Executive Director at NLAG. Family members working at NLAG and HUTH.
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.
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.
Murray Macdonald, Vice Chair / Non-Executive Director	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

1.5 - MINUTES OF THE MEETING HELD ON THURSDAY, 12 DECEMBER 2024

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

BIC(25)002 - Minutes of the Meeting held on Thursday, 12 December 2024.pdf

TRUST BOARDS-IN-COMMON MEETING IN PUBLIC

Minutes of the meeting held on Thursday, 12 December 2024 at 9.00 am
in the Main Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

Present:

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

In Attendance:

Rachel Farmer	NHS Liaison
Diana Barnes	Governor (attended virtually)
Ade Beddow	Deputy Director of Communications
Leonora Lockhart	Domestic Abuse Co-ordinator (for item 1.3)
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Yvonne McGrath	Group Director of Midwifery (for item 3.1.1 & 3.1.3)
Simon Nearney	Group Chief People Officer
Dr Ashok Pathak	Associate Non-Executive Director (HUTH)
Raj Purewal	C2-Ai
Ian Reekie	Lead Governor – NLaG (attended virtually)
Mr Peter Sedman	Group Deputy Medical Officer (representing Dr Kate Wood)
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. Sean Lyons wanted to thank all Board members and staff for their hard work during a challenging year.

Sean Lyons welcomed Emma Sayner, Group Chief Financial Officer, Sarah Tedford, Interim Site Chief Executive (South) and Clive Walsh, Interim Site Chief Executive (North) to their first Trust Boards-in-Common meeting.

Sean Lyons thanked Stuart Hall as this was his last Board meeting with the Trusts. An appointment had been made to the HUTH Vice Chair role which included the Associate Non-Executive Director (NED) role at NLaG. Sean Lyons was pleased to confirm that Murray Macdonald would be joining both Trusts from the 1 January 2025.

It was reported that Ian Reekie had been re-elected as Lead Governor and Rob Pickersgill as Deputy Lead Governor.

The following apologies for absence were noted:

Prof Laura Treadgold	Non-Executive Director (HUTH)
Dr Kate Wood	Group Chief Medical Officer

1.2 Staff Charter and Values

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

1.3 Patient Story

Amanda Stanford welcomed Leonora Lockhart, Domestic Abuse Co-ordinator to the meeting. Leonora Lockhart explained about her role at the Trusts, she added that this was a new role with only three being employed in the country. Leonora Lockhart shared the patient story with the Trust Boards-in-Common. The patient had been referred to the Breast Care Unit where concerns were raised with Leonora Lockhart. The patient had fled a war torn country and was living with her daughter and son in law. Leonora Lockhart explained how they had to become involved and had used interpreters to support the lady due to English not being her first language.

Jonathan Lofthouse queried whether there was any difference in the number of referrals between the two Trusts. Leonora Lockhart explained there were differing services on both banks. There was nothing for standard and medium risk in place although it was recognised those cases were also concerning. Processes were in place if there was imminent harm. It was highlighted that champions were there to advocate and raise awareness of domestic abuse and support colleagues in making referrals. They were also the first point of contact for making disclosures and working with colleagues to ensure responses were answered.

Jonathan Lofthouse queried what the position was for the harmonisation of the service across the group. Melanie Sharp explained there was now one person that worked across the two organisations with two deputies reporting into that role. It was reported the team had done exceptionally well in working together and joining as one team. Amanda Stanford advised that there were slightly differing processes across the group in terms of local authority regulations, this had, therefore, meant retaining the two deputies. Work was also being undertaken with the local authorities to ensure partnership working improved.

Gill Ponder felt this story had been very moving and queried whether this service was available to staff members. Leonora Lockhart confirmed this was available to staff. Gill Ponder added that it was disappointing this role was only funded until March 2025. Melanie Sharp advised engagement had already commenced with Blue Door to identify whether this could be extended further, the option of this was positive at the moment. It was noted that Blue Door was the North Lincolnshire Support Service for abuse that was in place for anyone that required support to flee abusive relationships and included therapeutic support for others.

Dr Ashok Pathak queried whether interpreters were easily accessible and whether they were provided face-to-face. Leonora Lockhart explained that the service was not always face-to-face and that this was mostly over the telephone. However, on this occasion it had been face to face due to a member of staff providing support that had formed a relationship with the lady. Dr Ashok Pathak further queried how soon Leonora Lockhart's support had ended in terms of the other required staff taking over support for the patient. Leonora Lockhart explained she continued to provide support where required.

Simon Parkes queried the number of contacts that had been made to this service, and whether it was the role of the NHS to identify those issues even though it was beneficial. He further added that this could also be seen as a benefit to the NHS in terms of savings as supporting those patients early could hopefully mean they would not require further care in the future. Leonora Lockhart explained that in terms of support to staff this did have some benefit as in some circumstances it would mean they remained at work instead of potentially being off sick, this also supported them having financial independence and support from other colleagues. In respect of patients, it meant there was early intervention, this would of course have the potential of them not requiring certain care services from hospitals in the future. Simon Parkes queried whether any data was being collated to highlight this. Leonora Lockhart explained this would be included within the Business Case to extend the role. Amanda Stanford highlighted that local authority colleagues were important in this process in terms of working in partnership with them.

Sean Lyons thanked Leonora Lockhart for the presentation shared. It was noted that the individual had thankfully gained the required support from the team. It was recognised that the request for additional funding to support this role may be received by the Boards in the future.

1.4 **Declarations of Interest – BIC(24)223**

Sean Lyons referred to the report and sought any comments, none were received. Sean Lyons reminded Board members to continue to check their individual declarations.

1.5 **To approve the minutes of the Boards-in-Common meeting held on Thursday, 10 October 2024 – BIC(24)224**

The minutes of the meetings held on the 10 October 2024 were accepted as a true and accurate record and would be duly signed by the Chair.

1.6 **Minutes of the HUTH Annual General Meeting held on Wednesday, 16 October 2024 – BIC(24)225**

The minutes of the meetings held on the 16 October 2024 were accepted as a true and accurate record and would be duly signed by the Chair.

1.7 **Matters Arising**

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

1.8 **Action Tracker – Public – BIC(24)226**

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 that a patron had still not been identified for the role. It was reported that an option to create ambassador roles were being considered. This would include inviting local celebrities to undertake those roles. It was advised that the search for a patron continued.

Trust Boards-in-Common

- Item 1.5, 8 August 2024 - Quality & Safety Committees-in-Common Highlight Report - Never Event. Mr Peter Sedman advised there were currently two Never Events being investigated. One was on the North Bank, work was still ongoing around this. The second was on the South Bank which was also still under investigation. Mitigations had been put in place in respect of both Never Events.
- Item 3.1, 10 October 2024 – Quality & Safety Committees-in-Common Highlight Report – Infection Control NED Champion. Amanda Stanford advised it had been agreed there would be no NED Champion in respect of infection control. However, Dr David Sulch had agreed to observe some of the infection control reviews which would be fed into the Quality & Safety Committees-in-Common. It was agreed this action would be closed. Linda Jackson added that normal practice was that there would only be NED

Champions for the five core areas and that the Committees-in-Common would have oversight of any other issues.

- Item 3.2, Performance, Estates & Finance Committees-in-Common Highlight Report – Equality Impact Assessment (EqIA) Report. Amanda Stanford advised the report would be shared outside of the meeting with Sue Liburd and Dr David Sulch to agree this formally. It was agreed this action would be closed.
- Item 3.2.1, 10 October 2024 - Winter Plan. It was advised this item was due to be discussed later in the meeting.

1.7 **Group Chief Executive's Briefing – BIC(24)227**

Jonathan Lofthouse referred to the report shared.

Jonathan Lofthouse wanted to thank Rob Chidlow who had now left the organisation for the work he had completed during his time with Humber Health Partnership. It was reported that the role would now be advertised on the national market.

It was highlighted several conferences had recently been held which had provided the opportunity for staff to come together and learn from one another. It was noted that Professor Tim Briggs had attended the system a few months ago and had recently visited again for a check and challenge where extremely positive feedback had been received. It had been recognised that the Trusts had moved to standardised pathways and continued to improve in respect of long waiting patients. This had also extended to any child under the age of 16 needing to wait over 40 weeks from next year which was ahead of national targets if achieved. Conversations had also progressed with Sheffield Childrens Hospitals in respect of a service relationship and a potential brand extension. Discussions around this would continue with the Chief Executive at that Trust. The benefits for this would be in respect of recruitment, retention and training with the prospect of rotational shifts for clinicians through that service. This would support services that are vulnerable within some areas. Any options would be agreed through the Trust Boards-in-Common.

Sarah Tedford reported of a national drive to ensure ambulance handovers were completed within 45 minutes. The Yorkshire Ambulance Service (YAS) were keen to support this as it was currently a one-hour time period. The organisation was working closely with YAS to support this. Particular areas of work would be focussed on including how patients moved through the Emergency Department (ED), work with the clinical teams to identify initiatives to improve flow around the services and how the site was managed on a daily basis. It was recognised the 45 minutes would not be achieved immediately, however, and that over a two-week period this would start at 80 minutes then reduce to 65 minutes with achieving the 45 minutes by the 13 January 2025. Escalation meetings were also in place with colleagues to identify issues effectively as they arose. The clinical teams were keen to take this forward as recognised the need for improvements to patients.

Clive Walsh reported that the organisation would likely move to tier one at the end of January 2025. Regular tier meetings were currently being held with the Integrated Care Board (ICB). It was reported Multi-agency Discharge Events (MADE) had been held over the previous two weeks with partners, this had enabled

lessons to be learnt and was positive interaction. It was advised external funding had been granted to support the reconfiguration of the ground floor area within ED at Hull Royal Infirmary (HRI). It was noted this would of course be problematic at this time of year due to the building work that would be required. Focus would be in place in terms of the safety and experience of patients. It was explained that the winter period would be a challenge due to the infections that were being experienced.

In respect of Strategy and Partnership Developments Ivan McConnell referred to the report and advised the devolved local authorities had been agreed by the Secretary of State. Those on the South Bank were working at pace. It was important to recognise that Mayoral elections were due to take place in May 2025 which may cause some disruption. It was reported that on the South Bank there was a year one funding allocation of £24 million being allocated into areas looking at housing and trade.

Jonathan Lofthouse reported on the recently held Digital Hackathon which had been a superb event where it had shown the great progress possible. The event had been well resourced in terms of Microsoft staff. Some of the options being reviewed were the use of Artificial Intelligence (AI) and Co-pilot, staff had been inspired at the opportunity of the new technology that would be available. A trial would be in place over the next four months to support the Business Case being considered, it was noted the organisation was one of the first Trusts in the country to have this opportunity.

Emma Sayner reported the organisation finances were being reviewed on a weekly basis due to the move into year end. It was noted the team were working hard to identify opportunities to put in place for the year end. Work was being undertaken with the ICB and wider system in respect of what the forecast outturn position was. The deficit was at £20.7 million; however, she was confident this would improve. Any declaration of deficit would go through a robust forecast protocol amendment process in conjunction with NHS England (NHSE). In terms of capital money, work was being undertaken with the facilities team to ensure this was maximised.

Simon Nearney referred to the report and advised the Group Corporate inductions were now in place at all four larger hospitals and these were working well for new staff.

Dr Ashok Pathak raised a query as to whether there would be enough anaesthetists to support the paediatric surgery at Castle Hill Hospital. Jonathan Lofthouse advised discussions had been undertaken directly with the service team to ensure anything required would be available. Mr Peter Sedman explained that the existing arrangement had been reviewed and that there would be two further anaesthetists in place, this would continue to be risk stratified.

Jane Hawkard queried with Sarah Tedford how the flow would be improved and what would be different over the winter period, and how much confidence there was that this would improve. Sarah Tedford explained there would be no quick fix, the data had been reviewed to identify what issues arose each day in terms of the admissions of patients and their discharge. There had been engagement with the Chief of Staff of each service to discuss how this could be undertaken differently. It was felt the monitoring of this would see improvements, this would also be

monitored regularly throughout the day to identify issues as they arose. Staff had also responded well to this which had been positive.

Stuart Hall was pleased there was engagement with YAS to improve ambulance handover times. He highlighted however, that they too had to fulfil certain criteria to ensure the organisation could achieve this. Jonathan Lofthouse agreed there had been some pushback on their protocols that had not previously occurred, however, there had been assurance from the ICB that this would be monitored. Stuart Hall queried whether lessons being learnt during this time were being captured. Clive Walsh advised that these would be fed back through the flow programme and would also be supported by the Physician Assistants (PA) consultants.

Tony Curry felt that the issues were greater than the ambulance handover times and discharges and that there needed to be more confidence in putting initiatives in place. Jonathan Lofthouse advised that as an emergency system it had been sub optimal for several years and was recognised as this. What had been achieved was a marked reduction in no criteria to reside (NCTR) and better partnership working to improve flow. However, it was reported more patients had been seen through the front door than there had been previously. Sarah Tedford explained that in totality this was being looked at and a review of what happened in other areas and that changes should deliver this. She added that she was confident the teams were communicating and working together in an improved way which would support this. Helen Wright felt the improvements needed to be sustained once they were made. Although, success was being seen it needed to be embedded as the organisation moved forward. Simon Nearney queried whether there was a danger that implementing the 45 minutes would mean the ambulance services would leave patients. Sarah Tedford advised they would leave patients once they had been cohorted, this would be a safe process as they did not want to endanger any patients. Amanda Stanford explained the Trusts were working on specific quality and safety metrics that would be reviewed on a daily basis.

Sue Liburd referred to Goole District Hospital (GDH) and queried how the narrative would be regained to ensure a decision would not be rushed. Jonathan Lofthouse felt the reaction was to be expected, however, it was unfortunate that this had been misinterpreted at a recent session. Meetings were due to be held with Members of Parliament (MPs) and Councillors the following week to clarify the position with them. Ivan McConnell added that further meetings would also be held with relevant individuals.

1.8 **Winter Plan – BIC(24)228**

Clive Walsh referred to the report and advised this had also been reviewed at Cabinet and the Performance, Estates & Finance Committees-in-Common. It was noted there was still some work to be completed on the plan. Further updates would be reported through the Performance, Estates & Finance Committees-in-Common.

Clive Walsh explained that in terms of funding, small Business Cases would be produced, challenge would be received through the ICB. Linda Jackson referred back to previous discussions where it had been raised that the plan was difficult to put together due to the new care group structure, she queried whether there was now more confidence in respect of this. She further queried that it had also been raised that the resources in terms of staffing on the North Bank was inadequate

compared to the South Bank and whether that was still the case. Clive Walsh explained it had been agreed that further investment in the site teams would be made on the North Bank considering this. It was advised that the Winter Plan would be part of Sarah Tedford's portfolio going forward. Sarah Tedford added that this did reflect what many organisations were experiencing due to the funds available, however, she was confident this was the right plan for the organisations. Jane Hawkard added that Jenny Hinchliffe had discussed this at the Performance, Estates & Finance Committees-in-Common meeting and had taken responsibility in terms of delivery. The Committees had felt more confident after this discussion. Jane Hawkard queried whether the plan fitted well with local partners to ensure this was supported. Jonathan Lofthouse advised the City Health Care Partnership (CHCP) were working closely with HUTH with additional resources now being made available to provide support. Clive Walsh advised there had been some positives during the MADE Event in terms of the discharge of complex patients. Tony Curry queried whether there had been a recent surge in admissions. Jonathan Lofthouse highlighted the current period was busier than expected due to the increase in flu and Respiratory Syncytial Virus (RSV) patients, it was felt this would continue into the winter period.

2. GROUP DEVELOPMENT

2.1 NHSE Developments & Updates including the 'Insightful Provider Board' – BIC(24)229

Jonathan Lofthouse provided an update in terms of the paper shared. Jonathan Lofthouse advised it was recognised the following year would be more difficult. It was requested during a recent call with the Secretary of State that planning would shortly need to commence for Christmas 2025. In respect of the 10-year plan it was anticipated there would be further discussion over coming weeks. Jonathan Lofthouse advised that the 10-year plan would be included as part of a Board Development session. It was anticipated that the NHS Operating Framework would be received earlier this year and the broad sentiment for this would be that the aspirations would be clearer than they had previously been. Jonathan Lofthouse added that an emerging narrative would be a robust workforce reduction for all NHS Providers in 2025/26. Further details of this would be shared when available. This would mean some check and challenge of the workforce. Sean Lyons asked if colleagues could review the documents in the links provided within the paper, it was recognised there would be huge challenges ahead.

2.2 Update on Group Strategy – BIC(24)230

Ivan McConnell referred to the report and drew the Boards' attention to key points. In respect of the Strategies Board members were reminded that of the process that had previously been undertaken. Dr David Sulch felt it was ambitious to deliver the Strategies within the next three months and queried whether there would be any slippage. Ivan McConnell explained this would be a challenge, however, it related more to the streamlining of them. He wanted to thank colleagues for the speed of implementing this.

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

3.1 Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)231

Sue Liburd referred to the highlight report and raised key points. Dr Ashok Pathak noted thanks and congratulated the team and Stuart Hall on the Transcatheter Aortic Valve Implementation (TAVI) achievement. Linda Jackson added that the work around this had also improved morale with the staff along with the strong leadership that was now in place to support the improvements. Mr Peter Sedman added that further specific pieces of work would be undertaken to continue improvements being made. Dr David Sulch referred back to the report and advised concerns had been raised in respect of the mortality review process as there had been some issues around the coding, it was noted there needed to be caution around this. It was highlighted there had been some improvements in terms of Summary Hospital-level Mortality Indicator (SHMI) on the North Bank which had been positive.

3.1.1 Maternity Safety: CNST Maternity Incentive Scheme (MIS) – BIC(24)232

Yvonne McGrath referred to the report and advised that in respect of safety action one there were no concerns. In respect of safety action two, the Boards were informed that both Trusts had achieved this. It was reported that a meeting had been held in November 2024 with the Local Maternity & Neonatal System (LMNS) in respect of safety action three to update them on progress. A further meeting was now due to be held with Heads of Midwifery to revisit the objectives and targets already agreed. In respect of safety action four, the Boards were informed of an amendment to the HUTH figures that had been included in the Locum Staffing Audit Report, the compliance remained at 100% which was to be noted. A further amendment to be noted was in respect of the Consultant Attendance Audit Report, the update replated to weekend compliance which had not been included in the report received by the Boards in August 2024, this compliance remained at 100%.

Yvonne McGrath reported that in respect of safety action five, this was now compliant with the supernumerary status of the Labour Ward Co-ordinator at the start of each shift. In respect of birth rate plus, progress had been made with compliance as processes were now in place for identifying gaps. A further update would be shared in respect of the staffing report at a later date for consideration. In respect of safety action six, a quarterly review had taken place the previous day and LMNS had now confirmed that both organisations had met this action.

In respect of safety action eight, training had now been achieved at both organisations. In regard to PRactical Obstetric Multi-Professional Training (PROMPT) training, six anaesthetists have recently rotated into post in November and required training. It had been specified that a lower compliance rate for rotational staff would be accepted. The action plan was approved. In respect of safety action nine it was reported by Yvonne McGrath that HUTH and NLaG culture surveys had provided an update on the progress made to date which would also be included in an overarching action plan. Yvonne McGrath also referred to the Claims Scorecard for quarter two and explained that this was based on national annual claims reporting and triangulated with the quarter two maternity incidents,

complaints and themes. The Board were informed that the Maternity Safety Champions and Perinatal Leadership team met in November.

Yvonne McGrath reported that in respect of safety action ten, three cases had been reported through Maternity and Newborn Safety Investigations (MNSI) at HUTH and NLaG. Those patients had been provided with a duty of candour letter and information was provided on the MNSI and Early Notification Scheme.

Amanda Stanford thanked Yvonne McGrath and the team for all the work undertaken to achieve all ten standards.

Simon Parkes queried whether mechanisms were in place to ensure that the organisations remained compliant, and that the progress was not lost. Yvonne McGrath confirmed that there would be oversight over the next 12 months to ensure this became “business as usual” in the future. Standards would be checked on an ongoing basis to support this. Amanda Stanford added that there was attention on the submission and the year seven submission and what this would mean. A Time Out session was due to be held in the new year in respect of the three-year Strategy.

Sean Lyons referred to birth rate plus defined roles as they were high and queried whether this needed to be the case. Yvonne McGrath advised this was the case in some areas, however, it would be favourable for current staff to have more portfolio roles to capture all requirements.

3.1.2 **Maternity & Neonatal Safety Champions’ Overview Assurance / Escalation Reports – NLaG and HUTH – BIC(24)233**

Sue Liburd referred to the report and noted key highlights. It was highlighted that the governance structure was now in place and was working well which had supported significant improvements over the year. In the new year there would also be the introduction of a safety champion tool kit. It was reported that further industrial action had taken place since the previous Trust Boards-in-Common meeting. It was noted a letter of concern had been received at HUTH for maternity services. It was reported that although HUTH was under the Maternity Safety Support Programme (MSSP) anything that was being raised was also being cross referenced across to NLaG to ensure any improvements identified were being implemented across the group where required.

Stuart Hall advised that as he was due to leave the organisations his role as Maternity Safety Champion for HUTH would be undertaken by Dr David Sulch. It was highlighted that there had been an increase in caesarean sections, this would need to be monitored as it should not be a default option. It was reported that it was disappointing that Electronic Prescribing and Medicines Administration (EPMA) was still not in place across the group or a dedicated pharmacy. In respect of the voice of the child it was recognised this needed to be further developed. Stuart Hall had recently met with Yvonne McGrath, and it had been reported that there was currently a challenging position due to the number of patients and sickness amongst some staff. It had, therefore, been recognised that there needed to be focus on the day-to-day operation of the service. Amanda Stanford referred to the point in respect of the voice of the child and advised it had been discussed and agreed that there would be a Couple Years of Protection (CYP) Group that would be introduced in the new year around what would need to be focussed on. Amanda

Stanford referred to the letter of concern received and advised this would be discussed further, however, it was noted that the contents of this was already sited on and being worked through. Linda Jackson felt that the day to day and the "unblocking" of the basics must continue to be overseen as that was as important in ensuring improvements.

In respect of the industrial action, Jonathan Lofthouse reported that Simon Nearney had met with Unison colleagues. There was a solution for each of the staff members involved based on their individual principles. After further discussion those solutions had now been universally accepted, however, further legal requirements had to be reviewed around the process. It was hoped the remuneration settlements to staff would be at the end of January 2025. In light of this the Maternity Support Workers (MSWs) had withdrawn all other planned industrial action. Simon Nearney recognised relationships would need to be rebuilt with the MSWs as they had felt aggrieved. Thanks were given to Yvonne McGrath and the team for supporting staff during this time as patients had still been put at the forefront during this time to ensure the service was safe. Sean Lyons agreed with the point made and asked that those thanks were given to staff.

3.1.3 **Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH – BIC(24)234**

Yvonne McGrath referred to the report and noted key highlights.

Yvonne McGrath advised that there was awareness that there were issues around the induction of labour and that a deep dive had been undertaken in September 2024 to identify those issues. Following on from this there were now some recommendations including a planned time out day. It was recognised those issues would be challenging to resolve; however, contact had been made with the regional teams to identify if other Trusts were managing this in a better way. Amanda Stanford added that it had been recognised that patients being in for five days for induction was not suitable, so this was also being reviewed. It was appreciated there were some improvements to be made around the induction of labour.

Stuart Hall explained the statistics had been reviewed in terms of the labour ward and although they were within the required timescales this was still very close. It was recognised there were some issues in this area due to the fact that there were delays in patients being able to access labour areas. The organisations understood that there were some issues of flow, and this was being reviewed. Difficulties in filling vacant posts did also contribute to some of the issues, interim measures were in place, but this was still making the service fragile at times.

Sean Lyons thanked Yvonne McGrath for the update provided.

3.2 **Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)235**

Gill Ponder referred to the report and noted key highlights. In respect of cancer, Jonathan Lofthouse reported a new bespoke monitoring tool was due to go live across the group. It was felt this would provide improvements into the new year. This was part of the single referral to treatment (RTT) across the ICB. Dr Ashok Pathak queried whether the waiting list improvement was due to in-house services or whether care had been outsourced. Jonathan Lofthouse explained this was

blended with some being outsourced and also internally reduced, however, the outsourced patients had reduced from the previous year. Through harmonisation there would now be a bridged rate for the majority of surgeons for all times of working - this had previously been very high. Further recommendations were also awaiting approval through the consulting committee. It was anticipated that the agreement of the group's harmonised rate would be reached by January 2025 in line with other organisations around the country to a sustained level.

Stuart Hall referred to the ageing equipment on site as recently some of that equipment had failed. He queried whether alternatives for financing was being reviewed. Jonathan Lofthouse advised there was in place a substantial portfolio of diagnostic kits, however, a piece of work was being undertaken to bring a comprehensive case for managed service agreements across diagnostics. In respect of the Positron Emission Tomography (PET) scanner, this was mainly funded through the Daisy Charity at the Castle Hill Hospital (CHH) site through a subcontract. This was due to come to an end in 2025/26 and was yet to be released to market. It was expected this scanning would still be available on the CHH site.

Sean Lyons queried whether there were any more obvious issues that could be resolved quickly in terms of the Dual-energy X-Ray Absorptiometry (DEXA). Jonathan Lofthouse explained there was a particular problem with the DEXA scanning which had meant moving patients across the sites daily. The organisation was underperforming in terms of capacity in the mobile equipment scanners. The productivity of the mobile scanners was poorer due to the logistics of them for patients. Further discussions in light of this was being undertaken. Sean Lyons queried whether funds were available to ensure suppliers were paid in a timely manner. Emma Sayner confirmed this was a priority and payments continued to be reviewed to ensure this was achieved. Emma Sayner explained that the cash forecast for NLaG was strong, however, there were some differentials at HUTH.

Simon Parkes referred to the match funding requirement and queried whether this distorted our priorities in terms of capital expenditure. Jonathan Lofthouse explained that the schemes taken on board so far had brought forward schemes that would have been undertaken anyway, this had merely accelerated how quick they could be undertaken.

3.3 **Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)236**

Tony Curry referred to the report and noted key highlights. Jonathan Lofthouse referred to the issue around the abuse of staff and advised that a zero-tolerance project would be launched to identify any issues. It was reported that action would be taken with individuals as required, at the moment it was too early to produce any theme and trends. Linda Jackson highlighted a discussion that had taken place in respect of the number of band 8s and 9s that were leaving the organisations. A request had been made to undertake a deep dive into this to identify any issues. Sean Lyons explained that in respect of appeals, Non-Executive Directors would not be required for all appeals, however, they would be asked to support when necessary.

3.3.1 **Freedom to Speak up Guardian (FTSUG) Report – Quarter Two – BIC(24)237**

Liz Houchin referred to the NLaG report and noted it was the first time that bullying and harassment (B&H) had made it into the top three concerns raised for NLaG. It was noted that morale amongst staff was low with concerns being raised that staff were burnt out and issues around psychological safety. Sean Lyons recognised that this was something that had been raised elsewhere. It was felt that the Boards would need to be mindful of this issue. Gill Ponder referred to the inappropriate behaviours category being quite broad as it made it difficult to identify whether there was anything serious that had been raised in respect of sexual safety in the workplace. Liz Houchin explained categories were determined by the Regional Office. In respect of bullying and harassment there was a definition, but this was not always specified. It was explained that the National Guardian Office guidance was used for categorising. Liz Houchin confirmed there was nothing of concern being raised that the Boards needed to be made aware of. Fran Moverley advised that a group wide Sexual Safety Charter Policy was due to be introduced around March 2025.

Simon Parkes referred to the B&H figures as they had been reported significantly above the range, he queried where this sat in terms of work around culture. Simon Nearney felt that having to make changes in certain areas in terms of reducing staff had had an impact as the work still needed to be undertaken. It was recognised staff were under huge pressures. Simon Nearney explained that although the group had been implemented at pace, it had not always been well received by staff. Linda Jackson highlighted that NLaG did have a mature FTSU arrangement in place which did mean there was more reporting than other Trusts. Liz Houchin also had regular meetings with Jonathan Lofthouse and Simon Nearney to raise any concerns staff had made. As the FTSU NED Champion, Linda Jackson also met regularly with Liz Houchin to discuss trends. Liz Houchin explained that the report was also shared with the care groups and that she met with them to discuss any required details.

Amanda Stanford reported that the psychological impact on staff had also recently been discussed at the Top 100 Leaders event. Dr David Sulch felt there would be a need for triangulation against the staff survey in terms of the feeling amongst staff. Clive Walsh felt there would be further concerns raised as the organisations went into the new year due to changes that would be made. Sean Lyons noted the point made and felt there would be a need to construct the best way to speak to staff around the improvements that had to be made whilst making changes.

Fran Moverley shared the HUTH report and noted to key highlights. It was highlighted that one had been escalated to Human Resources (HR) as it had been in respect of patient safety. Both Fran Moverley and Liz Houchin had been recognised nationally as a case study, this had meant attending particular events with other FTSUG seeking advice. Sean Lyons congratulated both Fran Moverley and Liz Houchin in respect of this. A further point noted was the positive growth of champions at the organisations. Clive Walsh queried whether there were any particular concerns raised from administration staff. Fran Moverley advised that there was, it was agreed a discussion would be held outside of the meeting to address any concerns.

3.3.2 **Establishment Review of Safe Staffing – BIC(24)238**

Amanda Stanford referred to the report and noted key highlights. She explained that the process had been helpful in raising specific variations which would now be addressed. Risk assessments had been undertaken in those areas with further work around red flags that would also be mapped across. One piece of work to be undertaken was the rostering of staff. It was noted that this would provide assurance to the Boards in respect of safety and staffing. Linda Jackson referred to the high priority red risk areas and queried whether they correlated with the other indicators. Amanda Stanford advised that Tracy Campbell and the team were working closely with the Ward Managers on those wards. It was explained that some of the concerns were in respect of clinical risks and not in respect of staffing, a piece of work would be shared at Cabinet and then the Trust Boards-in-Common in February 2025. Gill Ponder highlighted that the risks areas appeared to require more investment and queried whether there was set budgets in place that would not be able to meet anything additional. Amanda Stanford advised that discussions would be undertaken with Emma Sayner in respect of this. Various pieces of work would be undertaken to resolve those issues around rostering. Emma Sayner added that the organisations needed to be in position where finance and staffing triangulated together. David Sharif referred to the table as it stated that the organisation was £9.2 million short, he asked for clarification around this. Amanda Stanford explained that a risk-based approach allowed discussions to take place as to what the risks were and to put mitigations in place where required as to whether they were quality or staffing risks. There was an understanding that improvements would of course take time. Discussions had already started to take place with the teams in respect of what the top risks were.

3.4 **Capital & Major Projects Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)239**

Gill Ponder referred to the report and noted key highlights. In respect of the Allam Building, discussions had taken place with the family with agreement that the building would be completed by the end of the financial year. Linda Jackson requested an update on the Humber Acute Services Review be shared with the Boards in February 2025 to provide an update, and this was agreed. Gill Ponder added that a paper was also due to be shared at the Capital & Major Projects Committees-in-Common meeting due to be held in January 2025.

Action: Ivan McConnell to provide an update on HASR at the February 2025 Trust Boards-in-Common meeting.

4. GOVERNANCE & ASSURANCE

4.1 **Board Assurance Framework (BAF) & Strategic Risk Register – NLaG & HUTH – BIC(24)240**

David Sharif shared the BAF and highlighted comments within the report. It was confirmed this had been shared with all the Committees-in-Common in the revised format with positive comments received. This also highlighted some work that was still required to address the group wide risks. The new format also showed a risk centred approach on how mitigating gaps were being progressed. There was challenge around quantifying some of those actions and he hoped that future reporting would include a scale and understanding on timings of these actions.

Simon Parkes referred to the detail that showed a catastrophic impact and queried whether there was agreement that this should be the rating and if this was the case what would be put in place to address this. It was recognised the relevant committees discussed the ratings; however, the Boards should also be made aware of such high risks. Sean Lyons agreed with the point made and noted that the agenda should be more streamlined around strategy and risks, it was appreciated there was a need for more focus going forward. Gill Ponder felt that although the BAF was moving in the right direction it still did not show the journey to a more tolerable score whilst there were gaps and actions in place to address them. It was noted the scores should be reviewed to ensure they were correct. Jane Hawkard agreed the post mitigation actions needed to be a focus.

5. OTHER ITEMS FOR APPROVAL

5.1 Emergency Preparedness, Resilience and Response (EPRR) Regulatory Report – BIC(24)241

Clive Walsh referred to the report and advised there had been high level of assurance around the scorings. It was noted this had also been the highest within the ICB. He added that there was awareness around the improvements that were required. Linda Jackson highlighted that this had been a great achievement and thanked the teams for the work undertaken.

The Trust Boards-in-Common wanted to commend Matt Overton and the team for the work that had been undertaken.

The Trust Boards-in-Common approved the Emergency Preparedness, Resilience & Response Regulatory Report

5.2 Health Tree Foundation Trustees' Committee Terms of Reference – BIC(24)242

David Sharif shared the report with the Trust Boards-in-Common and sought approval.

The NLaG Trust Board approved the Health Tree Foundation Trustees' Committee Terms of Reference.

6. ITEMS FOR INFORMATION / SUPPORTING PAPERS

6.1 Items for Information / Supporting Papers

- Quality & Safety CiC Minutes – August 2024
- Performance, Estates & Finance CiC Minutes – September & October 2024
- Workforce, Education & Culture CiC Minutes – August & October 2024
- Guardian of Safe Working Hours Annual Report
- Guardian of Safe Working Hours Quarter Two Report
- Capital & Major Projects CiC Minutes – June, July & August 2024
- Integrated Performance Report (IPR)
- Trust Boards & Committees Meeting Cycle 2025 & 2026

7. ANY OTHER URGENT BUSINESS

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

Sean Lyons again wanted to thank Stuart Hall for all the work he had supported during his time at HUTH and NLaG. This had been invaluable to both organisations.

8. QUESTIONS FROM THE PUBLIC AND GOVERNORS

Sean Lyons sought questions from the public and Governors, none were received.

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, 13 February 2025 at 9.00 am in Boardroom, Hull Royal Infirmary.

The meeting closed at 13:15 hrs.

Cumulative Record of Board Director's Attendance 2024/25

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	5	5	Gill Ponder	5	5
Jonathan Lofthouse	5	5	Mike Robson	1	1
Julie Beilby	5	5	Emma Sayner	1	1
Lee Bond	3	3	David Sharif	5	5
Paul Bytheway	3	3	David Sulch	5	5
Tony Curry	5	5	Shaun Stacey	1	1
Stuart Hall	5	5	Amanda Stanford	4	4
Linda Jackson	5	4	Sarah Tedford	1	1
Jane Hawkard	5	5	Laura Treadgold	3	2
Sue Liburd	5	4	Kate Truscott	3	1
Ivan McConnell	5	5	Clive Walsh	1	1
Simon Nearney	5	5	Kate Wood	5	3
Ashok Pathak	5	3	Helen Wright	4	4
Simon Parkes	5	3			

1.6 - MATTERS ARISING

Sean Lyons, Group Chair

1.7 - ACTION TRACKER - PUBLIC

Sean Lyons, Group Chair

REFERENCES

Only PDFs are attached

BIC(25)003 - Action Tracker - Public.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(25)003

BOARDS-IN-COMMON ACTION TRACKER

2024 / 25

ACTION TRACKER - CURRENT ACTIONS - 13 FEBRUARY 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	It was agreed a further update would be provided at the February 2025 meeting.		
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.		
1.7	08.08.24	Group Chief Executive's Briefing - Flow Campaign		Simon Nearney to share a flow campaign report at a future board meeting	Simon Nearney	April 2025	The Flow Campaign was launched in September 2024. A further Campaign Report will be shared at the April 2025 meeting.		
3.1	10.10.24	Quality & Safety Committees-in-Common Highlight Report - Infection Control NED Champion		Discussion required as to whether a NED Champion was required in terms of IPC	Amanda Stanford	December 2024	Update to be provided at the December 2024 meeting.		December 2024 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.		
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.		
3.2	10.10.24	Performance, Estates & Finance Committees-in-Common Highlight Report - EqIA Report		Amanda Stanford to share an example report with the Trust Boards-in-Common on EqIA	Amanda Stanford	December 2024	Update to be shared at the December 2024 meeting.		December 2024 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.		
3.4	12.12.24	Capital & Major Projects Committes-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.		

Key:

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

ACTION TRACKER - CLOSED ACTIONS

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
Boards-in-Common ACTION									
1.7	11.04.24	Group Chief Executive's Briefing - Data highlighting a reduced number of ED attendances		Shaun Stacey to provide Boards with data highlighting reduced numbers in ED at HUTH due to the opening of the UTC	Paul Bytheway	June 2024	Information was to be shared with the Performance, Estates & Finance Committees-in-Common		
3.3.1	13.06.24	Freedom to Speak Up Guardian Annual Report		Fran Moverley & Liz Houchin to provide information on Senior Leaders training	Fran Moverley & Liz Houchin	August 2024	Information was circulated to Board Members		
1.5	08.08.24	Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH - Perinatal Mortality Review Case		Amanda Stanford to confirm if the NLaG PMRT case had been missed from the report.	Amanda Stanford	August 2024	Amanda Stanford confirmed this case had not been ommitted from the reporting.		
3.1.3	13.06.24	Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH - Growth Scans		Amanda Stanford to provide further information regarding growth scans being reported	Amanda Stanford	October 2024	Update to be provided at the October 2024 meeting.		Detail included within the report.
3.1.1	08.08.24	Maternity & Neonatal Safety Champions' Overview Assurance / Escalation Reports - NLaG & HUTH		Comments around leadership and mitigations to be included in reporting by Yvonne McGrath	Amanda Stanford / Yvonne McGrath	October 2024	It was agreed further details would be included with the reporting.		Detail included within the report.
3.3.2	10.10.24	Workforce Race Equality Standards (WDES) Report - Unconscious Bias		Board Development Session to be held on Unconscious Bias	Simon Nearney	November 2024	Session held at the November 2024 Board Development.		

Key:

Green	Completed - can be closed following meeting

1.8 - GROUP CHIEF EXECUTIVE'S BRIEFING

Jonathan Lofthouse, Group Chief Executive

REFERENCES

Only PDFs are attached

BIC(25)004 - Group Chief Executive's Briefing.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)004

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 13 February 2025
Director Lead	Jonathan Lofthouse, Group Chief Executive
Contact Officer / Author	Jonathan Lofthouse, Group Chief Executive
Title of Report	Group Chief Executive's Briefing
Executive Summary	This report updates the Trust Boards in Common on: • The visit by Professor Tim Briggs, national lead for the Getting It Right First Time (GIRFT) programme on Monday 27 January 2025. • The timeline for 2025/26 operational plan submissions following the publication of the 2025/26 NHS Priorities and National Planning Guidance on 28 January 2025. • The key messages to our senior leadership conference scheduled Friday 7 February 2025. • Key headlines on performance metrics across the Group, as well as our financial position. • Good news stories from across the Group over the last two months.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Group Chief Executive Officer

Briefing to the Trust Boards in Common
Thursday 13 February 2025

1. Introduction

1.1 I am very pleased to echo the Chairman's welcome to Murray McDonald at his first Trust Boards in Common meeting since joining us as Vice Chair and Associate Non-Executive Director. I am sure our Group will benefit from his experience in the NHS and the wider public sector.

1.2 I am delighted to update the Trust Boards in Common on the visit from Professor Tim Briggs to our Castle Hill Hospital site on Monday 27 January 2025. As the national GIRFT lead for elective care, Professor Briggs is at the cutting edge of practice nationally and what the NHS can do at its best. It was a privilege to showcase the work that our Theatre, Anaesthetic and Critical Care colleagues have undertaken already across the Group on pre-assessment and theatre scheduling. We were also able to detail the system-level work we are undertaking in elective recovery and using system capacity more advantageously for patients. Part of Professor Briggs' visit was a walk-around our Day Case Regional Super Centre at Castle Hill Hospital and the potential that this brings our patients and our clinicians for best-in-class day case rates. I really appreciate Professor Briggs' check and challenge during this, and the follow-up work we will undertake as a result of his visit, as well continuing to make progress with the support of the Further Faster programme.

1.3 At the time of writing this report, all NHS Trusts had just received the NHS Priorities and Operational Planning Guidance for 2025/26. We received some headline dates and some planning data for our system last week. We will be submitting our headline plan by Thursday 27 February 2025 to our regional colleagues, who will be submitting a system plan to the national team on the same date. There will then follow regionally-led assurance review meetings with system partners in the first two weeks of March 2025, with full plan submission on Thursday 27 March 2025. The final stage of the process will be NHS England to System Executive Board to Board meetings 7 – 14 April 2025, with 2025/26 contracts issued by the end of April 2025. We will ensure that our Trust Boards in Common have detailed oversight of our submitted plan.

2. Patient Safety, Quality Governance and Patient Experience

2.1 On Friday 7 February 2025, we will be holding our first senior leaders' conference of 2025. This will have a significant focus on our Group leadership culture. I will be highlighting the gains we have made collectively as a Group on patient safety and experience, and setting out the leadership skills and culture we will collectively develop over the coming year to rise to the challenges we face as a Group.

2.2 We will be spending time on the headlines that are starting to come from our draft supporting strategies – our People Strategy, our Research, Development and Innovation Strategy and our Digital Strategy. These underpin the delivery of our Group's Strategic Direction, as well as form large elements of our Group Clinical Strategy. We will also be sharing a top-line briefing on our latest staff surveys.

2.3 What is key in all of these is the culture we embed as a Group organisation: how we as leaders identify and work up options for the wicked issues that affect our patients and our care service delivery: the tone and the professionalism with which we have discussions to look at the range of options for our patients, how we ensure we work closely in partnership with our system colleagues on taking decisions and how we positively recognise and celebrate the successes we create for our patients.

2.4 All of this takes professional courage and curiosity, which will ultimately lead to higher quality, safer services for our patients, and I am grateful for the continued support of our senior leaders

and their teams for being on this journey.

3. Urgent and Emergency Care (UEC) and Planned Care

3.1 We were formally notified on 29 January 2025 that our ICB has moved into Tier 1 for Urgent and Emergency Care. This puts our system in the highest category nationally for scrutiny and support. The move up to Tier 1 has been as a result of an increased challenge in achieving the UEC targets throughout our system, as opposed to within a single provider, and the distance away from target performance, together with a deterioration in key performance indicators.

3.2 There will be a rapid phased response to this Tier 1 grading: the first phase is a system-wide 'diagnostic', to develop a shared narrative about the key issues and priority actions for all partners to form the improvement plan. This phase will include a commencement visit to the system, including an in-person meeting with the system executive leadership team and visits to relevant UEC sites. The second phase will be the delivery of the improvement plan, where an agreed and bespoke package of support to deliver the agreed improvement plan. The third phase will be ongoing assurance and oversight by the national Integrated Urgent and Emergency Care team.

3.3 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)030. Starting with our Group organisation's performance on ambulance handover and the four-hour Emergency Department standard, our performance for December 2024 is set out below.

3.4 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. Against this standard, we have a local trajectory to meet in order to reach and maintain 78% performance by March 2025. 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.

3.5 On a 'footprint' basis, the north bank collective four-hour performance for December 2024 was 64.9%, against a trajectory requirement of 76.7%. The Unplanned Care Board continues to scrutinise short-and medium-term recovery plans to impact on each part of the patient journey, ED performance and patient experience.

3.6 The ambulance handover position for the north bank in December 2024 saw a performance improvement from the third week of the month onwards, linked with a new set of actions implemented in partnership with Yorkshire Ambulance Service. We have agreed a trajectory to take handover of each patient within 85 minutes in the first two weeks of this project, then 65 minutes, and we are currently working towards a 45-minute standard. In order to undertake this, both ED and YAS have increased staffing and risk-assessed areas adjacent to the ED in order to take handover of patients and release crews to deal with emergency community calls. This is not without its challenges to patient comfort and dignity, as we have also increased the number of risk-assessed temporary escalation spaces on our wards in order to board patients and create flow in the ED. We have had positive feedback from our colleagues from Yorkshire Ambulance Service for the outstanding impact this project has had on patient safety for patients waiting for 999 response in the community, as we have been able to work to the trajectory each day with only a handful of exceptions. This does also bring further focus on the work with our clinical staff and colleagues in partner organisations on discharges and flow out of the hospital.

3.7 The south bank 'footprint' performance in December 2024 for all Type 1 and Type 3 activity, including the UTC in Goole, was 67.5% against a plan position of 74%, which is a deterioration compared to the last few months.

3.8 The ambulance handover position for the south bank in December 2024 saw more patient handovers over 60 minutes than in previous months (the highest since August 2024).

Improvement actions continue on flow continue, particularly ensuring assessment space is available in a timely manner to enable ambulance handovers, with a standard of zero tolerance to over 45-minute handovers being the aim.

3.9 In respect of elective care, the 65-week position remains under significant scrutiny. Specialty-specific action plans are being monitored fortnightly at the Planned Care Board, particularly those specialties with large volumes of patients at risk of breaching 65-weeks each month. The north bank December 2024 position was 86 breaches of the standard, against a Group control total of 8, with ENT and Plastic Surgery remaining the most pressured specialties for capacity. For the south bank, the end December 2024 position was 8 breaches. We are being held to account on landing the lowest possible outturn figure for 31 March 2025.

3.10 At system level and in particular through the Collaborative of Acute Providers (CAP), we continue to take system-wide actions to manage waiting list volumes through our collective capacity. This work is focusing particularly on the 52-week waiting list volume reduction requirement for this financial year and in anticipation of the mandatory requirement of waiting list volume reduction of 5% in 2025-26. This also links with the work through the CAP on usage of independent sector capacity this year and next year. These workstreams receive scrutiny at the Humber and North Yorkshire Elective Board, which I chair in my role Executive Senior Responsible Officer for elective recovery.

4. Strategy and partnership developments

4.1 We continue to undertake workshop sessions and stakeholder engagement meetings developing longer term options for the Goole and District Hospital site. I held the third of my regular Ask the Chief Executive sessions in Goole in January 2025, which was attended by circa 100 staff across two sessions.

4.2 As I have stated at these sessions, I really welcome the input and expertise of our staff and it is important to hear as many views as possible during this time. We have shared analysis on the healthcare needs of the population and what the current service offer is at Goole and District Hospital, and we are engaging with each specialty team to hear their ideas on what the future clinical model could look like. We have also shared the parameters that we need to take into consideration, such as backlog maintenance requirements and the critical infrastructure risks that exist across our estate.

4.3 The next meeting with the local MP as well as elective members and officers for East Riding of Yorkshire Council is scheduled at Goole and District Hospital this month and we will be able to spend time on this agenda at our Board Development session in March 2025. Our stakeholder engagement has also included our Governors, who had a session with our senior leadership team and a site tour in January 2025. We are keen to hear community feedback thorough our Governors in their engagement role, also.

5. Financial Performance and Estates and Facilities updates

5.1 In respect of the Group financial position, the Month 9 position was reported to the Performance, Estates and Finance Committee this month and the assurance and escalations report for this is at agenda item BIC(25)014

5.2 The Month 9 position is that: the Group's in-month deficit was £2.9m, circa £0.6m adverse to plan. The year-to-date deficit was £20.8m, which is £2.6m adverse variation to plan. The Group's capital spend was £31.5m, which is £16.1m behind plan, largely due to some slippage on the Community Diagnostic Centres. Capital spending plans have been reviewed in detail to ensure the full capital budget is utilised this year.

5.3 The Group reported delivery of £56m in cost improvements against a year-to-date target of £52.8m, which was £3.2m better than plan. Our cash balance was rated green at £53.4m and

will continue to be monitored closely. The Group spent £8.7m less on agency, bank and overtime costs than the same period in 2023/24. This remains below the NHS England 3.2% target of total pay expenditure, at 2.9%.

5.4 The focus for Q4 is to convert non-recurrent cost efficiencies to recurrent efficiencies as well as close the gap in unidentified efficiency schemes, which currently stands at £6.6m away from the £84.6m target.

5.4 Our Elective Recovery Performance was ahead of plan at 100.9% in M9, which is £1.9m ahead of plan. The year-end trajectory is to achieve 102%, which would represent £5.8m additional income.

5.5 Work continues at pace on our capital developments, particularly those at Castle Hill Hospital and the Community Diagnostic Centres. We took handover of Phase 3 of the Day Surgery Super Centre at Castle Hill in Quarter 3 and the final handover is due to take place in March 2025. I also look forward to holding our first sessions in our regional Education and Innovation Centre on the ground floor of the Super Centre in February 2025.

5.6 We have started patient appointments at our Community Diagnostic Centre in Scunthorpe and I am delighted that a number of Non-Executive Directors and Governors joined a walk-around the CDC in December.

6. Workforce Update

6.1 We have had positive feedback on our new approach to induction and it has been a pleasure to welcome a number of new colleagues to our organisation through our refreshed induction day. There is always a member of the Executive team.

7.2 On today's agenda, I am really pleased that we have an agenda item on our Group's first People Strategy. This has been through a co-production process across our workforce and with our People Directorate to put together the key strategic aims of what we want to achieve for our staff over the next five years, in delivery of our Group Strategic Framework. I have given the briefing for the strategy to be ambitious for our people in service of improving outcomes for our patients; to create a Group culture where our staff can be their authentic selves and bring their wealth of talents to our patient and corporate services and for our Group to be a place where we give our staff opportunities within their roles and their career paths that not only positively impacts them individually but also impacts our wider communities as a significant local employer.

7. Equality, Diversity and Inclusion (EDI)

7.1 Our Group-wide Equality, Diversity and Inclusion Steering Group has now held its third meeting and is confirming its workplan to support the delivery of our Strategic Framework objectives relating to our workforce.

7.2 Following our Group's Disabled Staff Network conference, I am glad to report that we are making progress on our work to provide more robust in-house support to staff who require reasonable adjustments in the workplace. We are piloting a Group-wide role to support the practical arrangements of making and embedding reasonable adjustments within teams as well as a specific member staff to support colleagues who are coming through the recruitment process to join our workforce.

8. Good News Stories and Communications Updates

8.1 **Hundreds show their liver some love**

Over 600 people attended a free liver health check event last week. The Community Liver Health Team set up shop at Scunthorpe's Ironstone Centre on Friday to offer free, four-minute liver scans to members of the public.

The team was joined on the day by colleagues from the British Liver Trust, North Lincolnshire Council's Healthy Lifestyle Team, and Humber and North Yorkshire Cancer Alliance, all of whom were on hand to offer support and healthy living advice.

8.2 Leadless pacemakers fitted in a first for Castle Hill Hospital

The first patients to be fitted with a leadless pacemaker underwent their surgery this month, marking a milestone for Castle Hill Hospital in Cottingham.

The most common reason for getting a pacemaker is a heart rhythm problem that makes the heart slow down a lot, which can cause the patient to faint or pass out. A leadless pacemaker is a one-piece device that is implanted directly into the heart via a vein. Unlike traditional pacemakers, it does not require a separate battery under the skin or leads that connect to the heart.

The benefits of leadless pacemakers over traditional pacemakers are substantial. Patients experience a reduced risk of complications and a minimally invasive procedure, leading to quicker recovery times and a lower chance of infection. The device's smaller size makes it more comfortable, eliminating the lump under the skin on the chest associated with traditional pacemakers.

8.3 From Harvard to Hull: Global experts gather for prestigious headache conference

World leaders in the treatment of headache and migraine descended on Hull during January.

Experts from as far afield as the United States and Brazil discussed the latest headache and migraine treatments and research at the 10th biennial National Meeting on Headache.

Organised by Hull Royal Infirmary's specialist neurology team since 2005, the event celebrated its tenth meeting of this kind having grown from 75 delegates in year one to almost 300 world-leading experts in attendance in 2025.

8.4 Infant feeding team lands UNICEF gold award

Midwives and health visitors in Grimsby, Scunthorpe, and Goole have achieved a prestigious international award for their breastfeeding and infant feeding programme.

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG), in collaboration with health visiting teams in North and North East Lincolnshire, has achieved the Baby Friendly Initiative (BFI) Gold Award, run by international charity UNICEF.

The teams received the accolade for embarking on a 16-year journey to deliver gold-standard feeding care for babies across all three towns, ensuring families across the area receive the highest quality care.

8.5 Scunthorpe Outpatient Antibiotic Therapy (OPAT) nurses save lives of patient and her family

Scunthorpe OPAT nurses Danni Parkin and Jess Bratton, who care for patients who still require hospital care but can receive it in their own homes, smelled gas in a patient's home during a home visit. Danni and Jess evacuated the house, called the emergency gas number, opened the windows and doors and shut off the gas.

They arranged for the patient and her husband to be taken to our Emergency Department, where it was confirmed they had carbon monoxide poisoning and arranged for the family dog to be moved somewhere safe. An amazing response which genuinely saved the lives of the patient and their family.

Jonathan Lofthouse
Group Chief Executive
4 February 2025

2 - GROUP DEVELOPMENT

2.1 - HUMBER ACUTE SERVICES REVIEW - UPDATE ON PLANNED CHANGES

Ivan McConnell, Group Chief Strategy & Partnerships Officer

REFERENCES

Only PDFs are attached

BIC(25)006 - Humber Acute Services Review - Update on Planned Changes.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)006

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**13 February 2025**
Director Lead	**Ivan McConnell, Group Chief Strategy & Partnerships Officer**
Contact Officer / Author	**Linsay Cunningham, Deputy Director of Strategy & Partnerships**
Title of Report	**Humber Acute Services Review – Update on Planned Changes**

Executive Summary	The report provides an update on the current status of the Humber Acute Services Programme and identifies key risks and mitigations.
	
	Current status:
	• Decision-Making Business Case (DMBC) approved by ICB Board in July 2024 – revised recommendation approved.
	• Implementation Planning phase commenced (Group responsibility).
	• Implementation Group established to take this forward.
	• SRO appointed
	• Project Manager Appointed
	• Challenge to outcome and request for local resolution lodged by North Lincolnshire Health and Wellbeing Board/NL Council – Multiple Engagement Meetings undertaken – Finalised November 2024 – Council agreed request to the Secretary of State for a "Call In"
	• Challenge to outcome – direct referral to SoS by Lincolnshire County Council
	Key risks:
	• Potential Delay to implementation should the Secretary of State choose to "Call In" the programme.
	  ○ mitigation – provision of supporting evidence on process for NHSE and DHSC
	  ○ mitigation - continue with implementation planning and implementation prior to any potential "Call In" by the Secretary of State.

Background Information and/or Supporting Document(s) (if applicable)	Update report attached. Full decision-making document pack on ICB website: https://humberandnorthyorkshire.icb.nhs.uk/meetings-and-papers/10-july-2024/
Prior Approval Process	**N/A**
Financial Implication(s) (if applicable)	**None**
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	**None**
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Humber Acute Services Programme

Implementation Update

Background

The Humber acute services (HAS) programme commenced in 2018 to address challenges faced by Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) and design hospital services that will be fit for the future. This had been through an extensive clinical engagement process of local clinicians in primary, secondary and tertiary care, as well as the independent Clinical Senate.

From 25th September 2023 to 5th January 2024, Humber and North Yorkshire ICB (HNY ICB) consulted the public and stakeholders on substantial variations to services including urgent and emergency care, inpatient care for some medical specialties, emergency surgery and paediatrics.

At its meeting on 10th July 2024, HNY ICB considered the feedback received on their proposals through consultation and approved the recommendation in the Decision-Making Business Case to implement a revised proposal based on consultation feedback.

Summary of Changes

The changes will improve the quality of care for patients across Northern Lincolnshire by bringing together specialist teams in fewer locations so that they can provide more timely access to specialised care for those patients with the most complex needs.

Service area	Original Proposal	Revised proposal
Trauma Unit	Consolidate to DPoW	Consolidate to DPoW
Emergency surgery	Consolidate to DPoW	Consolidate to one site (mixed approach)
– *Trauma and Orthopaedics*		– Consolidate to DPoW
– *Acute General Surgery*		– Consolidate to DPoW
– *Urology*		– Consolidate to SGH
– *ENT*		– Consolidate to DPoW
– *Ophthalmology*		– Consolidate to HRI
– *Gynaecology*		Retain on both sites – align to obstetrics review
Some medical specialities	Consolidate to DPoW	Consolidate to DPoW
– *Cardiology*		
– *Respiratory*		
– *Gastroenterology*		
Paediatric overnight (inpatient) care	Consolidate to DPoW	Retain inpatient beds on both sites but work towards a reduction in beds through implementation of community-based paediatrics model

Benefits

Key benefits of the proposed changes

- ✓ Ability to deliver clinical standards across a range of services.

- ✓ Improved ability to recruit and retain skilled workforce.
- ✓ Helps to address workforce challenges.
- ✓ Increased confidence in patients – access to specialist teams.
- ✓ Competency of staff in dealing with more complex cases improves.
- ✓ More resilient services, less likely to be impacted by key staff leaving.
- ✓ Opportunities to create more specialist teams.
- ✓ Improved quality of care.
- ✓ Provide responsive services 24/7, with local access maintained.
- ✓ Swifter discharge of patients working with local authorities and social care.
- ✓ Fewer cancelled operations and reduction in waiting times for treatment.
- ✓ Reduced waiting times and better outcomes for patients.

The changes will deliver more effective services that are better able to meet the changing health needs of our population. They make better use of the workforce we have and enable us to develop more effective staffing models in the future and create attractive career prospects for our current and future workforce. The proposed changes have been designed to support delivery of clinical standards in areas where services are currently falling short, improve clinical outcomes for patients and help to reduce inequalities of access and outcomes.

Implementation

Implementation is planned over a two-year period, with Year 1 focused on implementing the key enabling projects and developing detailed pathways and processes to ensure safe and effective changes. Once key enabling changes are in place, implementation of the proposed service moves will be phased over Year 2 – with changes to medical specialty inpatients being undertaken first, followed by changes to surgical specialties.

The programme has experienced a delay to implementation planning due to a mutually agreed pause in the implementation process to enable local resolution discussions to take place with North Lincolnshire Council. This process has now concluded with the Council asking the Secretary of State for a “Call In”.

The request for a “Call In” does not prevent us from implementing the changes agreed by the ICB. However, we must recognise that should the Secretary of State “Call In” the programme then implementation must pause for the duration of that process.

Should any further delays be incurred, this will impact upon delivery of the stated benefits of the changes (outlined above) and create further uncertainty for those working within the services where changes are planned.

In addition, there are specific issues that would result from further delays to implementation, including:

Capital Planning and Delivery

To deliver the proposed service changes, investment is required to refurbish, expand and/or rebuild key clinical areas at Diana Princess of Wales Hospital, Grimsby (DPoW) to accommodate additional patients for the consolidated services. Additional investment is required to deliver:

- an increase in non-elective inpatient beds
- an increase in critical care capacity

Some of the planned investment was within the organisation’s capital plan for 2024/25 and has been reprofiled into 2025/26. Further delays to implementation could impact upon the organisation’s ability to manage the capital budget and deliver capital projects across the financial year.

Workforce – Recruitment and Retention

The proposed changes were designed to address workforce issues and challenges across the organisation and in particular to make the best use of clinical workforce whilst delivering improved, 7-day services. The proposed model of care supports recruitment and retention by presenting a more attractive offer for current and future clinical staff.

Continued delays to implementation and uncertainty around the future model impact upon existing staff who may be making decisions about their own roles, including seeking opportunities for career progression. Additionally, it makes it more challenging to recruit into roles if the future service model is unclear.
There can be a significant lead-in time to recruit to clinical posts and therefore confidence in the implementation timeline is vital to deliver the stated benefits of the change.

Quality, Safety and Sustainability

The services where changes are planned are not consistently meeting all clinical and constitutional standards. This is driven by a wide range of challenges including:

- recruiting and retaining sufficient workforce to deliver specialist services across multiple sites (as outlined above).
- inefficiency and additional cost of running specialist rotas across multiple sites.
- insufficient patient volumes for specialist services impacting upon skills and training opportunities for staff.

The independent Clinical Senate concluded that the proposed model affords the opportunity to consolidate specialised skills and expertise on one site and as such the proposed models of care are clinically coherent, more sustainable and would provide quality care.
Further delays to implementation of the proposed changes will result in continued challenges in relation to quality, safety and sustainability of services as outlined above.

Implementation Governance

The Programme is now moving from planning and decision making to one of implementation. The leadership of the Programme is moving from the Strategy and Partnerships Team to Operational colleagues.

The SRO for the implementation of the Programme moving forward will be Sarah Tedford, Chief Executive South Bank.

A programme implementation plan and structure has been put in place by Sarah to manage the implementation of the programme.

Ivan McConnell
Group Chief Strategy & Partnerships Officer

Linsay Cunningham
Deputy Director of Strategy & Partnerships

February 2025

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 Director Committee Chairs

REFERENCES

Only PDFs are attached

BIC(25)007 - Quality & Safety Committees-in-Common Highlight Report & Board Challenge.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)007

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**13 February 2025**
Director Lead	David Sulch, Sue Liburd – Chairs of CIC
Contact Officer / Author	David Sulch, Sue Liburd – Chairs of CIC
Title of Report	Quality and Safety CIC Escalation Report
Executive Summary	This report sets out the items of business considered by the Quality and Safety Committees-in-Common at their meeting(s) held on Tuesday 17 December 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards. The CIC gave limited assurance to the following items and details are included in the escalation report: • Group Quality Priorities • Research Development and Innovation **The Board in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. • Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Financial implications are included in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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

Report for meeting of the Trust Boards to be held on:	13 February 2025
Report from:	Quality and Safety Committees in Common
Report from meeting(s) held on:	17 December 2024
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Quality and Safety Committees-in-Common at their meeting(s) held on 17 December 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

17 December 2024

- Operational Pressures Update
- EQIA Update
- Neonatal Surgery Out of Hours Decommissioning
- Quality Priorities
- Research, Innovation and Development Quarterly Update
- Maternity HUTH/NLAG AAA Report
- PSIRF Annual Report
- CLIP Report – Incidents/Claims/Complaints and PALs
- Patient Experience Q2 Report/Patient Experience Annual Report
- CQUINS
- Integrated Performance Report
- End of Life Annual Report (NLAG)

3.0 Matters for reporting / escalation to the Trust Boards

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

17 December 2024

- Flu cases, particularly at HUTH were increasing. Gold command monitoring had commenced being led by the IPC Team.
- Emergency Care pressures were raised and the work ongoing regarding the FLOW programme to reduce length of stay.
- The End of Life Annual Report was approved by the CIC.
- The Patient Experience Annual report was approved by the CIC.
- CNST reporting for the Group was at full compliance although induction of labour was still highlighted as a risk.

4.0 Matters on which the committees have requested additional assurance:

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

17 December 2024

- The CIC supported the Neonatal Emergency Surgery Out of Hours decommissioning although further assurance regarding outcomes of 'in hours' emergency surgery was required.
- The CIC was not assured regarding the Group Quality Priorities due to concerns regarding data quality and the pace of change.
- The Group Research, Development and Innovation report was presented and limited assurance was received mainly due to clinical research investment (time and money) in the teams.

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

4.2 The BAF report was not received at this meeting. The quarterly report would be presented to the February 2025 meeting.

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.

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

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

17 December 2024

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

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

REFERENCES

Only PDFs are attached

BIC(25)008 - Maternity & Neonatal Safety Champions Overview Assurance Report.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front sheet

Agenda Item No: BIC(25)008

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 13 February 2025
Director Lead	N/A
Contact Officer/Author	Sue Liburd, Non-Executive Director Stuart Hall/David Sulch, Non-Executive Director
Title of the Report	**Maternity & Neonatal Safety Champions Report**
Executive Summary	This report sets out the activities undertaken by the Non-Executive Maternity & Neonatal Champions to provide assurance to the Board in the provision of high quality, safe maternity, and neonatal clinical care. The Maternity & Neonatal Safety Champions continue to be proactive in engaging with staff across NLaG and HUTH. This activity is specifically documented in detail in the individual maternity reports produced by the Maternity teams and is summarised in this report. The report sets out matters of risk to escalate which include the instability in some senior leadership roles, but note the positive progress made which has included the appointment of a Group Director of Midwifery who commenced in post in June 2024.
Background Information and/or Supporting Document(s) (if applicable)	The role of the Non-Executive Director Maternity & Neonatal Champion is to provide Board level assurance that the following are in place: • High quality clinical care; • Maternity & neonatal service & facilities; • Workforce numbers; • Learning & training systems (includes ensuring authentic engagement with service users and ensuring the service acts upon their feedback); and • Effective team working.
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A

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

Maternity & Neonatal Safety Champion's Report
For December 2024 and January 2025

Executive summary:

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

- High quality clinical care.
- Maternity & neonatal service & facilities.
- Workforce numbers.
- Learning & training systems (includes ensuring authentic engagement with service users and ensuring the service acts upon their feedback).
- Effective team working is all in place.

This report has been developed to enable the Maternity & Neonatal Safety Champions for the two trusts to report on and provide assurance to the relevant committees and the boards in respect of the above areas. Where required, the report will include risks & concerns requiring escalation as well as good practice, improvement and innovation.

Activities undertaken this month:

Activities undertaken in October and November have included the standard programme of walk rounds, service level meetings, and meetings with service leaders including the Head of Midwifery for the respective Trusts.

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

HUTH

- 5 December — HNY LMNS Delivery Board
- 10 December — Introductory meeting with Maternity Safety Support Programme Advisors
- 11 December — Safety Champion Walkaround
- 19 December — MNAG
- 16 January — MNAG
- 27 January — Maternity Safety Champions Timeout

NLAG

- 5 December — HNY LMNS Delivery Board
- 9 December — NNEL MNVP quarterly meeting
- 10 December — Introductory meeting with Maternity Safety Support Programme Advisors
- 19 December — MNAG
- 16 January — MNAG
- 17 January — NLaG/LMNS Assurance Support Visit
- 27 January — Maternity Safety Champions Timeout
- 28 January — Listening Event DPOW

Positive News and Feedback
The Safety Champions note the improved access to training opportunities for staff across the Group using CPD funding. The Safety Champions are pleased to reflect on the improved Governance processes that are now in place across the Group. The Safety Champions are please to note the approval of the additional funding for Ward Manager and Matron Posts for HUTH. The Safety Champion Timeout Day on the 27th of January provided a useful opportunity to review the Safety Champions toolkit and plan arrangements for 2025. The Safety Champions are pleased to the note the overall positive feedback following the LMNS Assurance visits and the MNVP 15 Steps- full reports to follow and areas for improvement are also recognised. NLaG safety champion commends the work of the highly engaged and committed team who have achieved the BFI Gold Award for Sustainability and the Neonatal Team who have reached BFI Stage 1 Accreditation for the Neonatal Standards. The Safety Champions are pleased to note that MNSI Letter of Concern for HUTH is now closed.
Risks & concerns to escalate:
1. Concern raised via FTSUG at DPOW. Listening Events and a review of levels of staff sickness absence related to work related stress is being undertaken. 2. Recruitment challenges. Response to advertisements generated large numbers of applicants. However, only a small number of applicants met the criteria for shortlisting. 3. Increase in the number of stillbirths relating to diabetes. A deep dive into the occurrences is being undertaken. 4. Induction of labour. The delays and patient flows continue to be a challenge.

David Sulch
Non-Executive Director Maternity &
Neonatal Safety Champion (HUTH)

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

3.1.2 - MATERNITY & PERINATAL UPDATES

Amanda Stanford, Group Chief Nurse & Yvonne McGrath, Group Midwifery Director

MATERNITY & NEONATAL SAFETY ASSURANCE REPORTS - NLAG & HUTH

Amanda Stanford, Group Chief Nurse & Yvonne McGrath, Group Midwifery Director

REFERENCES

Only PDFs are attached

BIC(25)009 - Maternity & Neonatal Assurance Reports - NLAG & HUTH.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)009

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 13 February 2025**
Director Lead	**Amanda Stanford, Group Chief Nurse**
Contact Officer / Author	**Yvonne McGrath, Group Director of Midwifery**
Title of Report	Maternity & Neonatal Assurance Reports – NLAG & HUTH
Executive Summary	Maternity & Neonatal Assurance report provides an overview of quality and safety activity and provides assurance against national key indicators. 1. Key risk at HUTH regarding PMRT which has resulted in declaring non-compliance with this safety action 1 of MIS Year 6 at present. NLAG declaring compliance for all 10 Safety Actions. 2. Additional funding secured to stabilise the leadership structure at HUTH resulting in compliance with Safety Action 5. 3. LMNS have confirmed for both HUTH and NLAG that compliance for Saving Babies Lives for MIS Year 6 has been achieved in line with locally agreed trajectories. 4. Key risks regarding recruitment challenges across the group. 5. Maternity Survey results shared in assurance report.
Background Information and/or Supporting Document(s) (if applicable)	MIS Year 6 Progress Report MIS Year 6 Board declaration – HUTH & NLAG Claims Scorecard Triangulation Q3 – HUTH & NLAG Trust Board PMRT Report Q3 – HUTH & NLAG
Prior Approval Process	
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	[insert, if applicable]
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ü Assurance ☐ Other – please detail below:

Maternity & Neonatal Safety Assurance Report

Yvonne McGrath

January 2025

Contents

1: Executive Summary & Highlight Report

Executive Summary: Maternity and Neonatal Services Progress Report

This report provides an update on the ongoing developments, achievements, and challenges within maternity and neonatal services across Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG). The focus remains on enhancing safety, compliance, and quality of care while addressing workforce and service user feedback.

Key Highlights

1. **Maternity and Neonatal Safety Improvement Plan (MatNeoSip):**
    - Progress is underway to integrate local and national safety initiatives.
    - Plan on Page poster shared with this months MNAG pack
2. **CNST MIS Year 6 Compliance ("10 Steps to Safety"):**
    - HUTH: SA1 issue identified and NHSR contacted and awaiting feedback
    - NLAG: On track to submit compliance with all ten Safety Actions.
3. **Training Compliance:**
    - Both trusts achieved over 90% compliance in key areas, including fetal monitoring and emergency training, meeting year six requirements of the Maternity Incentive Scheme (MIS).
4. **Safety Monitoring and Incident Management:**
    - Reviews of perinatal deaths, moderate harm incidents, and duty of candour compliance are consistently conducted.
5. **Saving Babies' Lives Care Bundle (Version 3):**
    - HUTH achieved 91% compliance; NLAG reached 81%, with ongoing improvement work targeting full implementation by March 2026.
6. **Maternity and Neonatal Dashboards:**
    - Development of comprehensive dashboards is progressing, including key indicators like workforce metrics and risk management trends.

Positive Developments

- Funding agreed to stabilise leadership structure and achieve full compliance with SA5 (HUTH) and re-working of ground floor finances following funding of triage has released enough funding to support a Pre-term Birth Leader Midwife (Pan-Group) extra support for the Diabetes team and Fetal Monitoring**.**
- Appointment of Perinatal Pelvic Health Midwife (pan-group), Practice Development Midwife (HUTH) and substantive Ward Manager (NLAG-SGH)
- MNSI- Letter of Concerns- now closed (letter in MNAG pack)

Areas of Concern

- **HUTH:**
    - Induction of Labour

  - Recruitment challenges- rotational advert 125 applicants only possible to shortlist 6.
- **NLAG:**
  - Capacity issues in antenatal clinics and day units.

Service User Feedback

- Feedback from Friends and Family Tests (November 2024) reflects high levels of satisfaction:
  - HUTH: 96.2% positive feedback for maternity services.
  - NLAG: 94.6% positive feedback for maternity; 100% for neonatal care.
- Key concerns include inconsistent advice from staff and inadequate environments for sensitive discussions.

Conclusion

While significant strides have been made in training, safety compliance, and quality improvement projects, challenges remain in staffing, environmental conditions, and leadership stability. Both trusts are committed to addressing these issues through strategic initiatives, ongoing monitoring, and engagement with staff and service users.

Item 2: Key highlights

2.1 Maternity and Neonatal Safety Improvement Plan (MatNeoSip)

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

2.2 CNST MIS Year 6: 10 Steps to Safety

Hull University Teaching Hospitals NHS Trust

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

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

Safety action	Red	Amber	Green	Blue	
1 National Perinatal Mortality Review Tool					Q3 2024/25 PMRT report to be discussed at Trust Board in February 2025. Issue identified awaiting NHSR response
2 Maternity Services Data Set (MSDS)					Save Dec 24 Trust Board minutes.
3 Transitional Care Services					
4 Clinical Workforce Planning					Save Dec 24 Trust Board paper regarding correction in locum paper and consultant attendance audit.
5 Midwifery Workforce Planning					
6 SBLCB V3					
7 Service User Feedback / Co-produced Services					Save Dec 24 Trust Board minutes.
8 Training					Save Dec 24 Trust Board minutes regarding the Anaesthetic staff action plan.
9 Floor to Board					Q3 2024/25 Claims Scorecard – to go to Trust Board in February 24, require minutes to evidence discussion.
10 MNSI / Early Notification Scheme					
Total	**0**	**0**	**7**	**3**	

Northern Lincolnshire and Goole NHS Trust

Safety action	Red	Amber	Green	Blue	Comments/ Actions being taken
1 National Perinatal Mortality Review Tool					Q3 2024/25 PMRT report to be taken to Trust Board in February 2025.
2 Maternity Services Data Set (MSDS)					Save Dec 24 Trust Board minutes
3 Transitional Care Services					
4 Clinical Workforce Planning					
5 Midwifery Workforce Planning					
6 SBLCB V3					
7 Service User Feedback / Co-produced Services					Save Dec 24 Trust Board minutes
8 Training Plan					
9 Floor to Board					Q3 2024/25 Claims Scorecard – to go to Trust Board in February 24, require minutes to evidence discussion.
10 MNSI / Early Notification Scheme					New case reported November 2024, details of case in MNAG report taken to Trust Board in December 2024 – awaiting minutes.
Total	**0**	**0**	**5**	**5**	

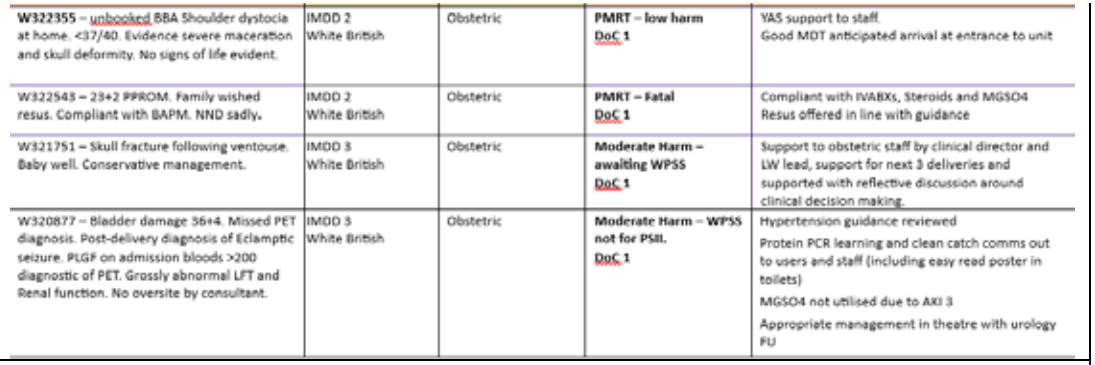
2.3 Perinatal Quality Surveillance Model

Hull University Teaching Hospitals NHS Trust

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

Maternity Support Programme	Yes

Data measure	November 2024
Findings of review of all perinatal deaths using the real time data monitoring tool	3 cases reviewed in November. Care graded A/B. Neonatal attendance and external attendance. Themes: Porcine use in LMWH. CNST compliance 100%
Number of cases referred to MNSI/ENS	MNSI referrals November - 0
Family's informed of referral to MNSI/ENSR	Yes
Findings of review of all cases eligible for referral to MNSI	MI - 038040 - delayed IOL 5 days (interview stage), MI - 038053 Interview stage, MI-038632 Interview stage Unbooked, Romanian, CTG concerns – MNSI rejected due to lack of family engagement and de-logged with patient safety team.

Number of incidents graded as moderate or above and what action is being taken	
Compliance with duty of candour	Yes
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively	Reviewed daily and plans put in place to mitigate risk e.g.double pay incentive, use of mutual aid across the group.

Midwifery staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	20575.75	17064.75	82.9%

Midwifery staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	8147.50	5712.38	70.11%

Neonatal staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	16577.50	10968.25	66.16%

Neonatal staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	872.50	513.50	58.85%

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	Staff struggling without a Ward Manager on Rowan Ward- funding now agreed and advert will shortly be released.

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	November 2024
Findings of review of all perinatal deaths using the real time data monitoring tool	6 perinatal deaths occurred in Q3 (Oct – Dec 24), 2 were for notification only, 4 are being/will be reviewed through the PMRT processes. All 6 have been notified to MBRRACE. Key themes identified from Q2 cases PMRT or continued from previous quarterly reviews are as follows: · Paediatrician not called soon enough for delivery despite end of life care pathway plan in place. · Mother not referred for uterine artery doppler or serial scans despite previous hypertension. · Kleihauer bloods not tested · All Postnatal bloods and investigations not being taken.
Number of cases referred to MNSI/ENS	0

Family's informed of referral to MNSI/ENSR	N/A		
Findings of review of all cases eligible for referral to MNSI	N/A		
Compliance with duty of candour *(within 10 working days)*	N/A		
Number of incidents graded as moderate or above / action taken	1		
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 %
	11,367.0	10,111.7	89.0%
Midwifery staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	4,605.0	3,161.6	68.7%
Neonatal staffing *(Registered Nurses and Midwives)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	5,865.0	4,769.8	81.3%
Neonatal staffing *(Unregistered Care Staff)*	Total Planned Hours	Total Actual Hours	Fill Rate %
	2,760.0	2,299.8	83.3%
Obstetrician staffing - cover on the delivery suite, gaps in rotas	100% compliant – no gaps identified.		
Service User Voice feedback	Please refer to body of report		
Staff feedback from frontline champions and walk-abouts	Overall positive feedback about the rollout of Badgernet. Maternity teams feeling burnt out.		
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	No		
Coroner Reg 28 made directly to the Trust	0		
Progress in achievement of CNST 10	Please refer to body of report		

2.5 Maternity and Neonatal Dashboards

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

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

These indicators will be underpinned with SPC charts where relevant to support recognition of themes, trends and risk and enable appropriate management and quality improvement. This process will be replicated for NLAG.

Item 3: In month developments and updates

3.1 Maternity and Neonatal updates

Positive News

- Funding agreed to stabilise leadership structure and achieve full compliance with SA5 (HUTH) and re-working of ground floor finances following funding of triage has released enough funding to support a Pre-term Birth Leader Midwife (Pan-Group) extra support for the Diabetes team and Fetal Monitoring**.**
- Appointment of Perinatal Pelvic Health Midwife (pan-group), Practice Development Midwife (HUTH) and substantive Ward Manager (NLAG-SGH)
- MNSI- Letter of Concerns- now closed (letter in MNAG pack)
- DPI now only by exception at HUTH and same process as NLAG for authorisation in place.
- Positive MNVP 15 Steps at Scunthorpe awaiting formal report.
- NLAG have successful in Stage 1 of the BFI Accreditation process for Neonatal units.
- Visit by Regional Chief Midwife to HRI on 18th of December.

Areas of Concern- Hull Royal Infirmary

- Diabetes a factor in 3/6 term stillbirths- review and deep dive ongoing considering diabetes and health inequalities to be shared in February MNAG

Areas of Concern- Northern Lincolnshire and Goole NHS Foundation Trust

- Concern raised via FTSUG at DPOW- plan for Listening Events and to review number of staff who have had sickness absence related to work related stress.

Areas of Concern- Group Wide

- Recruitment challenges- rotational advert 125 applicants only possible to shortlist 6. Plan to meet with Recruitment and develop Group-wide maternity recruitment plan.

Safety Champion Walkabouts in December

- 11th December 2024 at HUTH

Safety Champion time-out day planned on 27th January to further develop the role of Maternity & Neonatal Safety Champion.

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 – December 2024 (Incorporating K2 Competency Assessments - Intelligent Intermittent Auscultation, Antenatal CTG Intrapartum CTG, Human factors).	
Staff Group	**HuTH Compliance**
Obs consultants & SAS grade doctors	94%
Other medical staff on obs rota *(commenced **before** 01 July 24)*	100%
Other medical staff on obs rota *(commenced **after** 01 July 24)*	100%
Midwives	98%

PROMPT – December 2024 To include Live Skills Drills (Shoulder Dystocia, cord prolapse, APH, PPH, Eclampsia, vaginal breech), Sepsis, Deteriorating Patient.	
Staff Group	**HuTH Compliance**
Obs consultants & SAS grade doctors	100%
Other medical staff on obs rota *(commenced **before** 01 July 24)*	95%
Other medical staff on obs rota *(commenced **after** 01 July 24)*	60%
Midwives	99%
Midwifery Support Workers	100%
Anaesthetic consultants	100%
Anaesthetic staff on Obs rota *(commenced **before** 01 July 24)*	100%
Anaesthetic staff on Obs rota *(commenced **after** 01 July 24)*	*0%
*For rotational staff that commenced work on or after 1 July 2024 a lower compliance will be accepted. 6 anaesthetists commenced in November 2024, all 6 have been booked on training in January 2025, this is within the 6-month period grace period from their start-date as per MIS requirements. The action plan was shared at Trust Board in December 2024 for approval.	

Neonatal Resuscitation – December 2024	
Staff Group	**HuTH Compliance**
Neonatal/paediatric consultants / SAS grade doctors	90%
Neonatal/paediatric junior doctors *(commenced **before** 01 July 24)*	100%
Neonatal/paediatric junior doctors *(commenced **after** 01 July 24)*	Counted in above
Neonatal nursing staff / senior nurses	99%
Midwifery Support Workers	Not applicable
Advanced neonatal nurse practitioners	100%
Midwives	98%

Compliance has dropped with new obstetric medical staff starting at the trust and awaiting their previous compliance or booking onto training. Starting in January at HUTH, changes have been made to program delivery, aiming to improve compliance and monitoring of staff's mandatory training. Staff will now be assigned all mandatory training within a one-week period.

Northern Lincolnshire and Goole NHS Foundation Trust

Fetal Monitoring – December 2024 (Incorporating K2 Competency Assessments - Intelligent Intermittent Auscultation, Antenatal CTG Intrapartum CTG, Human factors).			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	100%	100%	100%
Other medical staff on obs rota *(commenced before 01 July 24)*	100%	100%	100%
Other medical staff on obs rota *(commenced after 01 July 24)*	100%	100%	100%
Midwives	96%	97%	97%

PROMPT – December 2024 To include Live Skills Drills (Shoulder Dystocia, cord prolapse, APH, PPH, Eclampsia, vaginal breech), Sepsis, Deteriorating Patient.			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	100%	100%	100%
Other medical staff on obs rota *(commenced **before** 01 July 24)*	100%	100%	100%
Other medical staff on obs rota *(commenced **after** 01 July 24)*	100%	100%	100%
Midwives	96%	97%	96%
Midwifery Support Workers	98%	100%	99%
Anaesthetic consultants	92%	92%	92%
Anaesthetic staff on Obs *rota* *(commenced **before** 01 July 24)*	100%	92%	96%
Anaesthetic staff on Obs rota *(commenced **after** 01 July 24)*	N/A	N/A	N/A

Neonatal Resuscitation – December 2024			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Neonatal/paediatric consultants / SAS grade doctors	86%	100%	93%
Neonatal/paediatric junior doctors *(commenced **before** 01 July 24)*	100%	100%	100%
Neonatal/paediatric junior doctors *(commenced **after** 01 July 24)*	100%	100%	100%
Neonatal nursing staff / senior nurses	100%	100%	100%
Midwifery Support Workers	Not applicable		
Advanced neonatal nurse practitioners	100%	-	100%
Midwives	98%	94%	96%

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?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
038040	IMDD 2 White British	No	No	Yes - sent 25/09/24	Yes	MNSI have contacted Family. Interviews conducted.
038053	IMDD 1 White British	No	No	Yes - sent 29/05/24	Yes	MNSI have contacted Family. Bereavement contact continues. Interviews conducted.
038632	IMDD 4 Pakistani	No	No	Yes - sent 15/10/24	Yes	MNSI referral consent gained and made. Notes shared and awaiting interview dates (January).

5.2 Detail of incidents graded moderate or above and rapid reviews

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
W32830 38/40 Stillbirth	IMDD 10 White British	Obs	**Fatal**	MLC. MIRM no learning identified. PMRT process. DoC followed.
W324688 39+2 Stillbirth	IMDD 1 Asian – Pakistani	Obs	**Moderate**	GDM – service thematic review being performed. Escalated to HoM and DoM and CD. IOL at 40+ planned. ECV performed. PMRT process. DoC followed.

W324948/W324820 Neonatal Death 23+2	IMDD 9 White British	Neonatal/Obs	**Fatal/Moderate**	Abnormal dopplers and IUGR from 20/40. Guarded prognosis. APH and SVD. MIRM planned 03/01/2024.
W324995 MOH 7.2l Interventional radiology and ITU admission	IMDD 6 White British	Obs	**Moderate**	MIRM review planned 03/01/2024. Service user back within maternity services. Verbal DoC provided.
W322962 – Skull fracture following ventouse/NBFD	IMDD 2 White British	Obs	**Moderate**	Sequential instrumentation due to consent being denied for EMLSCS. MIRM review. DoC followed.

Northern Lincolnshire and Goole NHS Foundation Trust

5.3 Maternity & Newborn Safety Investigation cases (ongoing)

MNSI number	Qualify for EN? If yes, include reference	Have the family received notification of role of MNSI/EN?	Written Duty of Candour complete	Compliant with Duty of candour?	Details/update
MI-039094	No	Yes	Yes – posted 29/11/24	Yes	No safety concerns identified at rapid review.
MI-039193	No	Yes	Not yet sent – consent for investigation required	N/A	Awaiting consent from family for MNSI investigation.

5.4 Detail of incidents graded moderate or above and rapid reviews

Incident number and detail	IMD/Ethnicity	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
33351 – concerns around neonatal resuscitation	IMDD 2 White British	Neonatal	Low	Clinical lead to discuss with the neonatal team regarding poor documentation.
34802 – Intrapartum stillbirth	IMDD 2 White British	Obstetric	No harm	Timings not accurate within the documentation for escalation and MO management. Discussed for dissemination at Manager's meeting.

Item 6: Listening to our staff

- Listening events at Scunthorpe and Hull with further events planned
- Ongoing work on Maternity Safety Champion Culture Improvement Plan
- Score survey feedback events for staff have now been completed and sessions with the Quad continue to develop an action plan.
- Ongoing work to develop action plan from staff survey findings.

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

Northern Lincolnshire and Goole NHS Foundation Trust

% of interventions fully Implemented	Assessment one	Assessment two	Assessment three	Assessment four	Assessment five	Assessment Six
Review quarter	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Assurance review date	25 Oct 23	18 Dec 23	20 Mar 24	10 June 24	19 Sept 24	11 Dec 24
Element 1: Smoking in pregnancy	10%	70%	70%	70%	90%	80%
Element 2: Fetal growth restriction	55%	70%	90%	90%	85%	90%
Element 3: Reduced fetal movements	50%	100%	100%	100%	100%	100%
Element 4: Fetal monitoring in labour	40%	80%	80%	80%	100%	80%
Element 5: Preterm birth	48%	70%	81%	67%	74%	74%
Element 6: Diabetes	17%	67%	67%	83%	83%	83%
TOTAL	**41%**	**71%**	**81%**	**77%**	**83%**	**81%**

Following peer validation of evidence submitted for quarter 2 2024/25 by the LMNS, a grading of "significant assurance" was assigned with an overall compliance of 81% for all 6 elements. The LMNS have confirmed that compliance with MIS Year 6 has been achieved through best endeavours and sufficient progress towards full implementation in line with locally agreed trajectories. 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	June '24	Sept '24	100%	1	5/5	100%
Element 5	81%	22/27			92%	3	25/27	100%
Element 6	67%	4/6			84%	1	5/6	100%
Total	81%	57/70			90%	7	65/70	100%

Hull University Teaching Hospitals NHS Trust

% of interventions fully implemented	Assessment one	Assessment two	Assessment three	Assessment four	Assessment five	Assessment Six
Review quarter	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25	Q2 2024/25
Assurance review date	13 Oct 23	18 Dec 23	19 Mar 24	10 Jun 24	18 Sept 24	11 Dec 24
Element 1: Smoking in pregnancy	30%	40%	50%	60%	70%	80%
Element 2: Fetal growth restriction	45%	50%	90%	95%	95%	100%
Element 3: Reduced fetal movements	0%	50%	50%	50%	50%	100%
Element 4: Fetal monitoring in labour	0%	20%	20%	20%	40%	80%
Element 5: Preterm birth	41%	48%	67%	70%	67%	89%
Element 6: Diabetes	17%	17%	83%	83%	83%	100%
TOTAL	**34%**	**43%**	**69%**	**73%**	**74%**	**91%**

Following peer validation of evidence submitted for quarter 2 2024/25 by the LMNS, a grading of “significant assurance” was assigned with an overall compliance of 91% for all 6 elements. The LMNS have confirmed that compliance with MIS Year 6 has been achieved through best endeavours and sufficient progress towards full implementation in line with locally agreed trajectories. 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	June '24	Sept '24	100%	1	5/5	100%
Element 5	81%	22/27			92%	3	25/27	100%
Element 6	67%	4/6			84%	1	5/6	100%
Total	81%	57/70			90%	7	65/70	100%

Item 8: Avoiding Term Admissions to NICU

Northern Lincolnshire and Goole NHS Foundation Trust

% of term babies that required admission to the NNU (December 2024)				
Site	Number of Births	Number of Births (≥37 weeks gestation)	Number of Term Baby Admissions to NNU	**%**
DPOW	166	146	9	5.4%
SGH & GOOLE	129	113	5	3.8%

Hull University Teaching Hospitals NHS Trust

% of term babies that required admission to the NNU (December 2024)				
Site	Number of Births	Number of Births (≥37 weeks gestation)	Number of Term Baby Admissions to NNU	**%**
HUTH	385	364	11	2.80

Item 9: Service User Feedback

9.1 Hull Royal Infirmary Friends and Family Test – November 2024

For November 2024 a total of 79 responses were received as part of the Friends and Family Test for Maternity Services. 84.8% of the feedback was positive.

Maternity Services	
Ward/area	**Number of responses**
Midwifery Led Unit	5
Maple ward	2
Rowan Ward	58
Labour and Delivery Suite	5
Community Midwifery Team	Not available
Rainbow/bereavement Suite	9

Maternity Services - Trust wide		
Response option	**Number**	**Percentage**
Very good	61	82%
Good	10	14%
Neither good nor poor	3	4%
Poor	1	1%
Very poor	0	0%
Don't know	0	0%

Some of the comments received are detailed below:

"The rainbow service really helped me, they made a care plan for me. Made the right appointments for me and on time. I always had someone to talk to. The whole team is made up of exceptional and amazing individuals who are so dedicated and supportive to people."

"Professional, friendly and approachable midwifery staff from Induction Clinic/Maple Ward to Labour Ward, theatre and recovery and post-natal Rowan Ward. Midwives were so thorough in all procedures undertaken and explained everything in depth. Felt safe and well looked after throughout. Also given a very detailed and informative discharge process."

"Staff were very patient and reassuring considering how anxious I was. I feel like mine and my baby's best interests were always at heart, even though I ended up having an emergency c section. The care on Rowan Ward was phenomenal and I really appreciate all of the support I received regarding breastfeeding. Thanks again, you're all doing a fantastic job."

"Whole induction process was well explained. Had my waters broken and my midwife Hazel was fantastic. Explained everything to me and my partner and involved him in my care. Anaesthetist Francis was fantastic and efficient at putting epidural in. Jo was fab when she relieved Hazel for a break. Unfortunately, my birth ended in an emergency C-section due to ctg concerns but again everyone involved was fantastic. Cathy the coordinator with Hazel kept me and my partner calm and informed. The registrar Sima went through everything and the theatre team were fab!"

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

Neonatal Care

For November 2024 a total of 11 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	70%
Good	3	30%
Neither good nor poor	0	0%
Poor	0	0%
Very poor	0	0%
Don't know	0	0%

Some of the comments received are detailed below:

NICU DPOW:

"The vibe on special care is wonderful for anyone visiting on there. The staff are very special dedicated people. Thank you from myself and my foster baby".
"The team are excellent, they really care for the babies. Carol and Dawn would be great godmothers, kind and nice, but no nonsense in directing us parents. We'd also like to mention the cleaners, during a difficult moment they offered kindness and compassion to us - everyone is above standard. We really can't thank everyone enough for the care and time. Unfortunately we can't remember everyone's names, but stand out excellent members of the team for us are Melissa, Michelle, Selina/Jo, Sabrice, Hannah, Kieley/Phillipa".

"My baby was born at 35+5 by cat 1 section. We had a week's hospital stay but I was discharged before my baby and the support me and my partner received has improved every day since birth. I can't thank you all enough, truly amazing reassurance. As it is our first baby everybody has supported and answered any questions we have had. There is not enough room to write out our stay but we thank you all so very much".

NICU SGH:

"Genuinely couldn't have had a better experience with this team. The care wasn't only for our baby but also we was showered with care and love. Fantastic overall 11/10".

"You have been amazing the whole team very supporting and helpful".

Maternity Care

For November 2024 a total of 49 responses were received as part of the Friends and Family Test for Maternity Services across the Trust.

94.6% of the feedback was positive.

Maternity – Trust wide		
Response option	**Responses**	**Percentage**
Very good	45	92%
Good	3	6%
Neither good nor poor	0	0%
Poor	1	2%
Very poor	0	0%
Don't know	0	0%

Some of the comments received are detailed below:

Maternity DPOW:

"All the midwives and nurses that were involved and help my partner bring our beautiful little girl into the world were all nothing less than amazing! A massive thank you to Beth, Becki. Danielle, Lauren and Tracey. What an amazing experience".

“All staff lovely, friendly and approachable and keeping us informed with what's going on throughout our stay here. Couldn't do enough for us and baby and all very supportive. 100% recommend this incredible team to anyone”.

“Exemplary care from every member of staff that helped me and my little boy. Nothing was ever too much trouble and I felt listened to at all stages of my pregnancy”.

Maternity Goole:

None received.

Maternity SGH:

“Maternity (ward 26) has been amazing throughout my stay. Extremely caring and reassuring during a difficult and emotional time, making my time on the ward so much easier”.

“Amazing nurses and doctors. The only thing I don't like is that I always hear different opinions from multiple doctors without even 2 opinions to coinciding, and it takes a long time to receive a concrete answer”.

“Staff are very polite and helpful. Always explain what's happening etc. They all use person-centered approach and they uphold dignity and respect”.

Item 10: Maternity Survey CQC Surveys

Northern Lincolnshire and Goole NHS Foundation Trust

The 2023 survey results action plan has been co-produced between maternity services and Maternity and Neonatal Voices Partnership (MNVP) Lead.

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

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

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

Hull University Teaching Hospitals NHS Trust

The 2023 survey action plan has been co-produced between maternity services and Maternity and Neonatal Voices Partnership (MNVP) Lead.

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

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

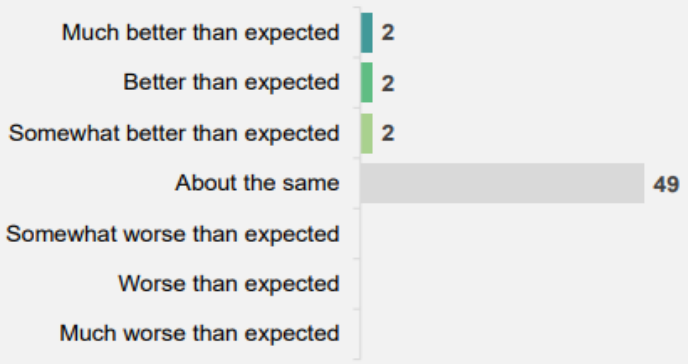
The action plan is monitored by Safety Champions and LMNS Board. **For further details please refer to appendix A.**

2024 Maternity Survey Results Northern Lincolnshire and Goole NHS Foundation Trust

Summary of findings

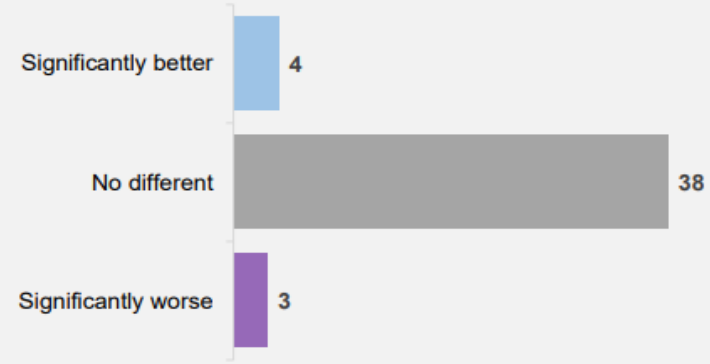
Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2024 vs 2023.



2024 Maternity Survey

Results for Northern Lincolnshire And Goole NHS Foundation Trust

Where service user experience is best

- ✓ **Postnatal Care: Care in the ward after birth:** Partner or someone else close to service user was able to stay as much as the service user wanted
- ✓ **Care after birth:** Midwife/midwifery team being aware of service user and baby's medical history
- ✓ **Care after birth:** Frequency of seeing or speaking to a midwife
- ✓ **Care after birth:** Being able to get support or advice about feeding baby during evenings, nights or weekends
- ✓ **Labour and Birth: The staff caring for you:** Left alone by midwives or doctors at a time when it worried them

Where service user experience could improve

- o **Postnatal Care: Care in the ward after birth:** Delays to discharge on the day of leaving hospital
- o **Care after birth:** Being given information about physical recovery after birth
- o **Triage: Assessment and evaluation:** Felt that concerns were taken seriously
- o **Postnatal Care: Care in the ward after birth:** Healthcare professionals doing everything they could to manage service user's pain
- o **Antenatal care: Antenatal check ups:** Midwives or doctor aware of service user's medical history

2024 Maternity Survey Results Hull University Teaching Hospitals

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.

Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2024 vs 2023.

2024 Maternity Survey

Results for Hull University Teaching Hospitals NHS Trust

Where service user experience is best

- ✓ **Postnatal Care: Care in the ward after birth:** Delays to discharge on the day of leaving hospital
- ✓ **Labour and Birth: The staff caring for you:** Feeling that concerns raised were taken seriously
- ✓ **Care after birth:** Being able to get support or advice about feeding baby during evenings, nights or weekends
- ✓ **Feeding your baby:** Midwives giving enough support and advice to feed their baby
- ✓ **Labour and Birth: The staff caring for you:** Being able to get a member of staff to help when needed

Where service user experience could improve

- **Postnatal Care: Care in the ward after birth:** Partner or someone else close to service user was able to stay as much as the service user wanted
- **Antenatal care: Start of your pregnancy:** Service users offered choice about where to have their baby
- **Antenatal care: Antenatal check ups:** Midwives or doctor aware of service user's medical history
- **Antenatal care: Start of your pregnancy:** Information from midwife or doctor to help service users decide where to have their baby
- **Labour and Birth: Your labour and birth:** Being involved in the decision to be induced

Item 11: Screening Key Performance Indicators

Hull University Teaching Hospitals

Indicator	Performance	Acceptable Threshold
ST2: Timeliness of antenatal screening	80.7%	≥50.0%
ST3: Completion of FOQ	100%	≥95.0%
NB2: Avoidable repeat NBS test	3.9%	<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	99.7%	≥95.0%
FA3: Coverage T21/T18/T13 screening	2	Not set
FA2: Coverage fetal anomaly ultrasound	99.6%	≥90.0%
NIPT S01: Coverage NIPT	91.7%	Not set

Northern Lincolnshire and Goole NHS Trust

Indicator	Performance	Acceptable Threshold
ST2: Timeliness of antenatal screening	78.9%	≥50.0%
ST3: Completion of FOQ	96.9%	≥95.0%
NB2: Avoidable repeat NBS test	2.6%	<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	98.9%	≥90.0%
NIPT S01: Coverage NIPT	81.0%	Not set

Item 12: Triangulation of Claims Scorecard Q3 2024/25

12.1 Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust - Maternity Incentive Scheme (SA9) Quarter 3
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 Q3 24/25

Claims opened:

- Alleged delay in diagnosis and management of ectopic pregnancy, resulting in rupture, surgery and removal of right fallopian tube.
- Allegations of Unsatisfactory management of anaesthesia prior to a medical termination of pregnancy including allegations of extravasation/arm injury leading to allegations of PTSD.

Existing claims: 22

Claims closed:

- Claim for wrongful birth. Alleged negligent ultrasound resulting in birth of baby with campomelic dysplasia. **Damages paid – Nil**
- Child born on 20/1/2024 which had a normal birth Apgar score 01. **Damages paid – Nil**

Incidents Q3 24/25

Top 5 incident by volume:

- Error /omission in health record **(23)**
- Unexpected admission to NICU **(20)**
- Below Safe Staffing Levels Following Escalation **(17)**
- Post partum haemorrhage (PPH) >1500mls **(17)**
- Staffing levels affecting patient care / monitoring of patients **(16)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **449**

Complaints Q3 24/25

There have been 3 new complaints received relating to the following:

- Communication – failure to liaise with a patient
- Delay in treatment

Clinical Audits Registered Q3 24/25

- Goole and Midwifery Led Unit – Documentation Audit
- SBL Element 1 (Q4): Reducing Smoking in Pregnancy
- SBL Element 2 (Q4): Fetal Growth Restriction
- SBL Element 3 (Q4): Reduced Fetal Movements
- SBL Element 4 (Q4): Fetal Monitoring
- SBL Element 5 (Q4): Pre-term Births
- SBL Element 6 (Q4): Type 1 & Type 2 Diabetes in Pregnancy

Deep Dive Reviews Q3 24/25

Complete:
Pre-term Births – Focusing on identifying any contributing factors, missed opportunities and to review the indications/appropriateness of pre-term inductions.

In progress:
None.

Learning Q3 24/25
• Further training and support was given on Badgernet • Blue wristbands to be applied for each thing left inside a patient to aide identification for removal • Never event – simulation performed and draft report stage

Themes Q3 24/25
• The introduction of Badgernet has caused issues • Staffing levels - mitigated with escalation policy. No harm caused by staffing levels.

Action Plan Q3 24/25	Not started / In progress / Complete	
Change in policy and way of working for PPH to include the use of blue wristbands for any retained objects.	January 2025	
Further support given for users for Badgernet.	December 2024	

12.2 Hull University Teaching Hospitals NHS Trust

Hull University Teaching Hospital - Maternity Incentive Scheme (SA9) Quarter 3

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 Q3 24/25

Claims opened:

- Alleged failure to perform fetal monitoring which led to a delay in delivery of the baby resulting in a hypoxic brain injury and subsequent death.
- Alleged failure to manage induction and labour resulting in a major obstetric haemorrhage plus avoidable extravasation injury around site of the cannula causing PTSD after obstetric haemorrhage.

Existing claims: 36

Claims closed:

- Alleged failure to perform a rectal suction biopsy at any point to look for ganglion cells and exclude possibility of Hirschsprung disease. If done so, it would have avoided anastomotic leak, leading to sepsis and death. **Damages paid – Nil**
- 37 week twins born by cat 2 section, ? fetal tachycardia in Twin 1. Baby born pale and floppy, no respiratory effort. Required intubation and CPR in theatre, admitted to NICU at 30 mins of age for ongoing ventilation and active cooling. **Damages paid – Nil**

Incidents Q3 24/25

Top 5 incident by volume:

- Term NNU admissions **(38)**
- Post partum haemorrhage (PPH) >1500mls **(30)**
- IUT for delay in IOL **(10)**
- Stillbirth **(6)**
- 3rd and 4th degree tears **(6)**

Number of incidents reported on DATIX for Obstetrics / Maternity: **291**

Complaints Q3 24/25

There have been 4 new complaints received relating to the following:

- Communication
- Delay in treatment
- Injury to baby at delivery

Clinical Audits Registered Q3 24/25

- Perinatal optimisation (Intrapartum antibiotics and steroids in preterm labour)
- Births <3rd Centile and >37+6 Weeks Gestation with no risk Factors Identified
- Low Risk Fetal Growth Restriction - Fundal Height Assessment by 28+6 weeks Gestation
- Percentage of Pregnancies where a SGA Fetus (between 3rd and 10th centiles) is Antenatally Detected
- Percentage of Babies >3rd Birthweight Centile Born <39 weeks gestation where Growth Restriction was Suspected.

Deep Dive Reviews Q3 24/25

Complete:

Delay in Induction of Labour - *Focusing on length of wait for IOL*

Born Before Arrival – *Focusing on theme identification following rise in cases.*

In progress:

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

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

Learning Q3 24/25
• ATAIN decrease in admission rate – CAT 3/4 caesarean section deep dive being conducted • When to take cord gas SOP approved • IUT for delays in IOL now being reported on DATIX • Better use of terbutaline • Never event – simulation performed and draft report stage

Themes Q3 24/25
• ATAIN decrease in hypothermic admissions • + Proteinuria not being sent for PCR • Rise in stillbirths within diabetic service users • Delay in IOL and ARM >24hrs

Action Plan Q3 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	

Item 13: Quality Improvement Projects

Early Breastmilk Feeding Project

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

Project aims:

- To increase the number of babies who receive breastmilk within the first 2 hours of life by 30% within the first 3 months of the project go live.
- To standardise the quality and consistency of conversations around breastfeeding within community and antenatal setting (including medics)

- To prevent admission on the Transitional Care Unit / Neonatal unit
- To reduce the length of stay of babies on Transitional Care and the Neonatal unit.

Progress was shared with the LMNS in November 2024 and satisfied the requirements for MIS year six.

A further meeting took place in January 2025 with the Heads of Midwifery, Infant Feeding Leads and Patient Safety Midwives to review the aims and targets initially agreed. It was provisionally agreed to reduce the original inclusion criteria and focus on improving early breastfeeding rates in mothers with diabetes in pregnancy only. Baseline data is available for HUTH and has been requested for NLAG, once available a further meeting will take place in January 2025 to update the scope of the project.

Appendix A: Co-produced CQC Survey Action Plan

Hull University Teaching Hospital

Maternity Survey Action Plan 2023

Version 1.0

NHS Humber Health Partnership

No.	Recommendation	Actions / Key Milestones	Strategic Lead	Forecast Completion Date	Progress	RAG Status
The Start of your Care in Pregnancy						
1	**B3 – Were you offered a choice about where to have your baby?** **B4 – Did you get enough information from either a midwife or doctor to help you decide where to have your baby?** Choice of place of birth is discussed on an individual basis with the community midwife at the booking appointment and then reviewed at opportunistic times during the antenatal period. Choice around place of birth can be changed by the woman at any point in her pregnancy. Decision around choice of home birth is undertaken with reference to Low risk midwifery guidelines and antenatal risk assessment, and women are advised of their risk factors. There is information on the Trust and LMS website to support women in their choices.	Review Booking Letter and make changes	AH/SS	Aug-24	06.02.24 – Badgernet implemented in community. Currently some families still using paper notes. Booking letter updated to reflect badgernet changes. 11.03.24 – Badgernet rolled out to to inpatient care. 13.11.24 – Badgernet changes made, to explore pan group booking information. To D/W SW changes across the LMNS to align all information.	
		Ensure the LMNS choice video is on the HUTH site	LC	Jul-24	15.04.24 – MNVP transfer between units video shared with the trust for rolling videos. Still awaiting filming for trust video. 20.09.24 – found a midwife to film the video and edit. Just awaiting actual filming of video. 13.11.24 – videos are played within all areas of acuity (ADU,Triage and ANC).	
		Review LMNS website to ensure it is easily accessible	SW	Jul-24	March 24 – accessible information. 13.11.24 – access is possible and possible review due to pan group.	
		Explore the potential of inviting women before booking to carousel event to explore choice and place of birth	GH/AH	Sep-24	13.11.24 – families of all gestations are invited and attend the carousel event	
		Look at carousel event across the Group	SW/LC	Sep-24	Jan 24 – carousel advertised on social media. 13.11.24 – fully implemented within HUTH.	
		Longer term plan review booking information informing women they are booking for the LMNS/ new branding and information across LMNS	SW	Dec-24	15.04.24 – MNVP video on inutero and Ex-utero transfer shared with the trust. 13.11.24 – Badgernet changes made, to explore pan group booking information. To D/W SW changes across the LMNS to align all information.	

Antenatal Check Ups						
2	**B7. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?** During every midwifery/medical contact with the woman and her family it is considered safe and good practice to question women in relation to their current and past medical history. This can be misinterpreted by the woman as the professional not been aware of her medical history. The group is currently implementing BadgerNet digital system to support personalised care planning.	Implementation of BadgerNet	Digital Midwife/Midwifery Managers	Mar-24	06.02..24 - Badgernet rolled out and implemented with community. 11.03.24 - Badgernet implemented with inpatient setting. 13.11.24 - fully implemented within HUTH.	
		Implementation of personalised care plan within BadgerNet	Digital Midwife/Midwifery Managers	Mar-24	06.02..24 - Badgernet rolled out and implemented with community. 11.03.24 - Badgernet implemented with inpatient setting. 13.11.24 - fully implemented within HUTH.	
		Feedback taken to the carousel event regarding the BadgerNet notes/and the App	JH	Jul-24	Monthly meetings with MNVP. 13.11.24 - regular feedback is taken from the MNVP and fed into the LMNS digital steering group.	
		Understand why the 20-week scan is not on the BadgerNet notes	LC	Aug-24	13.11.24 - continuing to use 2 systems and all scans are uploaded onto lorenzo. Scans are acknowledged within Badger and if escalation is required are documented within Badger.	
		Check if BadgerNet has the ability to translate leaflets into different languages and how many	Digital Midwife	Jul-24	Feb 24 - confirmed badgernet translates on roll out of badgernet. 13.11.24 - Badger translates into the familes chosen language.	
		Share learning across the Group for the implementation of BadgerNet at NLAG	Digital Midwife	Oct-24	Sept/Oct 24 - support from HUTH to implement the roll out of badgernet. 13.11.24 - digital midwife supported implementation of Badgernet within NLAG (pangroup).	
		Ensure reachdeck is publicized to families with additional needs for example language, literacy etc.	LC	Jul-24	Feb 24 - confirmed badgernet translates on roll out of badgernet. 13.11.24 - Badger translates into the familes chosen language.	
2.1	**B14 - Thinking about your antenatal care, were you involved in decisions about your care?**	Revisit personalised care plan that was developed across the LMNS	SW/LC	Oct-24	13.11.24 - personalised care plans are included within Badgernet.	
		Share video with midwives and women on personalised care planning	SW/LC	Oct-24	13.11.24 - videos are played within all areas of acuity (ADU,Triage and ANC).	
		Relaunch personalised care plan	SW/LC	Oct-24	13.11.24 - personalised care plans are included within Badgernet.	

Labour and Birth						
3	**C7 – At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?** "Comments about being sent home or 'turned away' as not far along enough, and feeling bad about going back and wasting midwives time".	Implementation of maternity telephone triage	JC/LC/WM	Nov-23	13.11.24 – fully implemented within HUTH.	
		Explore 24/7 telephone triage	JC/WM/RM	Oct-24	13.11.24 – central telephone system fully implemented to allow 24/7 telephone triage.	
		Visit to Southampton 16th July 2024 who have a group telephone triage model	LC/SW	Aug-24	Jan 24 – visit undertaken. 13.11.24 – action completed by Sallie and Lorraine.	
		Longer term aspirations for a group telephone triage	RM/YM/LC	Dec-24	13.11.24 – central telephone system fully implemented to allow 24/7 telephone triage in HUTH and exploring options of pan group telephone triage.	
Care in Hospital After Birth						
4	**D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?** Detailed Feedback from families "out of hours dads are not allowed on the ward to settle our loved ones in and to see what bed they are in which is inequitable". "My partner had a difficult birth and I was not able to stay to help with our baby"	Discuss feedback with PN manager and involve ward staff	CN	Sep-24	8.5.24 – 15 steps revisited. 13.11.24 – please refer to 15 steps spreadsheet.	
		Involve partners in birth revisited service if required and ensure they have support too.	SW/JC	Oct-24	8.5.24 – 15 steps revisited. 13.11.24 – birth afterthoughts clinics implemented and triaged by the LMNS.	
		Link dad representative to ward manager to work on collaborative post-natal QI projects	RS	Jul-24	8.5.24 – 15 steps revisited. Simon keen to have lots of input on the wards via MNVP. Maru 24 – Dad board put up. July 24 – Vending machines and hot drinks machine now on the ward.	
		Test some quick improvements of supporting partners to be able to settle their partners in to the ward overnight	TD	Jul-24	13.11.24 – continuing to explore the 'golden hour' on Rowan ward to support partners with that transition onto the ward.	
		Implement personalised planning for families with specific care needs with ward manager	CN	Oct-24	13.11.24 – personalised care plans are included within Badgernet.	
		Interim measure look at segregating the ward area for partners who stay over	TD	Oct-24	13.11.24 – continuing to explore the 'golden hour' on Rowan ward to support partners with that transition onto the ward.	
		Explore the feasibility of a partners facility on Rowan ward	CN	Dec-24	13.11.24 – cold drinks and food and hot drinks vending machine now on Rowan ward. Unable to have partner/family kitchen due to limited space on the ward.	
		Longer term aspiration plan to reintroduce dads staying overnight/ will need surveys and collaboration	TD	Dec-24	13.11.24 – MNVP dad group to aid collection of survey. Continuing to explore the 'golden hour' on Rowan ward to support partners with that transition onto the ward.	

Northern Lincolnshire and Goole NHS Foundation Trust

Maternity Survey Action Plan 2023

Version 2.0

NHS Humber Health Partnership

No.	Recommendation	Actions / Key Milestones	Strategic Lead	Forecast Completion Date	Progress	RAG Status
1	**D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?** Found partner was able to stay with them as long as they wanted (in hospital after birth) Trust 35% Picker average 57%	Revisit partners staying overnight at SGH (scope possibility of partitions)	Claire Brothwell (Maternity Matron SGH) Vicki Booth (Maternity Matron DPOW)	Aug-24	29/10/24 Claire Brothwell to arrange to meet with Kimberley Boyd (Lead for North & North East Lincolnshire Maternity & Neonatal Voices Partnership) to progress partners staying overnight at SGH. Partners are welcomed to stay overnight at SGH however the old estates available are not suitable currently. Re DPOW - partners have facility to stay overnight to support.	
		Review guidance re communication for partners	Shaliny Marjara (Acting Ward Manager - Ward 26 - SGH)	Aug-24	29/10/24 Leaflet in progress and will be ratified as per governance process.	

2	**F19. At the postnatal check-up (around 6-8 weeks after the birth), did the GP spend enough time talking to you about your own physical health?** Felt GP talked enough about physical health during postnatal check-up Trust 58% Picker average 70%	Add to agenda at Northern Lincolnshire Women and Children's Board	Nicola Foster (Head of Midwifery)	Aug-24	30/10/24 Discussed at LMNS Choice and Personalised Care working group (Nicola Foster) Northern Lincolnshire Women and Children's Board has been disbanded therefore unable to action as planned. Sallie Ward (LMNS midwife) has taken action to support communication to GP's (work ongoing within LMNS re communication with GP's)	
3	**F20. At the postnatal check-up (around 6-8 weeks after the birth), did the GP spend enough time talking to you about your own mental health?** Felt GP talked enough about mental health during postnatal check-up Trust 60% Picker average 72%	Add to agenda at Northern Lincolnshire Women and Children's Board	Nicola Foster (Head of Midwifery)	Aug-24	30/10/24 Discussed at LMNS Choice and Personalised Care working group (Nicola Foster) Northern Lincolnshire Women and Children's Board has been disbanded therefore unable to action as planned. Sallie Ward (LMNS midwife) has taken action to support communication to GP's (work ongoing within LMNS re communication with GP's)	
4	**B3. Were you offered a choice about where to have your baby?** Offered a choice of where to have baby Trust 65% Picker average 76%	Highlight to community midwifery teams re antenatal discussions including choice of where to have baby.	Michelle Smith (SGH community midwifery manager) Christine Page-Patrick (DPOW community midwifery manager)	Aug-24	9/10/24 Discussed at team leaders meeting. Community midwifery managers to cascade to community midwifery teams.	
5	**C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?** Partner / companion involved (during labour and birth) Trust 88% Picker average 94%	Discussion at Team Leader's Meeting	Nicola Foster (Head of Midwifery) Vicki Booth (Maternity Matron DPOW) Claire Brothwell (Maternity Matron SGH)	Aug-24	9/10/24 Discussed at team leaders meeting. Matrons to cascade to midwifery teams.	
		Antenatal education and communication to include and highlight involvement	Nicola Foster (Head of Midwifery) Michelle Smith (SGH community midwifery manager) Christine Page-Patrick (DPOW community midwifery manager)	Aug-24	9/10/24 Discussed at team leaders meeting. Community midwifery managers to cascade to community midwifery teams.	

MATERNITY INCENTIVE SCHEME - NLAG & HUTH

Amanda Stanford, Group Chief Nurse & Yvonne McGrath, Group Midwifery Director

REFERENCES

Only PDFs are attached

BIC(25)010 - Maternity Incentive Scheme - Year Six - NLaG & HUTH.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)010

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 13 February 2025**
Director Lead	**Amanda Stanford, Group Chief Nurse**
Contact Officer / Author	**Yvonne McGrath, Group Director of Midwifery**
Title of Report	Maternity Incentive Scheme Year 6 – NLAG & HUTH
Executive Summary	Progress report provides an overview of compliance with all Safety Actions for both HUTH and NLAG. 1. Key risk at HUTH regarding PMRT which has resulted in declaring non-compliance with this safety action 1 of MIS Year 6 at present. HUTH will be declaring compliance of the remaining 9 Safety Actions (as per attached Board declaration form). 2. Additional funding secured to stabilise the leadership structure at HUTH resulting in compliance with Safety Action 5. 3. NLAG will be declaring compliance with all 10 Safety Actions (as per attached Board declaration form) 4. Claims Scorecard for Q3 triangulates themes from claims, complaints and deep dives for HUTH and NLAG. 5. PMRT reports for Q3 details full compliance at NLAG against CNST standards and the issue identified at HUTH.
Background Information and/or Supporting Document(s) (if applicable)	· MIS Year 6 Progress Report · MIS Year 6 Board declaration – HUTH & NLAG **(national document – to be viewed online only)** · Claims Scorecard Triangulation Q3 – HUTH & NLAG · Trust Board PMRT Report Q3 – HUTH & NLAG
Prior Approval Process	
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ü Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

NHS Resolution
Maternity (and Perinatal) Incentive Scheme
Year Six

HUTH and NLAG PROGRESS REPORT

January 2025

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

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

United by Compassion:
Driving for Excellence

Background

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

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

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

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

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

Declaring Compliance

HUTH will be declaring compliance for 9/10 Safety Actions. Due to the change in verification period, HUTH cannot declare compliance for Safety Action 1.3. See page 6 for an explanation and mitigation. HUTH will have to await MBRRACE external verification to see if compliance is upgraded following taking this into consideration.

NLAG will be declaring compliance for all 10 Safety Actions.

Executive Summary

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

Key:

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

HUTH

Safety action					
1 National Perinatal Mortality Review Tool					Q3 2024/25 PMRT report to be discussed at Trust Board in February 2025. Issue identified, awaiting confirmation from NHSR regarding declaring compliance.
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					Q3 2024/25 Claims Scorecard – to go to Trust Board in February 2025, require minutes to evidence discussion.
10 MNSI / Early Notification Scheme					
Total	1	0	1	8	

NLAG

Safety action					Comments/ Actions being taken
1 National Perinatal Mortality Review Tool					Q3 2024/25 PMRT report to be taken to Trust Board in February 2025.
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					Q3 2024/25 Claims Scorecard – to go to Trust Board in February 24, require minutes to evidence discussion.
10 MNSI / Early Notification Scheme					
Total	0	0	2	8	

Next Steps for Sign Off:

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

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

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

Change to the verification period

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

Please refer to the tables below for a breakdown of qualifying cases/compliance.

NLAG						
MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	**%**	**Q4 Jan – Mar 24**	**Q1 Apr – Jun 24**	**Q2 July – Sep 24**	**Q3 01/10/24 - 30/11/24**	**Total**
Have all eligible perinatal deaths from **2 April 2024** onwards been notified to MBRRACE-UK within seven working days?	**100%**	-	7/7 (100%)	*7/9 (78%)	6/6 (100%)	***20/22 (91%)**
Cases applicable for PMRT review are applicable to the following standards						
For at least 95% of all deaths of babies who died in your Trust from **8 December 2023**, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	6/6 (100%)	6/6 (100%)	4/4 (100%) 1 not yet met as in process	4 not yet met as in process	**16/16 (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 **2 April 2024** been started within two months of each death?	**95%**	-	6/6 (100%)	5/5 (100%)	4/4 (100%)	**15/15 (100%)**
Were 60% of the reports published within 6 months of death?	**60%**	6/6 (100%)	6/6 (100%)	1/1 (100%) 4 N/A – post MIS qualifying date	4 N/A post MIS qualifying date	**13/13 (100%)**

*MBRRACE have advised (e-mail 30/09/2024) that on these occasions the late notifications will not be included in the verification of Safety Action 1, which MBRRACE-UK will be carrying out (as per the updated change to verification process described above). However, any future late notifications which are for deaths occurring more than two weeks after the date of this email will be included in the verification and may result in the Trust failing to meet the standards required for Safety Action 1.

HUTH							
MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	**%**	**Q3 08/12/23 – 31/12/23**	**Q4 Jan – Mar 24**	**Q1 Apr – Jun 24**	**Q2 July – Sep 24**	**Q3 Oct – Dec 24**	**Total**
Have all eligible perinatal deaths from **2 April 2024** onwards been notified to MBRRACE-UK within seven working days?	**100%**	N/A	N/A	8/8 (100%)	8/8 (100%)	8/8 (100%)	**24/24 (100%)**
Cases applicable for PMRT review are applicable to the following standards							
For at least 95% of all deaths of babies who died in your Trust from **8 December 2023**, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	1/1 (100%)	4/4 (100%)	8/8 (100%)	5/5 (100%)	6/6 (100%) (1 not yet met as in process)	**24/24 (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 **2 April 2024** been started within two months of each death? **1 case excluded as directed by MBRRACE*	**95%**	N/A	N/A	6/7 (86%)	4/4 (100%)	5/5 (100%)	***15/16* (94%)**
Were 60% of the reports published within 6 months of death?	**60%**	1/1 (100%)	2/4 (50%)	8/8 (100%)	4/4 (100%)	1/1 (100%) 6 N/A – deadlines post 30/11/24	**16/18 (89%)**

* Non-compliance identified for Standard C, commencing a review within 2 months of death, via MBRRACE case list downloaded in January. This was due to 1 case with the change of verification period. This was escalated to NHS Resolution and mitigation sent to MBRRACE. The non-compliance was due to sickness of the PMRT lead and no matron at the time. In this time, the Bereavement Midwives had inputted the factual accuracy and patient feedback required to the best of their knowledge within the timeframe. PMRT was commenced, however the session was closed out of this timeframe. As a result, there is now a rigorous process in place to ensure this does not happen again, reviewing the case list every 2 weeks for assurance. Moreover, more staff are trained in completing the PMRT process.

The Trust have been advised by NHS Resolutions to declare non-compliance with this action in the first instance, with a view to this position being reviewed by MBRRACE when the external verification is undertaken and mitigation considered. They advise that as it is an isolated omission, compliance may be upgraded. Any adjustment to the overall compliance following that external review will be conveyed quickly to the Trust after the final MIS submission date. The mitigation has been added to the action plan section on the Board Declaration Form as advised by NHS Resolutions.

Outstanding Action Required:
Quarter 3 PMRT reports to be discussed at Trust Board in February 2024. Minutes to be saved as evidence.

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

Requirement		**HUTH compliance**	**NLAG compliance**
2.1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?		
2.2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)		

Outstanding Action Required:
No outstanding actions.

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

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

Outstanding Action Required:
No outstanding actions.

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

Obstetric Workforce:

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

Anaesthetic Workforce:

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

Neonatal Medical Workforce:

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

Neonatal Nursing Workforce:

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

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

Outstanding Action Required:
December Trust Board minutes to be saved as evidence.

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

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

Outstanding Action Required: Nil.

HUTH:
Confirmation of funding now means HUTH meets Birthrate+ recommendation as per 5.3 and can now declare compliance following a previous action plan. A rapid review was completed regarding supernumerary Labour Ward Co-ordinator status and found that there was only 1 episode where a coordinator was overseeing a nurse in recovery whilst staff were moved at a time of high capacity. Confirmation from NHS Resolution that HUTH can still declare compliance in this circumstance.

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

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

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

Outstanding Action Required:

No outstanding actions.

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

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

Outstanding Action Required:

No outstanding actions.

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

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

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

HUTH:
6 new anaesthetic doctors commenced in November 2024 and had not completed their PROMPT training by the MIS deadline. An action plan was developed and shared with Trust Board in December 2024 (earliest opportunity following commencement of doctors) which satisfied the MIS requirements to complete their training within the 6-month grace period. In January, 4 completed their training. The remaining 2 doctors are rotating and will not be covering the obstetric rota and will no longer be included in these figures. Therefore, compliance is now at 100%.

Outstanding Action Required:
Nil.

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

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

Outstanding Action Required:

Q3 Trust Claims Scorecard to be shared with Trust Board (February 2025).

HUTH:
Recent engagement shared with staff. Additional evidence gathered to further strengthen evidence already obtained for ongoing engagement sessions with staff as per LMNS request.

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

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

Outstanding Action Required:

HUTH & NLAG:
Trust Board to be informed (February 2025) of recent qualifying cases for MNSI/EN, that families have been informed of the role of MNSI/EN and compliance for statutory Duty of Candour. Minutes to be saved once available.

Hull University Teaching Hospital - Maternity Incentive Scheme (SA9) Quarter 3

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

Claims Breakdown Q3 24/25

Claims opened:

- Alleged failure to perform fetal monitoring which led to a delay in delivery of the baby resulting in a hypoxic brain injury and subsequent death.
- Alleged failure to manage induction and labour resulting in a major obstetric haemorrhage plus avoidable extravasation injury around site of the cannula causing PTSD after obstetric haemorrhage.

Existing claims: 36

Claims closed:

- Alleged failure to perform a rectal suction biopsy at any point to look for ganglion cells and exclude possibility of Hirschsprung disease. If done so, it would have avoided anastomotic leak, leading to sepsis and death. **Damages paid – Nil**
- 37 week twins born by cat 2 section, ? fetal tachycardia in Twin 1. Baby born pale and floppy, no respiratory effort. Required intubation and CPR in theatre, admitted to NICU at 30 mins of age for ongoing ventilation and active cooling. **Damages paid – Nil**

Incidents Q3 24/25

Top 5 incident by volume:

- Term NNU admissions **(38)**
- Post partum haemorrhage (PPH) >1500mls **(30)**
- IUT for delay in IOL **(10)**
- Stillbirth **(6)**
- 3rd and 4th degree tears **(6)**

Number of incidents reported on DATIX for Obstetrics / Maternity: **291**

Complaints Q3 24/25

There have been 4 new complaints received relating to the following:

- Communication
- Delay in treatment
- Injury to baby at delivery

Clinical Audits Registered Q3 24/25

- Perinatal optimisation (Intrapartum antibiotics and steroids in preterm labour)
- Births <3rd Centile and >37+6 Weeks Gestation with no risk Factors Identified
- Low Risk Fetal Growth Restriction - Fundal Height Assessment by 28+6 weeks Gestation
- Percentage of Pregnancies where a SGA Fetus (between 3rd and 10th centiles) is Antenatally Detected
- Percentage of Babies >3rd Birthweight Centile Born <39 weeks gestation where Growth Restriction was Suspected.

Deep Dive Reviews Q3 24/25

Complete:

Delay in Induction of Labour - *Focusing on length of wait for IOL*

Born Before Arrival – *Focusing on theme identification following rise in cases.*

In progress:

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

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

Learning Q3 24/25
· ATAIN decrease in admission rate – CAT 3/4 caesarean section deep dive being conducted · When to take cord gas SOP approved · IUT for delays in IOL now being reported on DATIX · Better use of terbutaline · Never event – simulation performed and draft report stage

Themes Q3 24/25
· ATAIN decrease in hypothermic admissions · + Proteinuria not being sent for PCR · Rise in stillbirths within diabetic service users · Delay in IOL and ARM >24hrs

Action Plan Q3 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 3

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 Q3 24/25

Claims opened:

- Alleged delay in diagnosis and management of ectopic pregnancy, resulting in rupture, surgery and removal of right fallopian tube.
- Allegations of Unsatisfactory management of anaesthesia prior to a medical termination of pregnancy including allegations of extravasation/arm injury leading to allegations of PTSD.

Existing claims: 22

Claims closed:

- Claim for wrongful birth. Alleged negligent ultrasound resulting in birth of baby with campomelic dysplasia. **Damages paid – Nil**
- Child born on 20/1/2024 which had a normal birth Apgar score 01. **Damages paid – Nil**

Incidents Q3 24/25

Top 5 incident by volume:

- Error /omission in health record **(23)**
- Unexpected admission to NICU **(20)**
- Below Safe Staffing Levels Following Escalation **(17)**
- Post partum haemorrhage (PPH) >1500mls **(17)**
- Staffing levels affecting patient care / monitoring of patients **(16)**

Number of incidents reported on Ulysses for Obstetrics / Maternity: **449**

Complaints Q3 24/25

There have been 3 new complaints received relating to the following:

- Communication – failure to liaise with a patient
- Delay in treatment

Clinical Audits Registered Q3 24/25

- Goole and Midwifery Led Unit – Documentation Audit
- SBL Element 1 (Q4): Reducing Smoking in Pregnancy
- SBL Element 2 (Q4): Fetal Growth Restriction
- SBL Element 3 (Q4): Reduced Fetal Movements
- SBL Element 4 (Q4): Fetal Monitoring
- SBL Element 5 (Q4): Pre-term Births
- SBL Element 6 (Q4): Type 1 & Type 2 Diabetes in Pregnancy

Deep Dive Reviews Q3 24/25

Complete:

Pre-term Births – Focusing on identifying any contributing factors, missed opportunities and to review the indications/appropriateness of pre-term inductions.

In progress:

None.

Learning Q3 24/25
· Further training and support was given on Badgernet · Blue wristbands to be applied for each thing left inside a patient to aide identification for removal · Never event – simulation performed and draft report stage

Themes Q3 24/25
· The introduction of Badgernet has caused issues · Staffing levels - mitigated with escalation policy. No harm caused by staffing levels.

Action Plan Q3 24/25	Not started / In progress / Complete	
Change in policy and way of working for PPH to include the use of blue wristbands for any retained objects.	January 2025	
Further support given for users for Badgernet.	December 2024	

FAMILY SERVICES DIVISION

Hull University Teaching Hospital

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

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 3 2024/25)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

January 2025

1. INTRODUCTION

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

1.1 DEFINITIONS

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

- **Late fetal losses** – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- **Stillbirths** – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.
- **Terminations of pregnancy:** terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

1.2 MIS YEAR 6 NOTIFCATION REQUIREMENTS:

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

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

2. STANDARDS

A report has been received by the Trust Executive Board each quarter from October 2024 to December 2024 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

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

3. SUMMARY

3.1 Eligible Incidents in MIS Year Six (appendix A)

There has been a total of 35 incidents reported to MBRRACE-UK via the PMRT during MIS year six.

15 cases were reported to MBRRACE in Q3, 8 were included within MIS Year 6 (reporting period ended 30/11/2024).

Quarter	Eligible for full CNST assessment	Eligible for notification only	Total per Quarter
Q3 (8 Dec – 31 Dec 23)	2	3	**5**
Q4 (01 Jan – 31 Mar 24)	3	1	**4**
Q1 (01 Apr – 30 Jun 24)	8	1	**9**
Q2 (01 Jul – 30 Sept 24)	6	3	**9**
Q3 (01 Oct – 31 Dec 24)	10 (7 in MIS Year 6)	5 (1 in MIS Year 6)	15 (8 in MIS Year 6)
Total for MIS Year 6	**26**	**9**	**35**

9 cases were reported to MBRRACE so far in MIS year 6 but were for notification only due to termination of pregnancy and therefore not eligible for further measurement against CNST standards or review.

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

In addition, please note there are 2 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 complete the PMRT process. These cases do not appear on HUTH MIS year six case list but included in the yearly case list.

3.2 Summary of all incidents closed in Quarter 3 (appendix B)

There have been 6 incidents reviewed and published through the PMRT process. This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. However, it should be acknowledged that reporting relates to incidents that occurred during April and June 2024 due to the lag in the review and reporting process.

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

- 0 cases concluded that there were no issues with care identified up the point that the baby was born (A)
- 3 cases identified care issues which they considered would have made no difference to the outcome for the baby (B)
- 2 cases identified care issues which they considered may have made a difference to the outcome for the baby (C)
- 1 case identified care issues which they considered were likely to have made a difference to the outcome for the baby (D)

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

- 4 cases concluded that there were no issues with care identified up the point that the baby was born (A)
- 1 case identified care issues which they considered would have made no difference to the outcome for the baby (B)
- 0 cases identified care issues which they considered may have made a difference to the outcome for the baby (C)
- 1 case identified care issues which they considered were likely to have made a difference to the outcome for the baby (D)

Where actions have been identified, appropriate deadlines have been put in place and can be found in appendix 3.

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

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%
All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	100%
All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	100%
Multi-disciplinary reviews should be started within two months of the death.	94%
Multi-disciplinary reviews should be published within six months of the death.	100%
Quarterly reports should be submitted to the Trust Executive Board.	100%

Non-compliance identified for Standard C, commencing a review within 2 months of death, via MBRRACE case list downloaded in January. This was due to 1 case with the change of verification period. This was escalated to NHS Resolution and mitigation sent to MBRRACE. The non-compliance was due to sickness of the PMRT lead and no matron at the time. In this time, the Bereavement Midwives had inputted the factual accuracy and patient feedback required to the best of their knowledge within the timeframe. PMRT was commenced, however the session was closed out of this timeframe. As a result, there is now a rigorous process in place to ensure this does not happen again, reviewing the case list every 2 weeks for assurance. Moreover, more staff are trained in completing the PMRT process.

The Trust have been advised by NHS Resolutions to declare non-compliance with this action in the first instance, with a view to this position being reviewed by MBRRACE when the external verification is undertaken and mitigation considered. They advise that as it is an isolated omission, compliance may be upgraded. Any adjustment to the overall compliance following that external review will be conveyed very quickly to the Trust after the final MIS submission date. The mitigation has been added to the action plan section on the Board Declaration Form as advised by NHS Resolutions.

3.4 Learning and Action Logs for Outstanding Cases (appendix D)

Learning and progress against previous actions are included in appendix D.

4. Saving Babies' Lives (Appendix E)

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

- Identification and management of fetal growth restriction (FGR) was a relevant issue
- Issues associated with reduced fetal movement (RFM) management
- Identification of cases of severe brain injury where issues were associated with failures of intrapartum monitoring as a contributory factor
- The prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.

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

Appendix A – Summary of all Eligible Incidents Reported in MIS 6

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking / Primary AN Care	Location of Delivery	Location of Death (reporting hospital)	Parents involved and updated	MNSI	MBRRACE notified <7 days	Review started < 2mth	Review Publish < 6mth
Q3 – not MIS year 6	**96445**	Neonatal death	27+2	13.10.24	11.12.24	650g	HUTH	HUTH	HUTH	Yes	No	Met	Met	<6 months
	96455	Antepartum stillbirth	38+3	13.12.24	13.12.24	2810g	HUTH	HUTH	HUTH	Yes	No	Met	Met	<6 months
	96467	Neonatal death	37+1	13.06.24	15.12.24	3096g	HUTH	HUTH	HUTH	Yes	No	Met	Met	<6 months
	96528	Neonatal death	26+2	02.08.24	09.12.24	890g	HUTH	HUTH	HUTH	Yes	No	Met	Met	<6 months
	96596	Antepartum stillbirth	39+4	23.12.24	23.12.24	2860g	HUTH	HUTH	HUTH	Yes	No	Met	Met	<6 months
	96662	Neonatal death	23+2	25.12.24	27.12.24	360G	HUTH	HUTH	HUTH	Yes	No	Met	Met	<6 months
	96445	Neonatal death	27+2	13.10.24	11.12.24	650g	HUTH	HUTH	HUTH	Yes	No	Met	Met	<6 months
Q3	**95480**	Antepartum stillbirth	37+1	05.10.24	05.10.24	4665g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	*Post Qualifying date (<6 months)*
	95588	Antepartum stillbirth	26+1	13.10.24	13.10.24	357g	HUTH	HUTH	HUTH	Yes	No	Met	Met	Met
	95668	Antepartum stillbirth	26+4	19.10.24	19.10.24	373g	YORK	HUTH	HUTH	Yes	No	Met	Not Met – remains with York to complete	<6 months
	95688	Neonatal death	27+0	17.10.24	18.10.24	905g	HUTH	HUTH	HUTH	Yes	No	Met	Not Met – excluded from MIS as per MBRRACE	*Post Qualifying date (<6 months)*
	95990	Neonatal death	23+2	01.11.24	10.11.24	530g	MID YORKS	HUTH	HUTH	Yes	No	Met	Met	*Post Qualifying date (<6 months)*

	96177	Antepartum stillbirth	36+5	23.11.24	23.11.24	2210g	HUTH	HUTH	HUTH	Yes	No	Met	Met	*Post Qualifying date (<6 months)*
	96211	Neonatal death	22+1	25.11.24	26.11.24	324g	HUTH	HUTH	HUTH	Yes	No	Met	Met	*Post Qualifying date (<6 months)*
Q2	**94371**	Neonatal death	21+5	15.07.24	15.07.24	385g	HUTH	HUTH	HUTH	Yes	No	Met	Met	Met
	94419	Neonatal death	30+3	08.05.24	22.07.24	1500g	YORK	YORK	HUTH	Yes	No	Met	Met	Met
	94736	Antepartum stillbirth	34+4	13.08.24	13.08.24	2255g	HUTH	HUTH	HUTH	Yes	No	Met	Met	Met
	94816	Antepartum stillbirth	38+6	19.08.24	19.08.24	3315g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	Met
	94846	Neonatal death	30+3	20.08.24	22.08.24	3490g	YORK	YORK	HUTH	Yes	Yes	Met	Met	<6 months – remains with York
	95327	Neonatal death	39+3	24.09.24	26.09.24	3875g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	Met
	95328	Antepartum stillbirth	39+2	26.09.24	26.09.24	4550g	HUTH	HUTH	HUTH	Yes	No	Met	Met	Met
Q1	**92794**	Neonatal death	37+1	11.04.24	11.04.24	3045g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	Met
	92807	Antepartum stillbirth	25+5	12.04.24	12.04.24	137g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	Met
	93230	Antepartum stillbirth	26+4	09.05.24	09.05.24	975g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	Met
	93317	Neonatal death	34+3	26.04.24	14.05.24	2345g	HUTH	HUTH	Home	Yes	Yes	Met	Met	Met
	93319	Antepartum stillbirth	37+1	15.05.24	15.05.24	2775g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	Met
	93509	Antepartum stillbirth	33+1	27.05.24	27.05.24	1655g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	Met

	93693	Antepartum stillbirth	29+2	07.06.24	07.06.24	1235g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	Met
	93766	Antepartum stillbirth	24+2	12.06.24	12.06.24	403g	HUTH	HUTH	HUTH	Yes	Yes	Met	Not Met – as per 3.3	Met
Q4	**91674**	Neonatal death	41+1	28.01.24	02.02.24	3240g	HUTH - FABC	HUTH	HUTH	Yes	Yes	Met	Met	Not met – MNSI and coroner case
	91492	Neonatal death	33+3	10.01.24	22.01.24	1160g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	Met
	92339	Antepartum stillbirth	24+2	12.03.24	12.03.24	154g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	Met
	91332	Neonatal death	22+2	27.12.23	14.01.24	430g	SCARB	HUTH	HUTH	Yes	Yes	Met	Met	Not met – Shared case
Q3	**90872**	Antepartum stillbirth	28+1	14.12.23	14.12.23	565g	HUTH	HUTH	HUTH	Yes	Yes	Met	Met	Met
	90897	Neonatal death	26+4	15.11.23	15.12.23	1265G	HUTH	HUTH	HUTH	Yes	No	Met	Met	Met

Appendix B – Summary of all eligible incidents closed in Q3 of 2024-2025

Case	Cause of Death	Grade of Care	Issues Identified	Actions
91492: 33+3 NND	1. Trisomy 18 2. Prematurity 3. Polyhydramnios	**B/B/A**	1. initial full examination at admission was not documented in the notes 2. ETT was dislodged during the attempt to change the neofit as it was loose	1. a reminder for all staff regarding the importance of initial full examination was done during the mortality meeting and will be disseminated also in the learning points from the meetings **- ACTIONED** 2. agreed actions are, to move to using secure zinc oxide tape in similar situations where intubation and extubation isa changing point and if the patient is planned for cuddling. also, to discussing RESPECT and care plans regarding the agreed actions in reversible conditions as tubes and lines dislodgement. also, elective adjustment of ETT or its fixation to be done better during day times if not urgent. these agreed actions has been discussed during mortality reviews for all staff, will be disseminated through minutes of meeting and also through learning from mortality and datixes **- ACTIONED**
92339: 24+2 SB	. Severe intrauterine growth restriction	**B/A**	1. Ongoing work with the ultrasound scan guideline – due to this graded a B	
92807: 25+5 SB	. Severe intrauterine growth restriction	**B/A**	1. Aspirin was prescribed but not taken by mum – due to this graded a B	1. Aspirin QI project ongoing **- ONGOING**

93319: 37+1 SB	· Placental abruption secondary to pregnancy induced hypertension	**C/C**	1. 2nd episode of reduced fetal movements not recorded correctly 2. No magnesium sulphate given	1. Education to all staff on reduced fetal movements. Counter added to badgernet to monitor number of episodes. Posters around the unit to educate parents on reduced fetal movements **- ACTIONED** 2. Tea trolley on BAPM7. Ongoing work to increase trio of BAPM7 criteria **- ACTIONED**
94371: 21+5 NND	· Awaiting PM	**C/A/A**	1. Cerclage not offered in pregnancy	1. Guideline being reviewed. LMNS guideline updated and in the process of being modified and comments adjusted **- ONGOING**
94736: 34+4 SB	· Unknown	**B/A**	1. Aspirin was prescribed but not taken by mum – due to this graded a B	1. Aspirin QI project ongoing **- ONGOING**
95327: 39+3 NND	· Awaiting PM	**B/A/D**	1. This mother had poor/no English, and an interpreter was not used on every occasion when she was seen for her antenatal care 2. This mother had poor/no English and family members were used as interpreters during her labour and birth 3. Safe sleep information for families	1. A. Communication with all staff that interpreter use is an opt out service and an interpreter is required to decline use. Clear documentation of why an interpreter is declined B. Explore the use of badger net to audit interpreter use and explore barriers to use C. Explore the use of face-to-face interpreters in the intrapartum period **- ONGOING, 1/3 ACTIONED** 2. A. Communication with all staff that interpreter use is an opt out service and an interpreter is required to decline use. Clear documentation of why an interpreter is declined B. Explore the use of badger net to audit interpreter use and explore barriers to use C. Explore the use of face-to-face interpreters in the intrapartum period **– ONGOING, 1/3 ACTIONED** 3. A. Safe sleep information highlighted on screens around the unit for education B. Explore leaflets provided by LMNS C. Review

				trust leaflet on safe sleeping D. Liaise with health visitors on information provided at 36 week check and if all home visits are carried out - explore if the trust support with those who do not have home visits E. Utilise 'ask the midwife' service to raise awareness on the Facebook group surrounding safe sleeping **– ONGOING, 1/5 ACTIONED**
95328: 39+2 SB	· Hypoxia secondary to maternal diabetes	**D/A**	1. False reassurance given surrounding reduced fetal movements at 36+0 2. This mother had gestational diabetes, but it was not managed appropriately	1. A. Feedback given to member of staff involved in the discussion with mum. B. Ongoing e-learning training package being developed for all staff on reminders and education surrounding reduced fetal movements. C. Educational posters for both staff and patients are now widely distributed throughout the hospital and community settings to raise awareness of reduced fetal movements. D. Ongoing work with MNVP regarding communication surrounding reduced fetal movements to improve language **– ONGOING, 3/4 ACTIONED** 2. A. Ongoing work with the diabetic team to review process of reviewing blood glucose levels. B. Reinstated MDT meetings once a month to discuss diabetic women's care. Diabetic team workload also on the trust risk register for monthly review **– ACTIONED**
95588: 26+1 SB	· Severe IUGR secondary to placental insufficiency	**B/B**	1. This mother's progress in labour was not monitored on a partogram	1. A. Education for all staff on commencing partogram's on bereaved families B. Update within PMRT newsletters C. Update on mandatory training day **– ONGOING, 1/3 ACTIONED**

Summary of joint incidents closed in MIS year 6

Case	Cause of Death	Grade of Care	Issues Identified	Actions
91332: 22+2 NND	1. RDS 2. extreme preterm 22+2 3. maternal influenza A, SROM	**A/B/A**	1. The respiratory management of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate 2. During the first 24 hours of arrival on the neonatal unit appropriate investigations were carried but they were not timely 3. The ongoing metabolic management of the baby on the neonatal unit was not appropriate	1. length of ETT is going to be part of delivery handbook which will be disseminated to all staff 2. a discussion is going to happen with radiology team regarding dealing with NNU referrals as urgent with urgent response time 3. a reminder regarding following the hyperkalaemia guideline has been discussed and will be distributed through the lessons learnt
94419: 30+3 NND	1. Respiratory failure 2. Congenital myotonic dystrophy 3. Raised right hemidiaphragm, Grade IV IVH, hydrocephalus 4. Prematurity	**C/B/A**	1. No issues identified for HUTH	

GRADING OF CARE

Antenatal loss –

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

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

Grading of care of the mother following confirmation of the death of her baby:

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

Neonatal death –

Grading of care of the mother and baby up to the point of birth of the baby:

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

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

- ○ A - The review group concluded that there were no issues with care identified from birth up the point that the baby died
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following the death of her baby:

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

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

HUTH							
MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	**%**	**Q3 08/12/23 – 31/12/23**	**Q4 Jan – Mar 24**	**Q1 Apr – Jun 24**	**Q2 July – Sep 24**	**Q3 Oct – Dec 24**	**Total**
Have all eligible perinatal deaths from **2 April 2024** onwards been notified to MBRRACE-UK within seven working days?	**100%**	N/A	N/A	8/8 (100%)	8/8 (100%)	8/8 (100%)	**24/24 (100%)**
Cases applicable for PMRT review are applicable to the following standards (n=16)							
For at least 95% of all deaths of babies who died in your Trust from **8 December 2023**, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	1/1 (100%)	4/4 (100%)	8/8 (100%)	5/5 (100%)	6/6 (100%) (1 not yet met as in process)	**24/24 (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 **2 April 2024** been started within two months of each death? **1 case excluded as directed by MBRRACE*	**95%**	N/A	N/A	6/7 (86%) *	4/4 (100%)	5/5 (100%)	**15/16 (94%)**
Were 60% of the reports published within 6 months of death?	**60%**	1/1 (100%)	2/4 (50%)	8/8 (100%)	4/4 (100%)	1/1 (100%) 6 N/A – deadlines post 30/11/24	**16/18 (89%)**

NHS Resolution - change to the verification period

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

* Factual information entered but case not closed on MBRRACE site. In discussions with MBRRACE and NHS Resolutions.

Appendix D: Learning Points and Key Themes:

Key themes identified from **Q3** cases PMRT reviews are as follows:

- Reduced fetal movements guideline not followed
- 1 to 1 care not met in labour
- Ongoing aspirin accessibility and education issues
- DNA policy not followed
- Interpreter and/or language line not utilised in pregnancy and labour
- Partogram not used
- Gestational diabetes guideline not being followed

Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified				
		Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	0/3 (0%)	2/8 (25%)	1/4 (25%)	0/7 (0%)	**3/22 (14%)**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	1/3 (33%)	0/8 (0%)	0/4 (0%)	0/7 (0%)	**1/22 (5%)**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	1/3 (33%)	0/8 (0%)	1/4 (25%)	0/7 (0%)	**2/22 (9%)**
Element 5.2k	Cases where the prevention, prediction, preparation or perinatal optimization of preterm birth was a relevant issue.	0/3 (0%)	0/8 (0%)	0/4 (0%)	0/7 (0%)	**0/22 (0%)**

FAMILY SERVICES DIVISION

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

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 3 2024/25)

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Group Director of Midwifery– Family Services Care Group

January 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 DEFINITIONS

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

- **Late fetal losses** – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- **Stillbirths** – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.
- **Terminations of pregnancy:** terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

1.2 MIS YEAR 6 NOTIFCATION REQUIREMENTS:

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

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

2. STANDARDS

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

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

3. SUMMARY

3.1 Eligible Incidents in MIS Year Six (Appendix A)

There has been a total of 33 incidents reported to MBRRACE-UK via the PMRT during 2024:

Quarter	Eligible for full CNST Assessment	Eligible for notification only	Not eligible as baby still alive
Q4 (01 Jan – 31 Mar 24)	6	1	1
Q1 (01 Apr – 30 Jun 24)	6	1	1
Q2 (01 Jul – 30 Sept 24)	5	4	1
Q3 (01 Oct – 31 Dec 24)	5 *(4 in MIS yr 6 period)*	2	0
Total	**22**	**8**	**3**

32 cases fall within the MIS year six period (end date – 30/11/24). 21 cases are eligible for review and full assessment against CNST standards. 3 babies were still alive (twin of a reportable case), 8 cases were reported to MBRRACE but were for notification only (terminations for fetal anomaly) and therefore not eligible for full assessment against CNST standards or review. Of these, 6 were notified to MBRRACE within seven days and 2 were reported late (11 and 16 days after the date of the death).

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

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

In addition, please note there are 3 cases registered with MBRRACE where the deaths occurred at other Trusts and NLAG contributed to the care. It is the responsibility of the other Trusts to complete the PMRT process. These cases do not appear on NLAG MIS year six case list but included in the yearly case list.

3.2 Summary of all incidents reviewed through PMRT in Quarter 3 2024/25 (Appendix B)

There have been 4 incidents reviewed through the PMRT process. This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. However, it should be acknowledged that reporting relates to incidents that occurred 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>

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

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

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

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

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

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

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

3.4 Learning Points and Key Themes (Appendix D)

Learning and progress against actions are included in appendix D.

4. Saving Babies' Lives (Appendix E)

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

- Identification and management of fetal growth restriction (FGR) was a relevant issue
- Issues associated with reduced fetal movement (RFM) management
- Identification of cases of severe brain injury where issues were associated with failures of intrapartum monitoring as a contributory factor
- The prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.

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

Appendix A – Summary of eligible incidents (for review) reported in 2024 (n=22)

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	MBRRACE notified < 7 days	Review started < 2mth	Review Publish < 6mth
Q3 24/25	96717	Intrapartum stillbirth	38+3	31/12/24 (Outside MIS period)	31/12/24 (Outside MIS period)	3130g	SGH	SGH	SGH	Yet to be sought	Yes	Yes	Not yet started	Not yet published
	96208	Intrapartum stillbirth	38+6	24/11/24	24/11/24	3734g	DPOW	DPOW	DPOW	Yet to be sought	Yes	Yes	Yes	Not yet published
	96062	Antepartum stillbirth	38+4	15/11/24	15/11/24	4260g	SGH	SGH	SGH	Yet to be sought	No	Yes	Yes	Not yet published
	95970	Antepartum stillbirth	35+6	07/11/24	02/11/24	2736g	DPOW	DPOW	DPOW	Yet to be sought	No	Yes	Yes	Not yet published
	95943	Neonatal death	24+0	05/11/24	05/11/24	650g	SGH	SGH	SGH	Yet to be sought	No	Yes	Yes	Not yet published
Q2 24/25	95387	Antepartum stillbirth	37+6	29/09/24	30/09/24	2380	SGH	SGH	SGH	Yet to be sought	No	Yes	Yes	Not yet published
	95343	Antepartum stillbirth	28+5	26/09/24	26/09/24	2100	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Not yet published
	94938	Neonatal death	23+5	26/08/24	26/08/24	650	SGH	SGH	SGH	Yes	No	Yes	Yes	Not yet published
	94853	Antepartum stillbirth	24+6	21/08/24	21/08/24	592	Jessops	SGH	SGH	Yes	No	Yes	Yes	Not yet published
	94427	Antepartum stillbirth	35+2	20/07/24	20/07/24	2042	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met

	PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	MBRRACE notified < 7 days	Review started < 2mth	Review Publish < 6mth
Q1 24/25	93831	Neonatal death	29+0	17/06/24	17/06/24	2100	Unbooked	DPOW	DPOW	Yes	No	Yes	Yes	Met
	93830	Antepartum stillbirth	29+2	19/06/24	19/06/24	560	SGH	SGH	SGH	Yes	No	Yes	Yes	Met
	93399	Neonatal death	36+2	20/05/24	20/05/24	2300	SGH	SGH	SGH	Yes	No	Yes	Yes	Met
	92981	Antepartum stillbirth	30+0	23/04/24	23/04/24	1900	Unbooked	DPOW	DPOW	Yes	No	Yes	Yes	Met
	92872	Antepartum stillbirth	25+2	17/04/24	17/04/24	1290	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met
	92871	Neonatal death	23+3	17/04/24	17/04/24	532	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met
Q4 23/24	92608	Antepartum stillbirth	39+4	30/03/24	30/03/24	3112	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met
	92515	Neonatal death	27+4	21/03/24	21/03/24	1230	SGH	SGH	SGH	Yes	No	Yes	No	Met
	92441	Antepartum stillbirth	22+3	19/03/24	19/03/24	558	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met
	91639	Antepartum stillbirth	25+0	30/01/24	30/01/24	1790	SGH	SGH	SGH	Yes	No	Yes	Yes	Met
	91196	Neonatal death	26+4	04/01/24	04/01/24	910	SGH	SGH	SGH	Yes	No	Yes	Yes	Met
	91144	Neonatal death	22+5	01/01/24	01/01/24	510	SGH	SGH	SGH	Yes	No	Yes	Yes	Met

Appendix B – Summary of all incidents reviewed through PMRT in Q3 of 2024/2025

Case	Cause of Death	Grading of Care	Issues Identified	Actions
93399 Neonatal death 36+2 weeks	Pulmonary atresia with VSD and severe ventriculomegaly secondary to occipital encephalocele	The review group identified care issues which they considered would have made no difference to the outcome for the baby. The review group concluded that there were no issues with care identified from birth up the point that the baby died. The review group concluded that there were no issues with care identified for the mother following the death of her baby.	This mother lives with family members who smoke but they were not offered referral to smoking cessation services. This mother presented with reduced fetal movements, scans and/or other investigations were indicated but were not carried out. This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance.	Reminder to staff to document whether or not family members consent or not to smoking cessation referral services. Reminder to staff that any attendance after 26 weeks with reduced fetal movements with risk factors must be referred for scan and a CTG performed.
93830 Antepartum stillbirth 29+2 weeks	Severe fetal growth restriction.	The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died. The review group identified care issues which they considered would have made no difference to the outcome for the mother.	Estimated fetal weights from scans had not been plotted on a chart. Although indicated this mother was not offered appropriate investigations for underlying metabolic and/or haematological abnormalities.	FMU Consultant to be reminded to plot growth on GROW 2.0. Reminder to all staff to ensure all postnatal bloods are taken as per cherished care pathway.

Case	Cause of Death	Grading of Care	Issues Identified	Actions
93831 Neonatal death 29+0 weeks	Following the review, and despite a post-mortem and placental histology having been performed, the cause of death of the baby was undetermined.	The review group concluded that there were no issues with care identified up the point that the baby was born. The review group concluded that there were no issues with care identified from birth up the point that the baby died. The review group concluded that there were no issues with care identified for the mother following the death of her baby.	No actions identified relating to issues identified as directly relevant to the death of this baby. It is not possible to assess from the notes whether options for organ donation were considered and discussed with the parents as part of the end of life care for their baby.	Cherish pathways on the ward to be checked and old versions removed and replaced with the most up to date version.
94427 Antepartum stillbirth 35+2 weeks	Following the review which considered the results of the placental histology and other investigation the cause of death of the baby was undetermined. Having made this determination the review panel noted that the results of a post-mortem were needed to be certain about the cause of death.	The review group identified care issues which they considered may have made a difference to the outcome for the baby. The review group identified care issues which they considered would have made no difference to the outcome for the mother.	This mother presented with reduced fetal movements at >28 weeks and a CTG was not performed. This mother presented with reduced fetal movements, scans and/or other investigations were indicated but were not carried out. This mother presented with reduced fetal movements but management was not appropriate and was not in line with national guidance. This mother did not have Kleihauer test despite it being requested.	Update the DNA Policy DCG078 to include triage and timescales for following up of non-attendance and inform staff of the changes. Liaison with laboratory staff to ensure Kleihauers are always completed for all intrauterine deaths.

Please not additional actions relating to smoking in pregnancy are also in progress with linkage to the Saving Babies Lives' Care Bundle (version 3).

Appendix C – Summary of CNST Compliance as per MIS Year 6 standards (08/12/23 – 30/11/24)

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
Have all eligible perinatal deaths from **2 April 2024** onwards been notified to MBRRACE-UK within seven working days?	**100%**	-	7/7 (100%)	*7/9 (78%)	6/6 (100%)	**20/22 (91%)**
Cases applicable for PMRT review are applicable to the following standards (n=17)						
For at least 95% of all deaths of babies who died in your Trust from **8 December 2023**, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	6/6 (100%)	6/6 (100%)	4/4 (100%) 1 not yet met as in process	4 not yet met as in process	**16/16 (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 **2 April 2024** been started within two months of each death?	**95%**	-	6/6 (100%)	5/5 (100%)	4/4 (100%)	**15/15 (100%)**
Multi-disciplinary reviews should be published within six months of the death.	**60%**	6/6 (100%)	6/6 (100%)	1/1 (100%) 4 N/A – post MIS qualifying date	4 N/A post MIS qualifying date	**13/13 (100%)**
Quarterly reports should be submitted to the Trust Executive Board.	**100%**	Submitted May 2024	Submitted Aug 2024	Submitted Oct 2024	Submission Feb 2025	**N/A**

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

NHS Resolution - change to the verification period

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

Appendix D: Learning Points and Key Themes:

Key themes identified from **Q3** cases PMRT or continued from previous quarterly reviews are as follows:

- Kleihauer bloods not tested.
- All Postnatal bloods and investigations not being taken.
- Estimated fetal weights not plotted on growth chart.
- Family members not being offered referral to smoking cessation team.
- Management for reduced fetal movements not followed as per policy.

The following key learning points from **Q3** PMRT reviews have been shared with staff via Safety Bulletins or PMRT Newsletter:

- All postnatal investigations required to gain full clinical picture
- Discussion with Pathology that Kleihauer bloods are required to be tested following a stillbirth.
- Offer smoking cessation referral to family members and document is this was accepted or declined.
- Reduced fetal movements (RFM's) attendance after 26 weeks with risk factors to be referred for scan and CTG performed.
- Ensure up to date version of cherished pathways are in use and dispose of old versions to ensure organ donation is discussed
- DNA policy update to include triage and timescales to follow up non-attenders.

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				
		Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	1/4 (25%)	0/5 (0%)	1/4 (20%)	1/4 (25%)	**3/17 (18%)**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	1/4 (25%)	0/5 (0%)	0/4 (0%)	2/4 (50%)	**3/17 (18%)**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	0/4 (0%)	0/5 (0%)	0/4 (0%)	-	**0/17 (0%)**
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	0/4 (0%)	2/5 (40%)	0/4 (0%)	-	**2/17 (15%)**

Maternity incentive scheme - Year 6 Guidance

Trust Name	**Northern Lincolnshire and Goole Hospitals NHS Foundation Trust**
Trust Code	**T600**

This document must be used to submit your trust self-certification for the year 6 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D which is the board declaration form.

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the Board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust Board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering either 2023/24 financial year or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2025

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**

Technical guidance and frequently asked questions can be accessed in the year 6 MIS document:
MIS-Year-6-v1.1-20240716.pdf (resolution.nhs.uk)

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.

Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 8 December 2023 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 2 April 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose NA)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2 April 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 60% of the reports published within 6 months of death?	Yes
5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews, any themes identified, and consequent action plans.	Yes
6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?	Yes
2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?	Yes
2	Or Is there a Transitional Care (TC) action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.		
3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	Yes
4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	Yes

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance	Yes
3	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person.	Yes
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	N/A
Do you have evidence that the Trust position regarding question 3 & 4 has been shared:		
5	At Trust Board?	Yes
6	With Board level safety champions?	Yes
7	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	No
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
11	Was the above workforce action plan shared with the LMNS?	Yes
12	Was the above workforce action plan shared with the ODN?	Yes
d) Neonatal nursing workforce		
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
15	Was the above workforce action plan shared with the LMNS?	Yes
16	Was the above workforce action plan shared with the ODN?	Yes

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.	Yes
2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. If this process has not been completed due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.	Yes
3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Meeting midwifery staffing recommendations from Ockenden and evidence of the funded establishment being compliant with outcomes of birthrate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● Where deficits in staffing levels have been identified, the plan to address these findings must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.** An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
5	A workforce action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will NOT enable the Trust to declare compliance with this sub-requirement.**	N/A
6	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
7	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will enable the Trust to declare compliance with this sub-requirement.**	N/A

Safety action No. 6

Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	Yes
2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**	Yes
3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Yes
4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	Yes
5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**	Yes
6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	Yes

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes
2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as:** •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Yes
3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: •Job description for MNVP Lead •Contracts for service or grant agreements •Budget with allocated funds for IT, comms, engagement, training and administrative support •Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	N/A
5	Show evidence of a review of annual CQC Maternity Survey data, such as the documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.	Yes
6	Has progress on the coproduced action above been shared with Safety Champions?	Yes
7	Has progress on the coproduced action above been shared with the LMNS?	Yes

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2024?		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants	Yes
6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	Yes
7	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	Yes
9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	Yes

11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.	Yes
12	For rotational anaesthetic staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
13	At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff	Yes
	Neonatal basic life support (NBLS)	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births	Yes
16	For rotational medical staff that commenced work in neonatology on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of Neonatal nurses (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
19	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes

Safety action No. 9

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	Yes
2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes
6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Yes
7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes
2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Yes
4	Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Yes
6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes
7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes

NHS Resolution

Section A : Maternity safety actions - Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	6	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	3	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	14	0	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	0	0	0
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	6	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	6	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	19	0	0	0	0
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes	8	0	0	0	0

Section B : Action plan details for Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

NHS Resolution

Maternity Incentive Scheme - Year 6 Board declaration form

Trust name	**Northern Lincolnshire and Goole Hospitals NHS Foundation Trust**
Trust code	**T600**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2024/25) or the previous financial year (2023/24)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Name:	
Position:	
Date:	

Signatures added in PDF

Maternity incentive scheme - Year 6 Guidance

Trust Name	**Hull and East Yorkshire Hospitals NHS Trust**
Trust Code	**T559**

This document must be used to submit your trust self-certification for the year 6 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D which is the board declaration form.

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the Board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust Board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering either 2023/24 financial year or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2025

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**

Technical guidance and frequently asked questions can be accessed in the year 6 MIS document:
MIS-Year-6-v1.1-20240716.pdf (resolution.nhs.uk)

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.

Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 8 December 2023 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 2 April 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose NA)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2 April 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	No
4	Were 60% of the reports published within 6 months of death?	Yes
5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews, any themes identified, and consequent action plans.	Yes
6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?	Yes
2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?	Yes
2	Or Is there a Transitional Care (TC) action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.		
3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	Yes
4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	Yes

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance	Yes
3	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person.	Yes
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	N/A
Do you have evidence that the Trust position regarding question 3 & 4 has been shared:		
5	At Trust Board?	Yes
6	With Board level safety champions?	Yes
7	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	Yes
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	N/A
11	Was the above workforce action plan shared with the LMNS?	N/A
12	Was the above workforce action plan shared with the ODN?	N/A
d) Neonatal nursing workforce		
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	No
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
15	Was the above workforce action plan shared with the LMNS?	Yes
16	Was the above workforce action plan shared with the ODN?	Yes

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.	Yes
2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. If this process has not been completed due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.	Yes
3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Meeting midwifery staffing recommendations from Ockenden and evidence of the funded establishment being compliant with outcomes of birthrate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● Where deficits in staffing levels have been identified, the plan to address these findings must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.** An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
5	A workforce action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will NOT enable the Trust to declare compliance with this sub-requirement.**	N/A
6	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
7	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will enable the Trust to declare compliance with this sub-requirement.**	N/A

Safety action No. 6

Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	Yes
2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**	Yes
3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Yes
4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	Yes
5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**	Yes
6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	Yes

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes
2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as:** •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Yes
3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: •Job description for MNVP Lead •Contracts for service or grant agreements •Budget with allocated funds for IT, comms, engagement, training and administrative support •Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	N/A
5	Show evidence of a review of annual CQC Maternity Survey data, such as the documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.	Yes
6	Has progress on the coproduced action above been shared with Safety Champions?	Yes
7	Has progress on the coproduced action above been shared with the LMNS?	Yes

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2024?		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants	Yes
6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	Yes
7	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	Yes
9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.	Yes
12	For rotational anaesthetic staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff	Yes
	Neonatal basic life support (NBLS)	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births	Yes
16	For rotational medical staff that commenced work in neonatology on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of Neonatal nurses (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
19	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes

Safety action No. 9

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	Yes
2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes
6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Yes
7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes
2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Yes
4	Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Yes
6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes
7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes

Resolution

Section A : Maternity safety actions - Hull and East Yorkshire Hospitals NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	No	5	1	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	3	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	12	0	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	0	0	0
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	6	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	6	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	19	0	0	0	0
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes	8	0	0	0	0

Section B : Action plan details for Hull and East Yorkshire Hospitals NHS Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action	Q1 NPMRT	**To be met by**	Q1 = 2025/26
Work to meet action	*Assurance meeting now in place to monitor all PMRT cases and compliance with MIS requirements so there is oversight with matron and audit and compliance managers.*		
Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes
Action plan owner	*Rebecca Julian / Matthew Proctor / Yvonne McGrath*		
Lead executive director	*Amanda Stanford*		
Amount requested from the incentive fund, if required	*£0.00*		
Reason for not meeting action	*Advised by NHS Resolutions to use this tool to explain non-compliance for 1 case which dropped compliance below 95% (93.75%). The PMRT lead was off sick suddenly and as a trust we were in a position where there was no quality and safety Maternity Matron or Director of Midwfery in post and therefore limited oversight. During this time the bereavement team completed the notification and opened the PMRT case, as per*		
Rationale	*We now hold meetings every 2 weeks to ensure criteria is met with the PMRT Lead, Quality and Safety Maternity Matron and Maternity Audit and Compliance manager. We also cross-check with the other trust in our group as a further failsafe and have more midwives trained to complete the tool in the eventuality the PMRT lead was to go off again. Unfortunately, this is a genuine error with staff members trying to*		
Benefits	*Future inputting and process errors will be avoided.*		
Risk assessment	*New assurance meeting aims to minimise risk. Advised by NHS Resolutions to declare non-compliance for Safety Action 1 and explain mitigation to MBRRACE which has been completed. MBRRACE will externally review caselist and take this into consideration. Compliance can be then upgraded and this will be conveyed to the trust very quickly following final MIS submission date.*		

	How?	**Who?**	**When?**
Monitoring	PMRT reports. Assurance meetings	Clinical Governance Midwife, Quality and Safety Maternity Matron	Quarterly reports. 2 weekly meetings.

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	Who?	When?
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	Who?	When?
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	Who?	When?
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	Who?	When?
Monitoring			

Maternity Incentive Scheme - Year 6 Board declaration form

Trust name Hull and East Yorkshire Hospitals NHS Trust
Trust code T559

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	No	Yes	-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**9**	**1**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2024/25) or the previous financial year (2023/24)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Hull and East Yorkshire Hospitals NHS Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	Hull and East Yorkshire Hospitals NHS Trust
Name:	
Position:	
Date:	

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

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

REFERENCES

Only PDFs are attached

BIC(25)014 - Performance, Estates & Finance Highlight Report & Board Challenge.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)014

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**13 February 2025**
Director Lead	Helen Wright, Gill Ponder – Chairs of CIC
Contact Officer / Author	Helen Wright, Gill Ponder – Chairs of CIC
Title of Report	Performance, Estates and Finance CIC Escalation Report
Executive Summary	This report sets out the items of business considered by the Performance, Estates and Finance Committees-in-Common at their meeting(s) held on Tuesday 18 December 2024 and 4 February 2025 including those matters which the committees specifically wish to escalate to either or both Trust Boards. The CIC gave limited assurance to the following items and details are included in the escalation report: • Financial Performance • Urgent Care, Cancer, Elective and Diagnostic Performance **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 in item 4 and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Financial implications are included in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

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

Report for meeting of the Trust Boards to be held on:	13 February 2025
Report from:	Performance, Estates and Finance Committees in Common
Report from meeting(s) held on:	18 December 2024 and 4 February 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 at their meeting(s) held on 18 December 2024 and 4 February 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:

- CQC Actions update – HUTH/NLAG
- Finance – BAF rating change
- Group Finance Report
- PA Consulting work
- Update on Business and Operational Planning
- Performance (Integrated Performance Report Headlines)
- Deep Dives: Diagnostics and Operational Pressures (including Winter & Urgent Care)
- Update on audiology data quality
- Estates and Facilities – Update including ERIC/Model Health, PSDS Bid Values & HUTH Catering Review

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:

Financial Performance

- The CIC received a transparent financial forecast that highlighted the best case scenario (£14m adverse to plan (Dec) moving to £10m (Feb)), the likely variance to plan (£20m

(Dec) £15.7m (Feb)) and the worst case scenario (£44m). Risks included; ERF funding for elective activity, not receiving planned income from ICS, ERF cap and an additional risk from the Band 2-3 issue,

- There remains ambition to close the current gap to plan and good progress has been noted between December and February.
- Balance sheet flexibility has supported delivery of the plan and the CIC emphasised the need to ensure a prudent position was retained with regards management of the Balance Sheet. This is being reviewed by the ICB to ensure consistency across the Trusts.
- The CIC celebrated the £78m Cost Improvement Programme achievement in year versus planned £84m, however caution was advised with regards the balance between run rates and CIP. The focus needs to move to measuring improvements to overall run rates rather than grossing up to net down using CIPs. The current way of managing the cost improvement plans (CIP) has not been satisfactory and received a limited assurance rating from Internal Audit, hence the need for transformation and a different approach to ensure that recurrent savings are delivered to improve overall financial sustainability.
- The initial deficit position for 2025/26 of £136m was shared, which clearly reflects that the Group current position is not sustainable and supports the need for the PA Consulting transformation programme and a highly capable Project Management Office (PMO) given the scale of change required. Based upon transformation activity identified this reduces to circa £50m, however robust execution is critical to success after the planning stage has been concluded.
- The CIC supported the need to strengthen the PMO at the December meeting and whilst some skills will need to be bought in, there is a desire to build capability internally. It was agreed that results will be regularly evaluated to ensure strong performance.
- Approval had been received in February from NHS England supporting the PA Consulting activity until the end of March 2025. The remaining contract with PA is risk based (contingent fee structure) and will be monitored weekly. Programmes for 2025/26 will focus on theatres, diagnostics, outpatients and flow.
- Culture – the CIC commended the focus on patient experience as part of the PA Consulting Plans – this has patients at the forefront with financial savings being a consequence of delivering the best care in the most efficient way.
- In light of the revised approach to delivering the CIP and the continued reduction in gap to plan, it was agreed that the Committees would support the Finance Leadership proposal to not declare a protocol break at this stage. The ICB are fully aware of the Group's position.
- The transparency and completeness of the financial reports was commended alongside the grip and control evidenced by the finance team.
- The CIC recognised that whilst we are reporting a gap to plan and there is limited assurance the plan will be achieved, there is reasonable assurance that maximum effort is being applied by our teams to address this. This was praised alongside the work the team had carried out relating to Rossmore and the review of flow.

<u>Business and Operational Planning</u>

- The Operational Planning guidance had been published and assumed an A&E 4 hour target of 78%, 1% 52 week waits, 65% RTT 18 weeks; or a 5% improvement in the number of patients on the PTL, 75% 62-day Cancer and 80% Faster Diagnosis Standard. It would no longer be possible to earn additional ERF income for increasing activity levels above plan. The CIC noted the challenging future position and requested a briefing paper be issued to provide clarity on next steps and the approval process, as

Boards would be required to go through a detailed sign off process in line with planning submission dates.

Performance

- Audiology data quality and performance reporting was reviewed after previous concerns had been raised about the accuracy of the data. The CiCs were advised that visibility of all patients was retained, therefore there had been no increased risk of harm to patients, as it had been confirmed that this was a data submission issue.
- Urgent and Emergency Care remained under pressure with issues around time to see clinician, flow and ambulance handovers. A new initiative has been introduced to reduce ambulance handovers to 45 minutes working alongside Yorkshire Ambulance Service (YAS) and this has delivered significant improvements in ambulance lost hours in January, improving patient safety in the community. Plans are in place to rollout this initiative at NLAG in conjunction with EMAS
- The Group had moved into Tier 1 support for Urgent Care . PA Consulting focused on the flow improvement programme at Hull Royal Infirmary (HRI), where severe congestion was occurring at the front door, not just from ambulance arrivals. Sarah Tedford had conducted detailed reviews of the issues and concluded that improvement can only be made once overcrowding has been tackled to enable patients to be managed in a structured way and the 3 key enablers for improved performance to be achieved. Work is ongoing with the Care Groups to change cultures, improve ward and board rounds and encourage specialties to manage both their emergency and elective patients. The issues in Urgent Care require teamwork and collective action, so focus was on all teams pulling patients out of ED rather than the responsibility lying with ED to push, alongside the creation of temporary escalation spaces for boarding.
- Improvements in the Cancer Faster Diagnosis Standard (FDS) had not yet been reflected in improvements in performance against the 62-day standard, as that was expected to take around 6 months with a deterioration in that standard initially as the backlog is cleared.
- Concern was raised around the size and shape of the waiting lists as a result of the focus on the 65-week waiting targets (see section 4.0).
- Diagnostics reflected an improving position but further work was required to achieve the new 5% target. Waiting times were reducing, but the numbers of patients waiting were growing as increased activity was not keeping pace with increased demand. Once open, the Community Diagnostic Centres (CDCs) will increase capacity.
- Risks were flagged around demand and capacity mismatches for endoscopy and pressures that may arise due to bowel screening programme changes. Mitigations will be reviewed.
- For all operational areas, limited assurance was noted. There are lots of plans to improve and where there is focus this is evidenced, but the changes are not yet embedded into transformed processes and the improvements are therefore not sustained.

Estates and Facilities

- The CiC was assured by the Estates and Facilities report, including the plans to reduce the Backlog Maintenance and Critical Infrastructure Risks from allocated capital and Public Sector Decarbonisation Scheme (PSDS) funding. Whilst funding was nowhere near the level needed to eradicate those risks, significant improvements would be achieved in 2025/26 as a result of the PSDS work being carried out at Scunthorpe Hospital which would address 4 high risks on that site. In February £1m grant funding had been bid for and received. This would be used for investments relating to high risks.

- The HUTH catering arrangements had been reviewed by Cabinet and changes proposed to eliminate the negative contribution noted in prior year. The plans should lead to an initial break-even position without a detrimental impact on patient and staff wellbeing and will be reviewed in September 2025.

4.0 Matters on which the committees have requested additional assurance:

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

- The committee referred the overspend on clinical pay versus plan of £17.3m to the ARG committee for consideration, as there may be an opportunity for this to be reviewed by Internal Audit using data analytics tools. This may not be deemed a priority but should be considered in light of the value of overspend.
- At a previous meeting there was assurance provided that the target of no more than 8 65 week waiters would be achieved by the end of December. As there were 94 patients waiting over 65 weeks, the target was missed. Further information is being collated to better understand tipover risks and the issues behind this inaccuracy. Lessons learnt will be presented at the next meeting.
- The CIC concluded that there was insufficient clarity regarding actions to improve some areas of operational performance and that the commentary within the GIPR (Group Integrated Performance Report) required a refresh. There is a need to focus on the top improvement actions and the improvement towards target performance trajectories to provide assurance that improvements were on track for delivery.
- The CIC requested to understand which of the PSDS bids the Group would pursue should bids be successful, against the context of constrained capital funding levels versus requirements and the need to match any grants awarded. It was unlikely that the Group would know which bids had been successful until the end of April, but there was an opportunity to decline some at that point if the Group were offered more grants than could be matched with the capital available.
- An initial summary of the Estates Return Information Collection (ERIC) data for model health was provided by the Estates and Facilities team. This illustrates benchmark costs across the Trusts and nationally. The underlying data requires review to ensure consistency of data collection and apportionment of overheads. It was agreed that this would be undertaken as part of a check and challenge process which would include examining variation in products and services across the Group, with the intention of adopting best practice. This work would be carried out across a 12 month period and the outcome would be brought to the CiC based on prioritisation.

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

5.1 There will be an update as part of the BAF quarterly reporting cycle at the March meeting

5.2 The CIC received a presentation detailing the Finance risk and regarding the proposed BAF score of 20 (4 likelihood x 5 consequence) which was a reduction from 25. The CIC agreed that there were robust plans in place, with funding support achieved for transformation.

Whilst it was recognised that the Group is not in a position of financial sustainability, there are clear plans in place to initiate transformational change and line of sight to a significantly improved position. As such, it was concluded that the consequence was major (4) and not catastrophic (5). The overall BAF risk was recalibrated to 16 (4 x 4).

There is however a need to effect cultural change, as additional funding cannot continue to be the first solution to issues. The focus needs to be on a mindset shift towards value for money, efficiency and transformation in the future.

The CIC concluded that the finance score reducing to 16 should support continued focus on quality and safety of patients . Financial savings will be delivered through optimising the patient journey and experience. However, the need for system support in delivering this transformation should not be under-estimated.

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, Non-Executive Director and Chair of the Performance, Estates and Finance Committees in Common

Gill Ponder, Non-Executive Director and Chair of the Performance, Estates and Finance Committees in Common

4 February 2025

3.3 - WORKFORCE, EDUCATION & CULTURE COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORT & BOARD CHALLENGE

Tony Curry & Julie Beilby, Non-Executive Director Committee Chairs

REFERENCES

Only PDFs are attached

BIC(25)015 - Workforce, Education & Cultures Commitees-in-Common Highlight Report & Board Challenge.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)015

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**13 February 2025**
Director Lead	Julie Beilby, Chair of CIC
Contact Officer / Author	Julie Beilby, Chair of CIC
Title of Report	Workforce, Education and Culture CIC Escalation Report
Executive Summary	This report sets out the items of business considered by the Workforce, Education and Culture Committees-in-Common at their meeting(s) held on Wednesday 29 January 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:

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

Report for meeting of the Trust Boards to be held on:	Thursday 13 January 2025
Report from:	Workforce, Education and Culture Committees-in-Common
Report from meeting(s) held on:	29 January 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 at their meeting(s) held on 29 January 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 January 2025

- NLAG/HUTH CQC Actions Report
- Registered Nursing and Midwifery staffing report
- Integrated Performance Report
- Recruitment and time to hire KPI
- Group People Strategy 2025-18
- National Staff Survey results
- Sexual Safety Report
- Review of Executive, Senior and Operational structure
- Freedom to Speak Up Report HUTH/NLAG

3.0 Matters for reporting / escalation to the Trust Boards

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

29 January 2025

a) Good progress has been made and an agreement had largely been reached regarding the Band 2/3 maternity support workers. MoU being finalized.
b) The vaccination rates for the Group are 47%.
c) The CIC noted the improvements regarding the outstanding CQC actions, but queried the mandatory training compliance of the Medics. A review of mandatory training is taking place to harmonise between NLaG and HUTH and there are also national

changes planned. This will be brought back to a future meeting. Reasonable assurance was given to this item.

d) There is a risk regarding the 3 support posts (2 x Maternity and Apprenticeships Practice Learning Facilitators and 1 x Legacy Mentor) who are very important in onboarding new nurses and midwives transition into their new roles. The support they offer includes health and wellbeing and embedding new practice. Further work in hand to validate impact. CiC gave reasonable assurance on Registered Nursing and Midwifery Staffing
e) There have been marked improvements in the Time to Recruit KPIs. The CIC thanked the teams, particularly Occupational Health for their hard work. Reasonable assurance was given.
f) The CIC received an information report concerning the implementation of the Group Executive, Senior and Operational structure – the report described that implementation is far from complete but charted where the Group was and the recruitment of the site CEOs and the direction for 2025/26 and beyond. The CIC await a more comprehensive and critical review in 6 months for assurance purpose.
g) The CIC received the Group People Strategy 2025-28 and recommended approval by the Boards in Common. The CIC suggested linking the KPIs to objectives, a deep dive into the proposed new technology and ESR alignment across the Group as future discussion points. The CIC would like to review the funding support going forward to support delivery of the strategy.
h) Freedom to Speak up Guardians highlighted an increase in inappropriate behavior and a notable increase in those received from senior staff. The CIC agreed to discuss this further as part of the internal audit report, along with triangulating the data against other indicators. The CIC supported the involvement of FTSU guardians in future culture discussions. Reasonable assurance was given.
i) The initial Staff Survey figures were presented and early indications detailed a deterioration from last year. An action plan was being developed and would be presented to a future meeting.

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) Nursing and Midwifery staffing report. The CIC requested further information regarding Nurse and Midwifery work-life balance and flexible working. The engagement discussion would be drawn out from the Staff Survey item. Reasonable assurance was given.

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 BAF was not presented at this meeting.

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

29 January 2025

3.3.1 - FREEDOM TO SPEAK UP GUARDIAN (FTSUG) REPORT - QUARTER THREE

Liz Houchin & Fran Moverley, FTSUGs

REFERENCES

Only PDFs are attached

BIC(25)016 - Freedom to Speak Up Guardian Report - Quarter Three.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)016

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	13th February 2025
Director Lead	Simon Nearney, Chief People Officer
Contact Officer / Author	Elizabeth Houchin – NLAG Freedom to Speak Up Guardian Fran Moverley – HUTH Freedom to Speak Up Guardian
Title of Report	**Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 3) – NLAG** **Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 3) – HUTH**
Executive Summary	Each report provides the Q3 report for 2024/2025 for NLAG and HUTH respectively. Each report gives an update from the Q2 Board reports including an overview of the number of concerns raised, national and regional updates and the proactive work undertaken by each Freedom to Speak Up Guardian.
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 29th January 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 3 Report October to December 2024

Liz Houchin
14th January 2025

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Quarter 3 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 3 (Q3) of the 2024/2025 reporting year. The paper includes details of relevant regional and national updates for comparison and context. An overview of Group working as the NHS Humber Health Partnership is also provided.

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

2. Strategic Objectives, Strategic Plan and Group Priorities

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

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

3. Introduction / Background

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

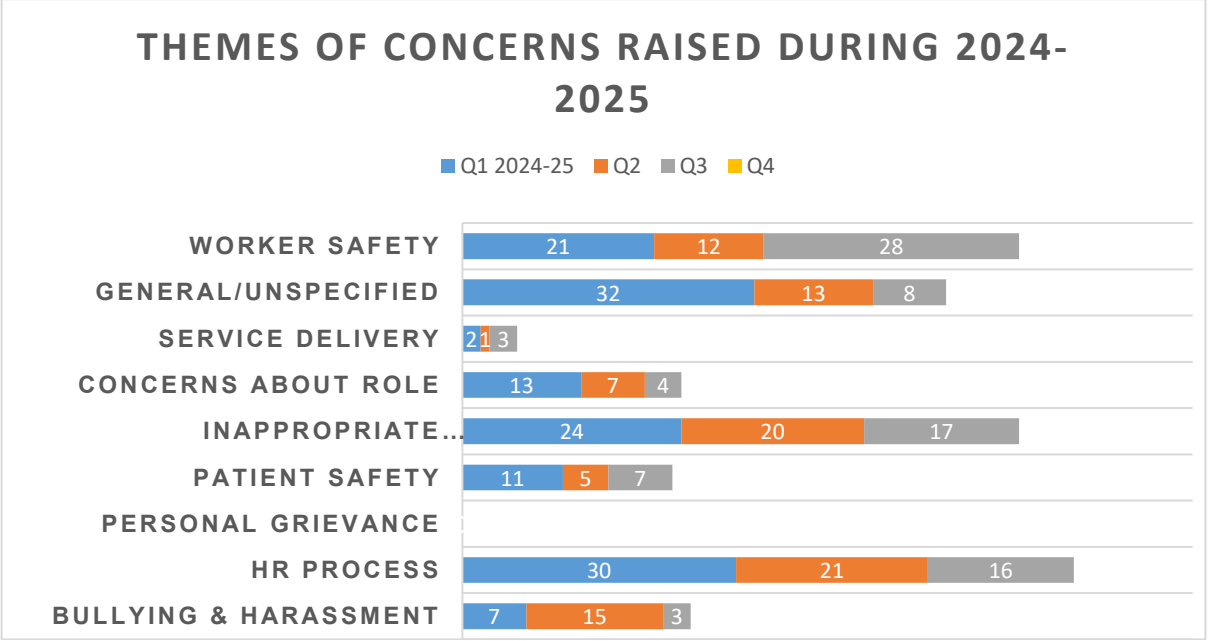
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Freedom to Speak Up Policy for the NHS (DCP126)
- Grievance Policy (DCP084)

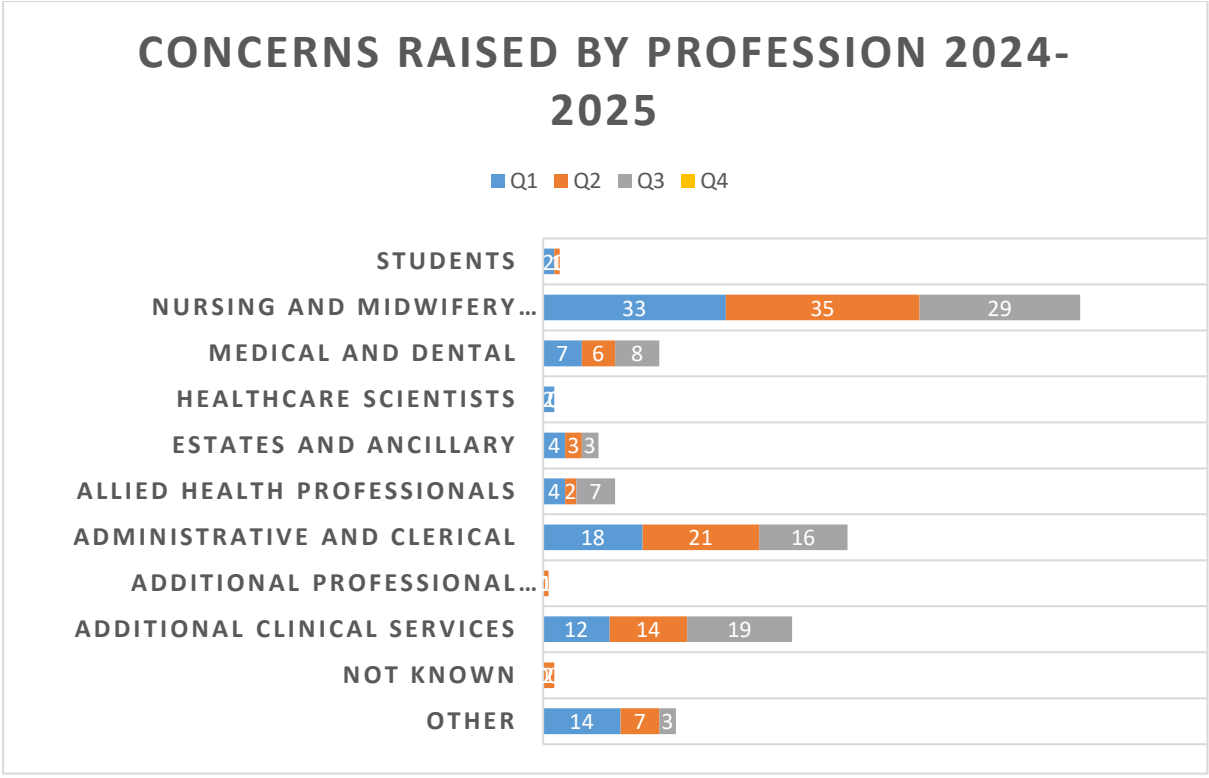
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during 1st October 2024 to 31st December 2024 (Q3) – data, comments and assessment.

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

4.2 The following graphs show the themes and the professions who contacted the FTSUG during 2024-25 up to and including Q3.





4.3 In Q3 2024-25, 85 concerns were received. 24% of these were closed on the same day after giving advice or signposting.

- 3 concerns were raised anonymously in Q3, all through the Staff App.
- In Q3 7 concerns involved an element of patient safety. This puts the Trust in the fourth quartile nationally, the peer figure being 5 (figures accessed from Model Hospital data January 2025).
- In Q3 3 concerns involved an element of bullying and harassment which puts the Trust in the second quartile nationally, the peer median figure being 5 (figures accessed from Model Hospital data January 2025).
- In Q3 17 concerns involved an element of inappropriate behaviours which puts the Trust in the third quartile nationally, the peer median figure being 11 (figures accessed from Model Hospital data January 2025).

4.2 The Q3 figure of 85 is significantly lower than Q3 in 2023-24 which was 104. The main themes raised were around worker safety, inappropriate behaviours and HR process.

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.

Quarter 2023-24	Feedback received	Would you speak up again? Yes
Q3	10	10

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 in Q3.

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

The Guardian treated my concern with great respect and confidentiality. I felt very supported throughout the whole experience.

Feel because we have spoken up we are now being treated differently

I can't thank Liz enough. I honestly felt like my concerns were valid and that I would be supported to address these. I have already had a positive response from my concern and hope that my experience will not happen to anyone again.

Thank you for your help but I won't speak up again.

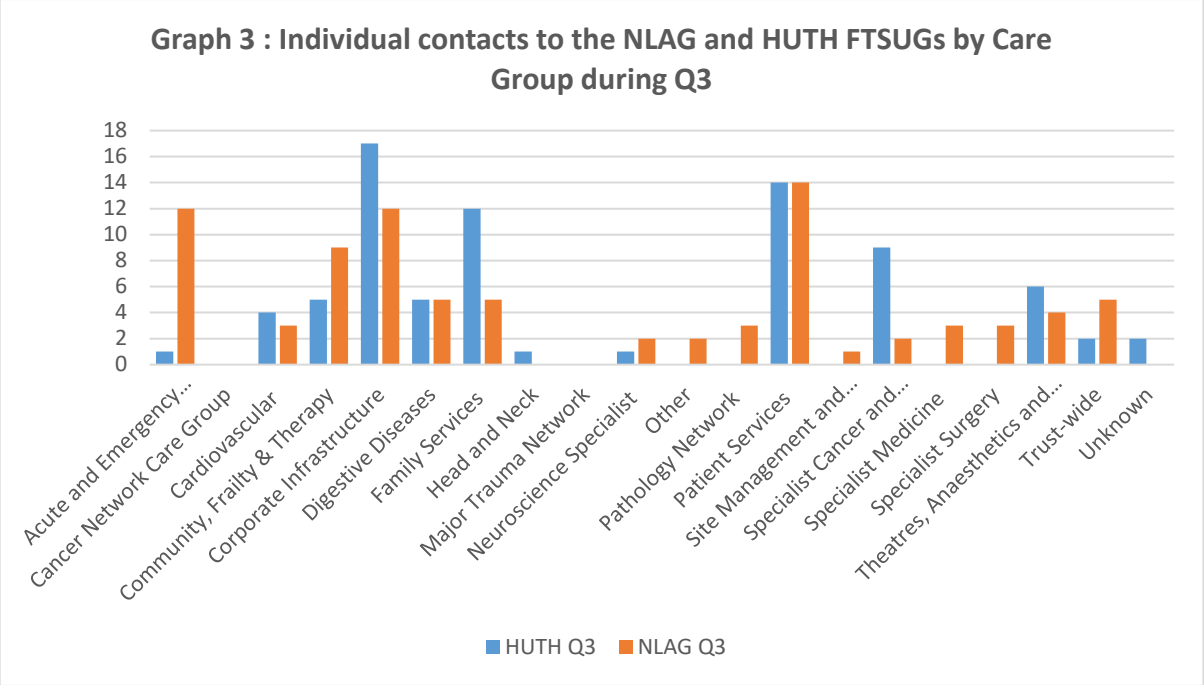
4.7 Case Study

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

The FTSU Guardian received a concern from a colleague who felt that a patient's care had been impacted by communication delays between different professions. The colleague had already completed an incident form and had spoken to their line manager who had escalated it appropriately and there was an ongoing investigation. The colleague wanted to know if anything else could be done and was also very distressed. The FTSUG confirmed that all appropriate actions were being done, and also signposted the colleague to support services and checked that they had access to clinical supervision which they confirmed. The colleague thanked the FTSUG and said they would contact them again if needed.

4.8 Care Groups – Concerns Combined:

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 3 provides a Group overview of the concerns raised to the sovereign HUTH and NLAG FTSUGs combined.



5. FTSUG activities and proactive work during Q3

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

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at all Trust inductions
- Champions network meeting
- Internal Audit Review of FTSU
- Joint working with Guardian of Safe Working – canteen drop-ins
- Continued work in support of the NHS England Board Self-Reflection and planning tool action plan. (A progress report against the improvement and strengths action plan is included as Appendix 1 to this report.)

5.2 Future plans:

- Continue to work with HUTH FTSUG to develop FTSU Group Strategy
- Continue to recruit and train FTSU Champions
- Work with Care Groups to ensure that learning from concerns is embedded into practice.
- Attendance at all relevant meetings
- Attendance at NGO Headquarters for Mentor work

6. Regional and National Information and Data

6.1 Regional update

The FTSUG continues to attend regional meetings virtually. Discussions and presentations have included how to support colleagues who are neurodivergent, the FTSU Champions training and what FTSUGs need to do to prepare for audits..

6.2 National update

There are now 1231 FTSU Guardians in 738 organisations.Q2 data has now been published, the number of cases raised with FTSUGs was the highest ever with a 23% increase from the same quarter last year. Inappropriate behaviours was the top theme (40%) followed by worker safety (38%). The increase in worker safety is mirrored at NLaG. The National Guardian, Dr Jayne Chidgey-Clark will be giving evidence at The Thirlwall Inquiry in the coming weeks.

7. Conclusion

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

8. Recommendations

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

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

Liz Houchin
14th January 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 3 Report
October to December 2024

Fran Moverley
January 2025

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Report Quarter 3 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 October 2024 to 31st December 2024 - quarter three (Q3) of the 2024/2025 reporting year. The paper includes details of relevant regional and national updates for comparison and context. An overview of Group working within the NHS Humber Health Partnership is also provided.

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

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 This paper contributes to the current HUTH Strategic Objectives of ‘Great Staff’ and ‘Great Care’.

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

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

3. Introduction / Background

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

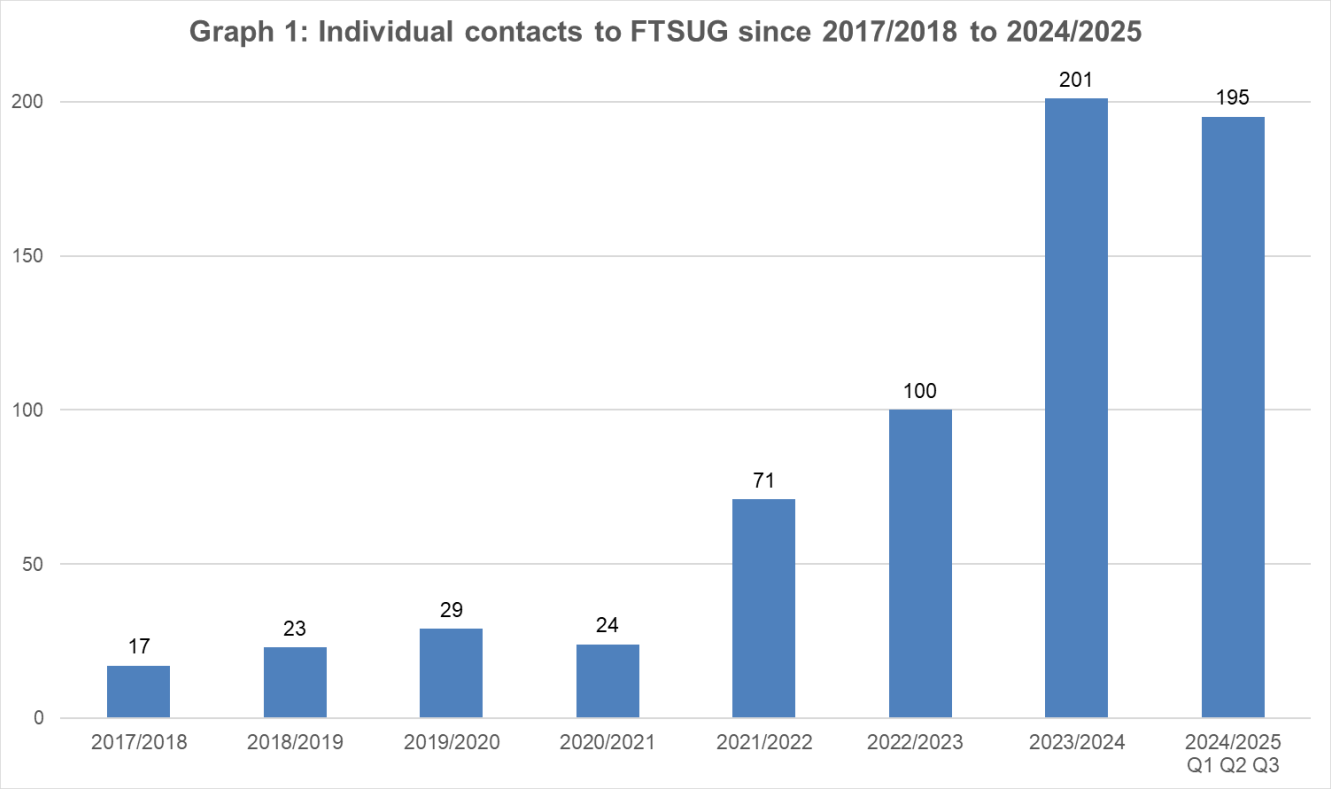
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Raising Concerns at Work (whistleblowing) policy (CP169)
- Freedom to Speak Up Policy for the NHS (CP451)
- Staff Conflict Resolution and Professionalism in the Workplace Policy (CP269)
- Grievance Policy (CP036)

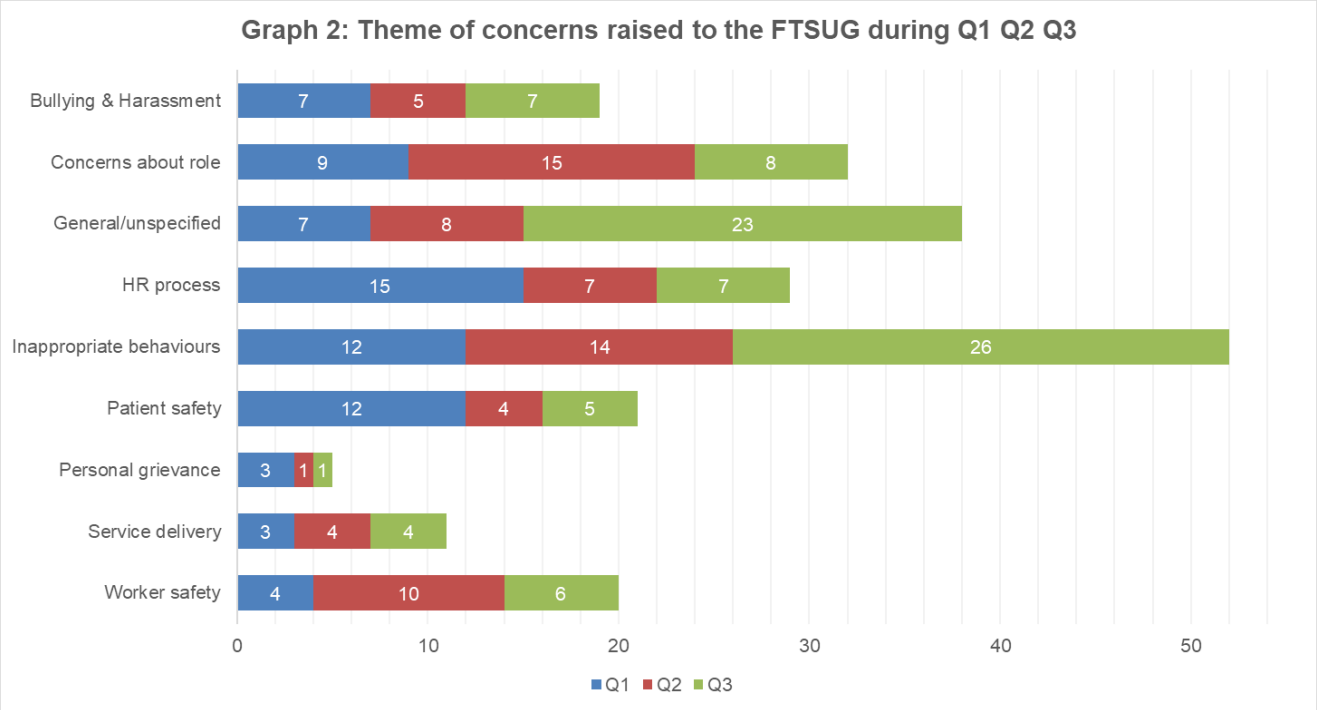
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during 1st October 2024 to 31st December 2024 (Q3) – data, comments and assessment

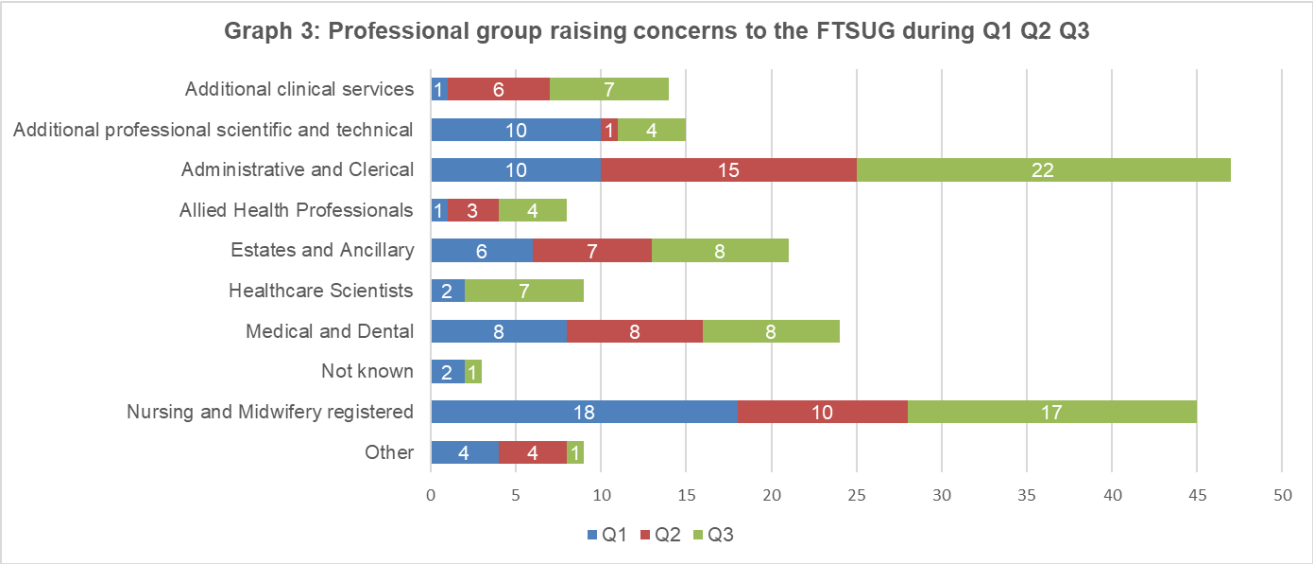
4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office.

4.2 Graphs 1, 2 and 3 summarise the Q3 data:





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



4.3 Observation and comments during Q3:

- During Q3 2024/2025, 79 concerns were received by the FTSUG. This was an increase of 46% from Q2 2024/2025 (54). Graph 1 shows that the total number of concerns raised year to date is close to exceeding the total annual number of concerns reported during 2023/2024.
- At 02.02.25. 39 concerns remain open (from Q2 and Q3).
- During Q3, 1 concern was raised anonymously (where the FTSUG did not know the identity of the individual). This was a general concern about an internal Trust process. The FTSUG escalated the concern to a relevant department manager and Matron, and received immediate feedback and assurance that the process will be changed as a direct result of the individual speaking up.
- An increasing number of individuals requested to be anonymous throughout the speaking up process (where the FTSUG knew the identity of the individuals but did not have consent to release their identities). This represented 20% (16) of the individuals approaching the FTSUG.
- 52% (41) 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 85% (35) of individuals had already spoken up to their line manager, before approaching the FTSUG.
- The highest number of reasons for staff approaching the FTSUG had an element of concerns related to:
    - Inappropriate behaviours (26)
    - General concerns (23)
    - Concerns about the individual's role (8)
- Concerns about inappropriate behaviours and general concerns both increased in comparison to Q2; whereas concerns about an individual's role reduced.
- During Q3 the most common professional groups raising concerns were administrative and clerical workers (22); followed by nursing and midwifery (17) and jointly medical and dental (8) and estates and ancillary (8).

- During Q3 no staff members reported being subject to detriment and/or negative impact as a result of speaking up. However, the FTSUG observed that many staff expressed a fear of backlash for speaking up.

4.4 FTSU Guardian Feedback/Evaluation:

The FTSUG has introduced a feedback survey to invite staff (where appropriate) who have spoken up to provide feedback on their experience. The FTSUG is split into two parts – firstly the worker's experience of the HUTH FTSUG, and secondly, their experience of speaking up to the wider Trust e.g. to their line manager or other appropriate individuals.

The National Guardian Office guidance only requires one mandatory question to be included in the survey - *'Given your experience, would you speak up again to the Freedom to Speak Up Guardian?'.*

During Q3, 11 responses to the survey were received and the key results related to the experience of the FTSUG included:

- 91% (10) found it very easy and 9% (1) found it fairly easy to make contact with the FTSUG. No respondents answered that the FTSUG was not easy or difficult to contact.
- 91% (10) had an excellent experience and 9% (1) had a good experience of the FTSUG. No respondents answered they had a fair or poor experience of the FTSUG.
- 100% (11) of respondents stated they were both well supported by the FTSUG and listened to and taken seriously.
- 91% (10) of respondents would speak up to the FTSUG again; 9% (1) was unsure.

Feedback provided about the FTSUG and what went well included:

- "Fran actively listened to my concerns and gave neutral advice and guidance. I felt supported and listened to"
- "With today's culture in the NHS it can often feel like none is listening especially when the problems involve senior staff member, or thinking no one will believe you"
- "The freedom to speak up guardian took seriously all of my concerns and I felt very comfortable speaking with them. I would certainly recommend that. I don't necessarily feel that the response that I got from the management was adequate, so was it worth my time?"
- "I felt that my issue was addressed well. Most importantly I felt valued and respected."
- Fran listened to my concerns, without judgment or dismissal. I felt safe as unfortunately in the past a manager broke her promise of confidentiality"
- "Fran was very prompt to pick up my concern and report back with updates when available. She took my concerns seriously and didn't make me feel like I was over reacting. I was pleased that we managed to find a way of raising my concerns without identifying myself or the individual I wished to flag concerns about".

Feedback provided about the FTSUG and what could be improved included:

- 5 respondents commented that nothing could be improved.
- 1 respondent stated that *"*Staff are still reluctant to come forward and need reassurance that it is safe to talk".

The second part of the feedback survey includes questions on the staff member's experience of speaking up to the wider Trust. Key results included:

- 91% (1) would speak up to the wider Trust again; 9% (1) was unsure. No respondents stated they would not speak up again.
- 71% (7) felt their concern was treated confidentially; 18% (2) were unsure and 18% (2) chose not to raise their concern.
- All respondents who chose to raise their concern (9), felt their concern was listened to and taken seriously.
- 45% (5) of felt their concern had been addressed and 27% (3) felt in part their concern had been addressed.

Feedback provided about speaking up to individuals at the wider Trust and what went well included:

- "A solution to the problem was found"
- "Manager whose area of responsibility it was also responded promptly and effectively"
- "The issue was addressed and actions were in place"

Improvements that the wider Trust could make to speaking up include:

- "It's difficult as there is a lot of red tape"
- "Managers need correct training on how to be a manager, not just promoted because there is no one else interested in the vacancy. Managers need to be fair and transparent with all staff and not just the ones they like better"
- "Problems still get dismissed and managers are reluctant to address any problems in their area"
- "Unfortunately, talking to a line manager about anything in the Trust is not a good experience, nothing is kept confidential, no one takes your concern seriously, they tell you they will deal with the concerns (even logged at a 1:1) but then nothing happens and the concern happens again (repeatedly)"
- "Even though everything with the freedom speak up guardian went exactly as it should. I feel that management gave a vague response and no particular promise to prevent future recurrences".

It is proposed that in the 2024/2025 annual report a full review of the survey responses received is conducted, with a greater number of responses over the year and consideration of the protected characteristics of the respondents.

4.5 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 a positive example of where a Trust

senior manager has listened and acted upon speaking up concerns:

The HUTH freedom to speak up guardian (FTSUG) received a number of concerns from a staff member about the poor behaviours and attitudes of a group of colleagues who had formed a 'clique' in their department. The staff member was very upset, felt isolated and as a result had decided to resign from the Trust. The staff member was also aware that others in the department were also being subjected to similar behaviours.

After receiving the request for support, the FTSUG met confidentially with the staff member and discussed their concerns, including agreeing that the FTSUG would escalate the information along with the name of the staff member.

The FTSUG met with the Care Group Nurse Director who immediately contacted the staff member to offer support, asked to meet and reassured the staff member that it is really important that concerns are raised.

Following this discussion, the Nurse Director provided an update to the FTSUG that the two had met and informal action had been taken with the staff identified. The Nurse Director and senior Nurse for the department had met with each individual and spoke about civility in the workplace and the staff charter; the Nurse Director also kept the staff member updated throughout to ensure they had feedback from speaking up.

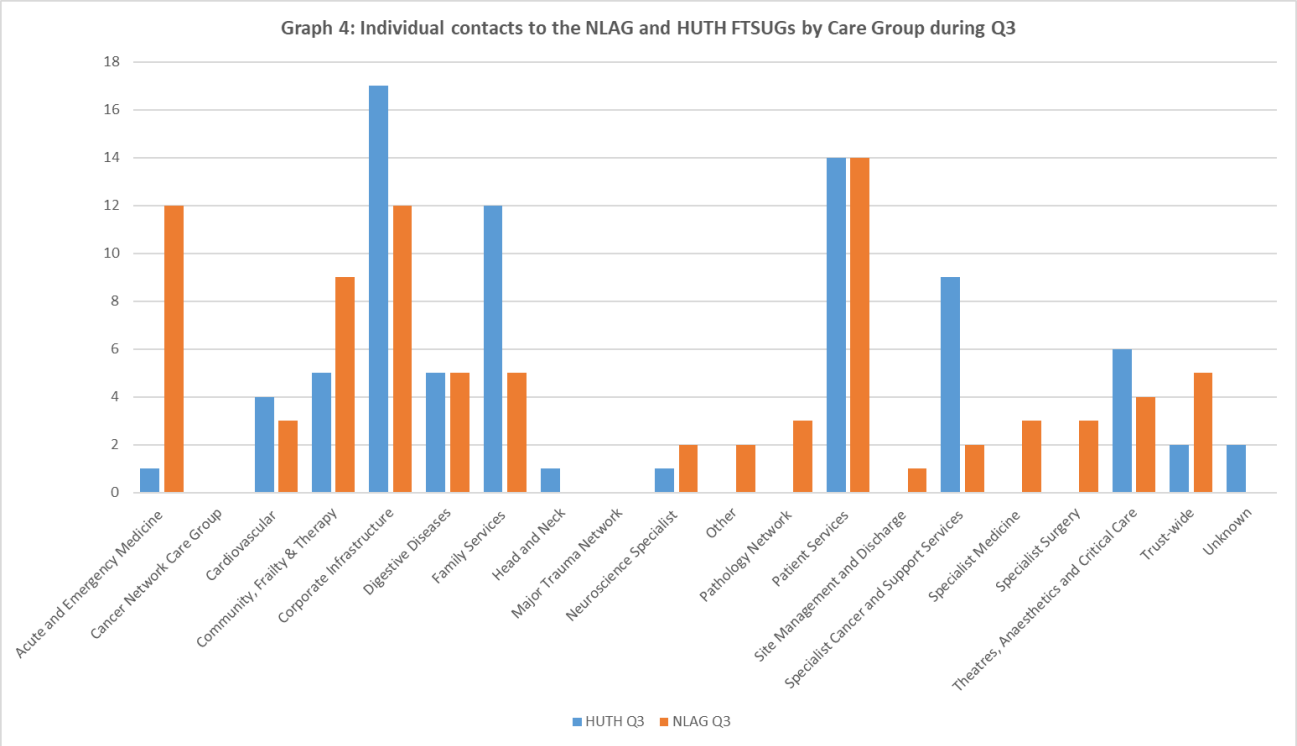
Whilst it was not possible to stop the staff member from leaving the Trust; speaking up about their experience has brought about action and change for the future.

4.6 Care Groups – concerns combined

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

At HUTH, the highest number of concerns were received regarding departments within the Corporate Infrastructure, followed by Patient Services and Family Services.

Collectively as a Group, the highest number of concerns received per Care Group were for a consecutive quarter Corporate Infrastructure, followed by Patient Services.



5. FTSUG activities and proactive work during Q3

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

- Continued work in support of the NHS England Board Self-Reflection and planning tool action plan.
- Completion of the first draft of the Group Speak Up Strategy, in partnership with the NLAG FTSUG.
- Activities during national awareness month for freedom to speak up:
    - Several face to face staff drop in sessions held at both Hull Royal Infirmary and Castle Hill Hospital
    - Several virtual staff drop in sessions
    - Offered two managers training sessions 'Supporting teams to speak up and creating a safe environment' in partnership with the NLAG FTSUG
    - Becoming a Speak Up Champion Q&A drop in virtual session
- At the Staff Disability Network Group conference, participated as a panel member at the Q&A session and provided a promotional stall.
- Promotional stall at the BAME Staff Network Group conference.
- A further five Speak Up Champions were trained, increasing the total number of Champions to 37.
- To celebrate two years of the Speak Up Champion Network, a Celebration Event was held with the Speak Up Champions and attended by the Group Chairman.
- Delivered induction presentations to the newly qualified Nurses 'Let's Get Started' programme and newly qualified Nursing Associates.
- Presented at the Therapies Clinical Leads meeting; introducing the FTSUG role and the importance managers play in speaking up.
- Commenced monthly 121s with the new Responsible Officer for the Group to work in partnership and promote the timely escalation of concerns regarding Doctors.

- Supported the delivery of a GMC training session ‘Raising Concerns and Duty of Candour’ in partnership with the NLAG FTSUG and GMC Regional Liaison Officer to HUTH and NLAG Doctors.
- Met with the new first year midwifery students to introduce the FTSUG role and the importance of speaking up.
- Participated in the first year student nurses university ‘prepare for practice’ week through presenting a refresher of FTSUG and an interactive training session prior to the students commencing their first placements at HUTH.
- Introductory meeting with the North Site Chief Executive.
- Ongoing regular meetings with the Group Chief Executive, Group Chief People Officer, Group Chairman and FTSU Non-Executive Director.

5.2 Future plans:

- Following the consultation and ratification process for the Group Speak Up Strategy.
- Continued work to introduce an online FTSU reporting form to assist accessibility of speaking up.

6. Regional and National Information and Data

6.1 Regional update

The FTSUG attends, where possible, the Yorkshire and the Humber and North East regional meetings to discuss best practice and contribute to active discussions. The recent meeting discussed information governance in relation to FTSUGs stepping down and the NGO mandatory training for FTSUGs.

6.2 National update

NHS England are undertaking a review of two of the e-learning programmes; ‘Speak Up’ (aimed at all workers) and ‘Listen Up’ (specific to line managers). The HUTH FTSUG participated in reviewing the modules and providing improvement ideas at two feedback sessions, to inform changes to the national e-learning education programmes.

The National Guardian Office have released the national Q2 figures; in total 9291 individual cases were reported to FTSUGs – the highest ever number of cases reported in a quarter. This represented a 23% increase in comparison to Q2 in the previous reporting year 2023/2024 (7548).

Nationally 40% of cases reported to FTSUGs in Q2 included an element of inappropriate behaviours (excluding bullying and harassment); in comparison HUTH reported 26% and 33% in Q2 and Q3 respectively. Nationally in Q2 the biggest change in the type of case reported were those with an element of worker safety, representing 38.6% of cases. In comparison at HUTH 18.5% in Q2 cases were reported under this category; and 7.6% during Q3.

7. Conclusion

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

7.2 The FTSUG has continued to be active in promoting speaking up and creating partnerships with internal and external stakeholders.

7.3 The Group arrangements have been developed, with the HUTH and NLAG FTSUGs working closely together to develop consistent reporting processes and recognition at national level as good practice.

8. Recommendations

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

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

9. Appendix: NGO Reflection Planning Tool – Development Actions Update

ACTIONS IN PROGRESS			
Development areas to address in the next 6–12 months	**Target date**	**Action owner**	**Progress update**
Action 8: Creating an organisational wide Circle group approach to better use FTSUG intelligence and other cultural indicators.	30/11/24	Group Director of Learning & Organisational Development	**Action in progress** • Initial discussion held between Head of Organisational Development and FTSUG to discuss what indicators and data could be appropriately used for a Trust wide group. • This action needs further thought as more reporting tools are made live. Zero tolerance to ableism launched October 2023 in addition to the existing zero tolerance to racism. • LGBTQ+ framework and circle group are due to go live February 2024. • Group Director of Learning and Organisational Development have identified a potential support/supervision need for staff network leadership teams – informal meeting to discuss further the scope of this work in February 2024. • Head of OD (South) now in post and has EDI and Cultural Transformation as part of their portfolio. Target date of 31st August 2024 for roll out of Zero Tolerance tools Group-wide. **At 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.**
Action 9: Development of a Trust wide Professionalism and Kindness programme that supports just and speaking up culture.	30/11/24	Group Director of Learning & Organisational Development	**Action in progress** • PACT "Professionalism and Civility Training" launched from late August 2023 onwards, alongside a marketing campaign to allow us to reflect on how "Bad Behaviour Doesn't Work – Time to Change". **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:
			  ○ Civility and Respect Campaign refresh and relaunch (bad behavior doesn't work)
			  ○ Required Learning for Leaders inc PACT
			  ○ "What's it like to be managed by me?" and "What's it like to work with me?" style content
			  ○ Cultural Ambassadors (NLAG have currently and scoping out group roll out)
			  ○ Cultural Dashboard – People metrics triangulated to give an overall picture of culture in a care group or department
			At 01/12/24:
			• As above, the bite sized leadership courses, including PACT training are now live and bookable across the Group.
			• The new staff behaviours charter to be rolled out; this will include workshops for leaders/teams and train the trainer. Managers will be trained to subsequently deliver workshops for values and behaviours and lead a conversation with their teams.
			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.**

Action 13: Review what triangulation of data is possible including what data can be obtained e.g. patient safety, staff survey. Link with action 8.	31/12/24	FTSUG	**Action in progress** • FTSUG conducted a breakdown per Health Group of the staff survey 2022 results. Presented information within the Health Group Governance briefing reports. • January 2024 – initial discussion with NLAG FTSUG to discuss best practice and different ideas for triangulation. • March 2024 commenced reviewing 2023 staff survey results in relation to the four speaking up questions. Trust-wide results communicated to each Health Group in the governance briefing reports. • Ongoing discussions with the Workforce Intelligence team to provide data to Care Group triumvirates, in conjunction with other relevant workforce data.

			At 16/07/24: • BI spreadsheet in development with assistance from the Workforce Intelligence team, to develop reporting data for Care Groups. At 01/12/24: • FTSUG continues to be a member of the zero tolerance to discrimination and departmental incivility circle groups, to aid triangulation. • HUTH FTSUG and NLAG FTSUG have co-created a Group-wide graph using speaking up data to assist in triangulating data across the Care Groups. • HUTH FTSUG and NLAG FTSUG have commenced meeting with the South site triumvirates to discuss speaking up data and aid the triumvirates in triangulating key data. 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.
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.**

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	30/11/24	Group Director of Learning &	**Action completed**

transformation pieces e.g. Maternity and Cardiology and ensuring the FTSUG is used as an "internal consultant" to bring expertise into bespoke work design.		Organisational Development	• The Maternity reporting tool is now live and Cardiology is currently in progress. • FTSUG a member of the new Circle Group for Maternity and is actively part of triaging and discussing any concerns raised. • Cardiology incivility reporting tool launched on 10th November 2023. • FTSUG continues to be involved in the monthly circle groups. At 01/12/24: • Maternity incivility tool has been relaunched; including direct staff communications via a maternity tea trolley. The tool is part of business as usual. • Action closed.
Action 10: Implementation of the new NHS England speaking up policy. To 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.

3.3.2 - PEOPLE STRATEGY - 2025 - 28

Simon Nearney, Group Chief People Officer

REFERENCES

Only PDFs are attached

BIC(25)017 - People Strategy - 2025 - 28.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)017

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 13th February, 2025
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer / Author	Paul Bunyan, Deputy Chief People Officer
Title of Report	Group People Strategy 2025-28
Executive Summary	The Group People Strategy 2025-28 is presented for Trust Board-in-Common approval. The strategy sets out five workforce themes which have been informed and shaped by our people, partners and key stakeholders. Our National Staff Survey results show a decline which leaves us in the lower quartile nationally for our Group. In response, our strategy is ambitious and deals with the basics of enabling a solid psychologically safe environment, whilst pushing the boundaries and practicalities of what a positive and healthy staff experience should look and feel like. The People Strategy is one of the main strategies under the Group Strategic Framework. Time and care has been taken to ensure alignment both vertically and horizontally across the wider strategic frameworks. The People Strategy is enabled by five workforce frameworks which set out, in detail, the supporting activity, timelines and the associated KPI performance. The performance against our plan will be monitored and managed by the Group's Workforce, Education and Culture Committee-in-Common. The Group strategic project team are currently reviewing all strategies. Therefore the look and format of the people Strategy may change to ensure alignment, but the content and intent will remain unchanged.
Background Information and/or Supporting Document(s) (if applicable)	The People Strategy 2025-28 is driven by known organisational issues such as the workforce performance (vacancy, sickness, turnover) and the associated cost where these metrics are high. Unlocking performance in these areas directly relates to the lived experience of our staff as defined in the main by the National Staff Survey (NSS) results. Research shows that the higher the organisational NSS engagement score is, the lower sickness and turnover is. The higher the NSS engagement score is, staff morale is higher and importantly so too is patient experience, care and lower levels of mortality. Improving our staff engagement score will be a key focus of this strategy over the next 4 years.
Prior Approval Process	Workforce Education and Culture Committee, JLNC, JNCC, Workforce Transformation Group, Group Senior Management Team, People Directorate SLT.
Financial Implication(s) (if applicable)	Delivery of the strategy will be through existing resources within the People Directorate and wider Group resource in the main. Improving staff Health & Well-being has been identified as an area

	requiring delivery investment and as such a business case has been submitted. There is however a clear ROI identified seeking to reduce psychological and MSK related sickness in areas with higher levels of additional backfill staffing cost.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The People Strategy 2025-28 seeks to address known and emerging issues that impact EDI and Health Inequalities within our staff groups.
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST

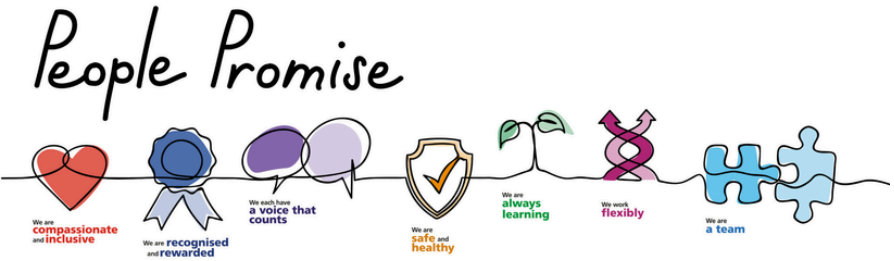
HULL UNIVERSITY TEACHING HOSPITAL NHS TRUST

NHS Humber Health Partnership

FINAL DRAFT

NHS HUMBER HEALTH PARTNERSHIP PEOPLE STRATEGY

2025 - 2028



Responsible Officer

SIMON NEARNEY
CHIEF PEOPLE OFFICER

COMPASSION - HONESTY - RESPECT - TEAMWORK

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FOREWORD

COMPASSIONATE LEADERSHIP TO CREATE AND SUSTAIN A PEOPLE FIRST, VALUES BASED CULTURE.

The NHS Humber Health Partnership group strategy includes the key objective: Our People Feel Proud To Work Here. We recognise that through investing in our people; their training and development, their opportunities and career pathways, the quality of our leaders and the support networks available to them, our patients will benefit.

SIMON NEARNEY
Group Chief People Officer

JONATHAN LOFTHOUSE
Group Chief Executive

Our organisational vision: United by Compassion, Driving for Excellence, emphasises the belief that by managing with compassion, caring for our people, putting them first in every decision and action we take, we will deliver care that is safe, effective and high quality. Creating an organisation where our people feel safe to be creative and innovative, where our employees feel engaged, valued and empowered to continually improve the care they give to patients, they will feel valued. They will be proud to work here. Our patients will receive the best care possible, and we will thrive.

As an established teaching hospital and a partner in the Hull York Medical School, we are committed to providing opportunities for learning and development for all of our staff in a wide variety of clinical and non-clinical roles. That commitment extends to the development of new roles and the provision of apprenticeships, for which we have an excellent reputation on a national scale.

We are the largest employer in the region with over 18,000 staff. This comes with a broader responsibility to the health of our community and the local economy. We understand the important role we play in providing opportunities for improving skills and employment for local people, both of which contribute the health of our population, and we have reflected this in our strategy.

We are deeply committed to valuing diversity and fostering an inclusive environment. We believe that embracing diversity is not only a moral imperative but also a strategic advantage. A diverse workforce brings a wealth of perspectives, experiences, and ideas that drive innovation and improve decision-making. By valuing diversity, we create a culture where every individual feels respected, valued, and empowered to contribute their best. This inclusivity enhances the quality of care we provide to our patients, as it allows us to better understand and meet the diverse needs of the communities we serve.

We want all of our staff to recommend our organisation as a place to receive treatment and to work. This means creating an organisation that is recognised as an ‘employer of choice’; an organisation that people want to work for, where staff are passionate about what they do and feel that it is more than ‘just a job’.

Over the next four years the NHS landscape will undoubtedly change; so, it is essential we innovate and think differently using digital solutions to address rising demand whilst remaining financially viable. Our relationships with partners will be key to ensure we as a system enable our people to reach into primary and community care, reducing the need for patients to come into hospital, allowing them to receive care rapidly and in the right place for them. This will improve the experience of care both for them and our workforce.

We are making great progress in some of our people measures, but we must maintain an effective relationship with our staff, built on trust in one another and our values of Compassion, Respect, Honesty and Teamwork.

A culture built on our values and the seven elements in the NHS People Promise will be crucial to our ongoing success. We are committed to ‘putting people first’, supporting our staff to be the very best they can, so that they can provide excellent care and be proud to work for NHS Humber Health Partnership.

NHS HUMBER HEALTH PARTNERSHIP

WHO WE ARE

Our Group is one of the largest in the NHS, with a budget of over £1.4 billion, employing over 18,000 staff.

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 the Greater Lincolnshire area, including district nursing, physiotherapy, psychology, podiatry and specialist dental services.

We see well over a million patients every year with around 275,000 attendances at our emergency departments, 214,000 hospital admissions and more than a million outpatient appointments. We deliver around 8,700 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.

In the context of this strategy - we are our People. We are proud of the dedicated individuals that work tirelessly for our patients across all of our services. Our people are united by compassion and drive for excellence in all that they do.

We are committed to creating a culture that values well-being, inclusivity, and professional development. We will empower our colleagues to deliver exceptional care both now and in the future. This is our promise to our workforce: to be an organisation that values you, that invests in you, that protects you, and supports and enables you to grow personally and professionally.

WHERE ARE WE NOW?

IN NUMBERS (DECEMBER 24)

GROUP VACANCY RATES

GROUP LEVEL

4.6%
Vacancy Rate

0%
reduction from previous year

MEDICAL AND DENTAL VACANCY RATE

GROUP LEVEL

5.4%
Vacancy Rate

9.9%
reduction from previous year at

15.3%

NURSING AND MIDWIFERY REGISTERED VACANCY RATE

GROUP LEVEL

1.4%
Vacancy Rate

1.2%
increase from previous year

AGENCY USAGE RATES

GROUP LEVEL

153 FTE
Agency usage

55 FTE
reduction from previous year

£7.7 m
reduction from previous year

TURNOVER RATES

GROUP LEVEL

8.7%
Turnover

2.1% reduction from previous year

NLAG

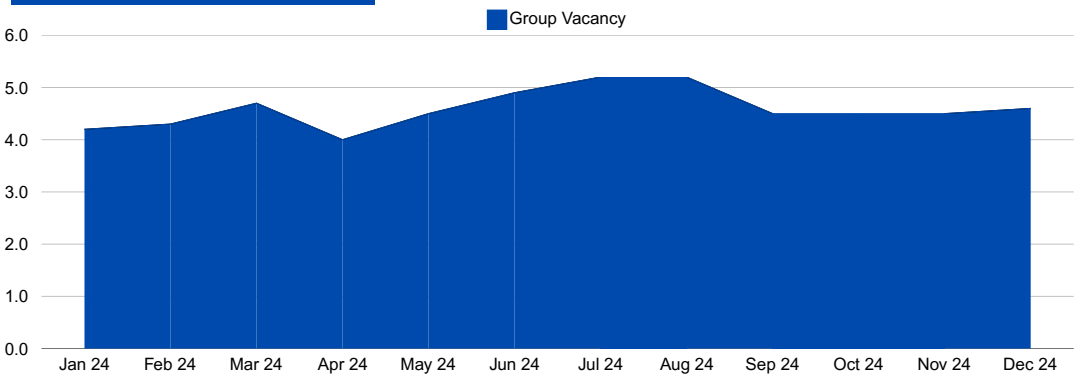
9.6%
Turnover

1.1% reduction from previous year

HUTH

8.2%
Turnover

2.1% reduction from previous year

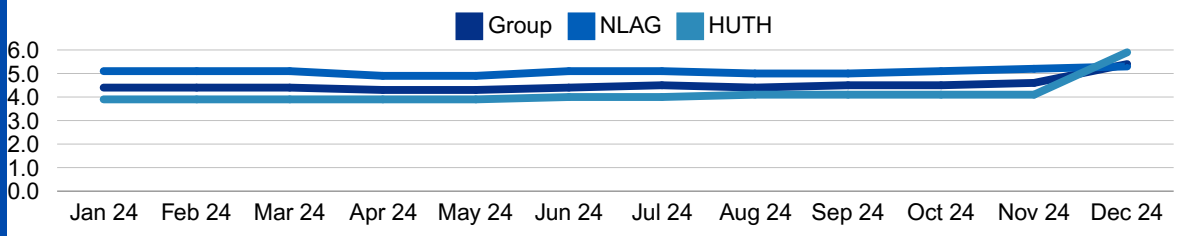


ABSCENCE RATES

GROUP LEVEL

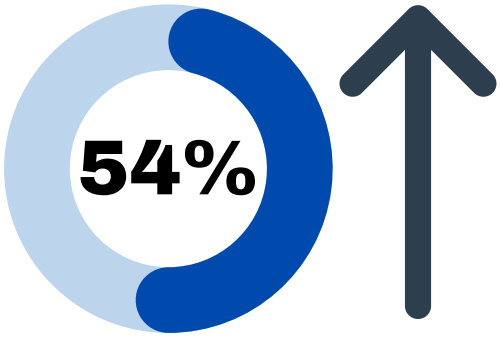
5.4%
Absence Rate

SUSTAINED PERFORMANCE



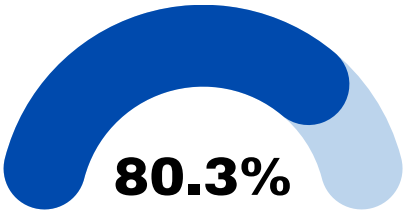
APPRENTICESHIPS

Apprenticeships Increase

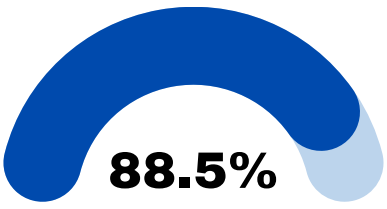


Increase in apprenticeship levy spend from £1.7m to £1.8m. This equates to a 6% growth

APPRAISAL RATES



CORE MANDATORY TRAINING RATES



LEADERSHIP

371 Leaders have attended Leadership Training across the Group

WHERE ARE WE NOW?

STAFF SURVEY

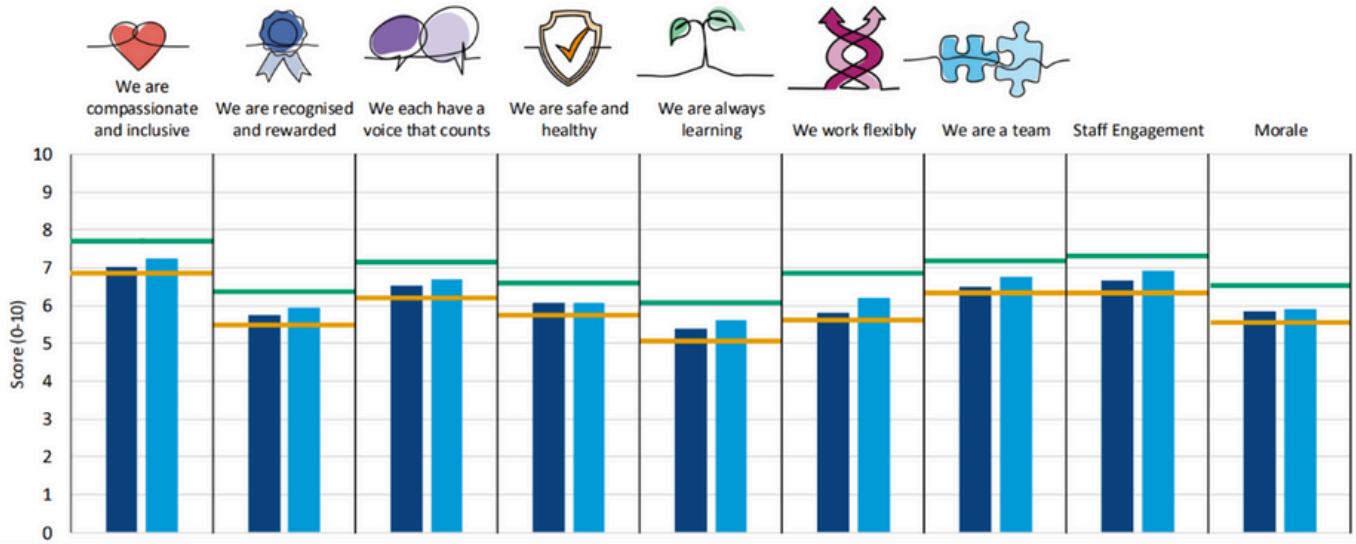
NLAG 2023

Our previous national staff survey results provide a guide against our workforce performance and staff experience. Both NLaG and HUTH share many data similarities and have room for improvement across the seven people promise domains. Typically both organisations perform between the national worst and average. This strategy aims to be better than the national average and progress to in the top 20% for each domain.

People Promise elements and themes: Overview

Survey Coordination Centre | NHS

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



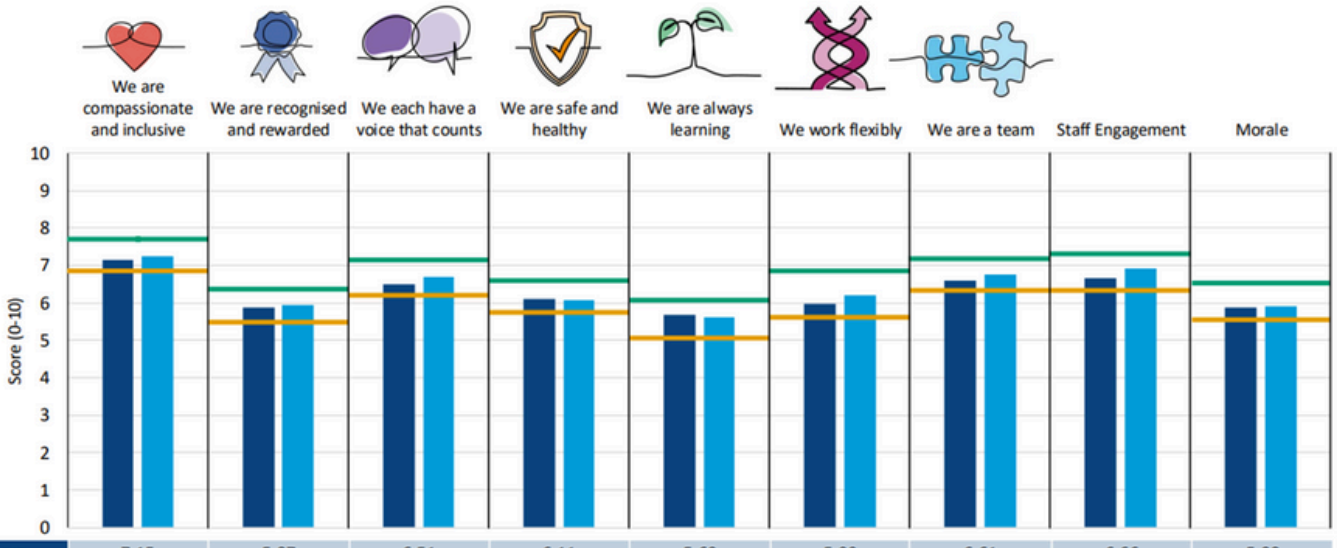
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.03	5.76	6.52	6.08	5.39	5.82	6.49	6.65	5.84
Best result	7.71	6.37	7.16	6.59	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.09	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	3486	3489	3454	3132	3242	3467	3479	3496	3495

HUTH 2023

People Promise elements and themes: Overview

Survey Coordination Centre | NHS

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



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.15	5.87	6.51	6.11	5.69	5.99	6.61	6.66	5.88
Best result	7.71	6.37	7.16	6.59	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.09	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	4594	4588	4566	4144	4262	4567	4591	4598	4597

WHERE ARE WE NOW?

NHS Humber Health Partnership (HHP) is committed to a People Strategy that supports, values, enables and empowers our workforce, aligned with the NHS Long-Term Workforce Plan and the NHS People Promise. This strategy aims to build on the progress already made and reflects our on-going dedication to fostering a compassionate and innovative culture, ensuring we are ready to tackle the significate challenges across the health and core landscape.

Where does our focus remain?

Well-being and Culture
Colleagues continue to face significant pressures across the NHS, with circa a third having taken time off due to mental health concerns such as stress, anxiety, and burnout. High workloads, demanding hours, and the emotional impact of frontline healthcare have left many feeling overworked and overwhelmed. There is an urgent need for better preventative well-being action alongside responsive support. Words like, blame, discrimination, bullying and hierarchy still feature within our organisational narrative, this needs a conclusion. We will continue to develop a culture that values, protects and prioritizes colleagues inclusively whilst promoting excellence in patient care.

Vacancies and Retention
Although HHP has made significant strides in filling vacant roles, gaps remain, with the medical professions being a focus. Exploration of new ways of working, global workforce partnerships, new roles and increasing our ability to attract and recruit new talent will be critical to our future success.

Retention remains a challenge; although turnover improvements are evident. There is a growing national trend of healthcare professionals reducing their hours or seeking roles outside the NHS to find more balanced and rewarding career opportunities. Flexible working and career growth opportunities will remain areas of significant focus within the People Strategy.

Student pipelines are reducing across all clinical modalities nationally, therefore we will continue to increase engagement with schools, colleges and regional universities to engage and connect people with the NHS and its many different and meaningful opportunities. We will increase the routes of entry through T-levels and apprenticeships and support career mapping and on-going professional development as the norm.

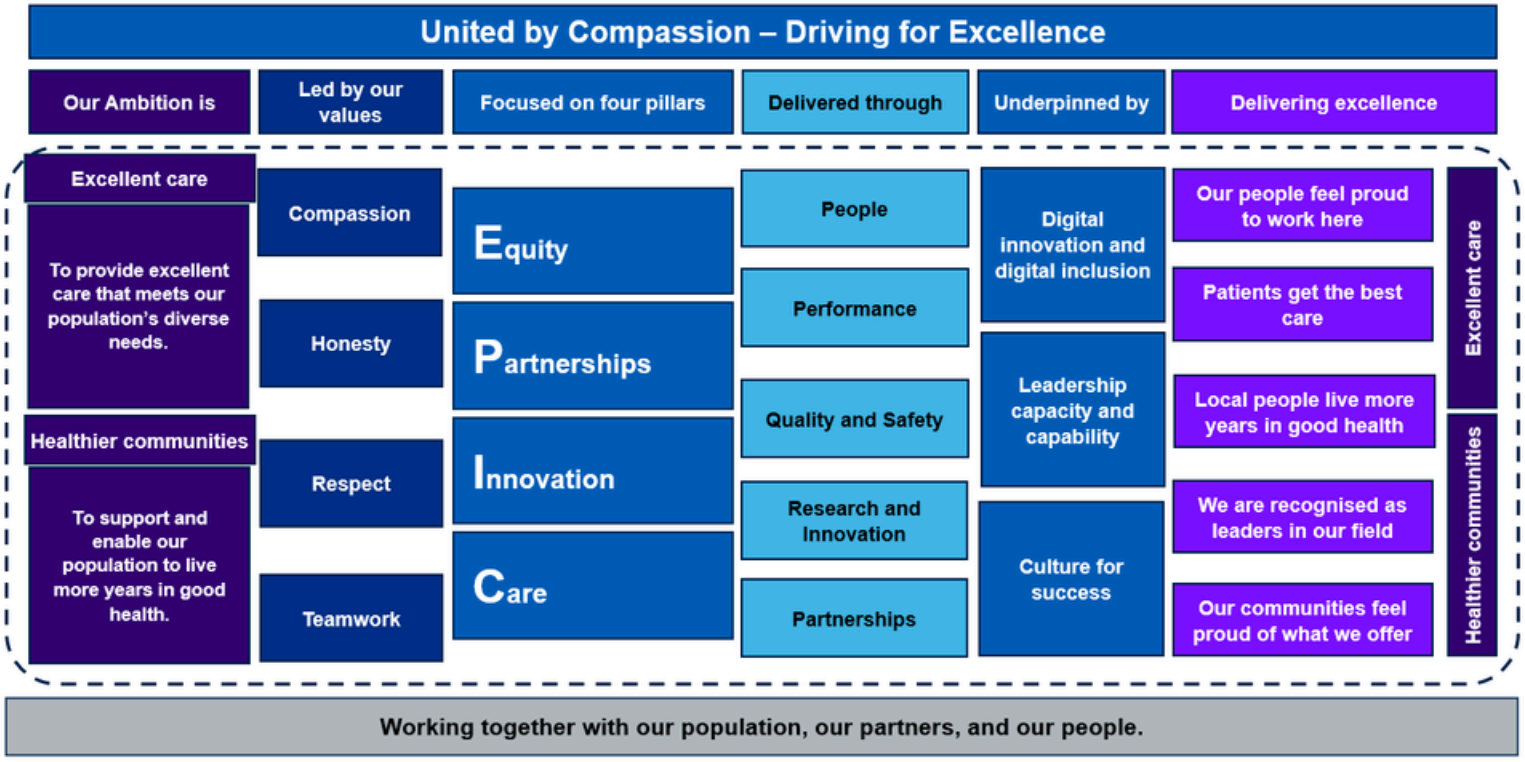
Evolving nature of care & Innovation
Health and social care is shifting focus to a more localised, integrated, and preventive approach, focusing on delivering personalised and accessible services closer to people's homes. Technology, such as telemedicine and remote monitoring will become the norm, enabling remote support and reducing hospital dependence. Emphasis on community health workers, social determinants, and health education will empower individuals and address broader social factors, creating healthier, more resilient communities. This will inevitably mean a shift in workforce design with the potential creation of new clinical and non-clinical roles and retraining of our current workforce. Roles will need to evolve with appropriate systems in place that enable individuals to work across traditional organisational boundaries.

WHERE DO WE WANT TO BE?

Individual	Team	Hospital Group	System	National
• Colleagues belong in the HHP free from discrimination • All colleagues have access to meaningful career development opportunities • Colleagues experience strong and inspirational leadership • Flexibility in role design is the norm • Colleagues experience our values within every interaction • Colleague health & well-being is prioritized • Colleagues are empowered to innovate and engage in quality improvement • Colleagues experience policy that is enabling and based within just & learning principles • Colleagues are recognised for there contribution routinely • Colleagues feel proud to work with HHP and would recommend as a place to receive treatment.	• Teams feel like teams and not just a collection of individuals • Teams are flexible well-led and this is consistent across the Group • Leaders receive world class leadership development • Teams innovate and are always seeking to learn and improve • Team health and well-being is a constant focus • Teams take time out to focus on team dynamics and relationships • Teams understand how they fit into the delivery of the Group strategies • Teams live by Group values and behavioral standards and feel empowered to speak up where this is not evident	• We will become an employer of choice both nationally and internationally • We will put our people first in all of our endeavors so that they can put our patients first • We will trust our devolved leadership and empower them to act • We will prioritize people engagement actively listen and respond • We will serve our workforce, ensuring any barriers are removed and any enhancements made • We will work hard to ensure that colleague health and well-being is prioritized across the Group	• Together with our health and social care partners we will lead innovative workforce practices • We will support partners in their own workforce developments, particularly where this impacts on HHP patient flow • We will harmonize workforce practice wherever possible across the system enabling workforce mobility and to me efficient. • We will collaborate with our acute partners to ensure decision making doesn't have unintended consequence • We will achieve alignment on both bank and agency rates at a system level • We will have a greater understanding of workforce data at a system level and be able to plan more effectively.	• Be one of the top performing Groups in the country across all workforce metrics • Be a trail blazer in workforce initiatives with published case studies • Regularly be in the running for national awards and recognition • Inform workforce policy development on a national level • Attract the very best of talent from across the country and beyond as an employer of choice • Thrive nationally despite being rural & coastal with high levels of deprivation. • Be in the top 20% performing results in the National Staff Survey

THE GROUP STRATEGIC FRAMEWORK

The People Strategy is vertically aligned to the Group Strategic Framework responding to the people elements defined. The People Strategy also integrates across all subsidiary strategies identified under the Groups Framework. This read across enables co-delivery of defined objectives and purpose with the patient at the heart of our approach.



GROUP STRATEGIC FRAMEWORK - THE PEOPLE FOCUS

The People focus within the Group Strategic Framework is clear - We must put our people first so that they can put our patients first. We will enable this through a real focus on colleague health & well-being, improving working environments and building trust and empowerment. A more engaged workforce is a more productive and innovative workforce.

Our People

NHS
Humber Health
Partnership

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

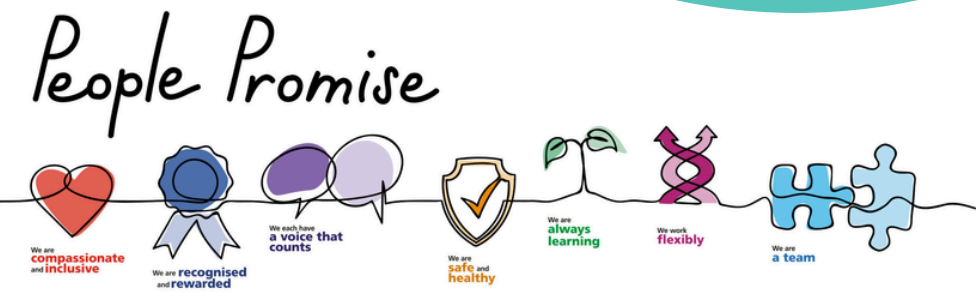
Delivering our strategic ambitions will require us to build the confidence and resilience of our people – instilling pride in our group and the work that we do.

We will:

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

PEOPLE STRATEGY FRAMEWORK

The People Strategy framework responds to the current identified people need whilst creating the space for future focused people innovations. This strategy aims to push the boundaries of traditional people practices whilst also addressing some the basic and fundamental needs required to create meaningful working experiences. The people first approach taken within this strategy aims to create an inclusive culture across NHS Humber Health Partnership that enables colleagues to thrive, with excellent patient centered care at our core. Our approach in defining our culture and engagement practices wraps around all that we do defining our "how." The themes identified are as a result of extensive engagement and feedback from our people with alignment to the NHS Long Term Workforce Plan and the NHS People Promise. Each identified theme has a framework of delivery associated over the strategy period.



PEOPLE & PARTNERSHIPS

People and Partnerships Framework

Strategic framework drivers.
We will build a flexible and adaptable workforce for the future
1. Workforce innovation, mobility & adaptability
2. Building workforce partnerships to enable future ways of working

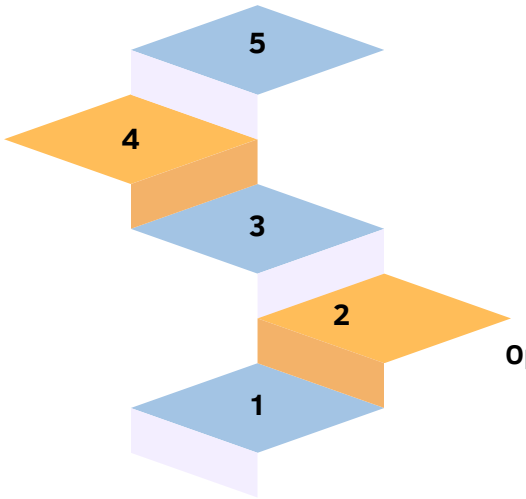
We will ensure a workforce that is fit for purpose today whilst planning for the future. Our workforce will have the very best development and career opportunities available and work across traditional organisation borders with the patient in mind. As we continue to innovate digitally and with a smarter approach to our work, we will challenge our workforce requirements. This will release workforce and people resource efficiencies meaning a lower organisational headcount.

1 Implementing Effective Workforce Planning and Role Innovation

Understanding our current and future workforce needs, role innovation and aligning resources to meet service demands. Enabling a sustainable workforce will reduce vacancy and agency usage

2 Development of Talent Acquisition and Sourcing

Building on existing innovation to attract the very best talent. We will develop and launch a new Group recruitment portal alongside attractive offers of employment linked to career development teaching and research.



Governance, Sustainability and Safety 5

Integrating and enhancing workforce governance processes, facilitating sustainability, safer staffing and workforce accountability.

Enhancing Workforce Partnerships 4

Forming and maintaining workforce partnerships to aid access to potential candidates, provide a richer training and employment experience, to improve collaboration and shared service innovation regarding workforce challenges within the region.

Development Opportunities for Existing and New People 3

Providing development opportunities for our people, to facilitate access to ongoing professional development, with a focus on skill enhancement and career progression This may mean the introduction of new roles, different ways of working within existing roles and facilitation of apprenticeship opportunities.

1 Leaders will have the data, tools and support to develop workforce plans at all levels, from Group to specialty, ensuring effective workforce management. Colleagues will have greater access to flexible roles and career development opportunities that align to workforce plans. In addition to expected demand, workforce plans will incorporate innovative role and service design to achieve medium to long term workforce sustainability. Technology and AI will optimise staffing schedules, automate tasks, and forecast future workforce needs.

2 Leaders will have access to a wider and more diverse pool of candidates to fill vacancies. We will establish NHS Humber Health Partnership as an employer of choice, leveraging new sourcing methodologies and technologies. Candidates will have a seamless recruitment and on-boarding experience that is ethical and free from bias. Candidates will experience excellence in organisational induction that is complete with the right tools, training and knowledge that begins to build the foundations of a great career with HHP.

3 Aligned to our Learning, Leadership and Talent development ambitions, colleagues will have access to career development frameworks and mentors, offering clear direction and support in achieving their ambitions with fit to defined workforce need. Early-stage career opportunities and development roles will provide diverse pathways, alongside formal academic routes, including more undergraduate placements.

4 Through strengthened partnerships locally, regionally, nationally and internationally the Group will diversify talent pools. We will increase links with health and social care partners to address known workforce issues collectively. We will continue build relationships with international partners to address known short term workforce needs. In addition, we will continue to work closely with regional educational partners to co-create career pathways with aligned levels of local student enrolments in relation to workforce demand.

5 Robust and dynamic workforce governance arrangements will ensure accurate tracking of performance against plan with accountable mitigating actions in place where required. We will ensure that services are right-sized and that minimum safe staffing levels are defined for all clinical areas. This will align with workforce plans to ensure that we have the right people with the right skills, in the right place, at the right time. Achievement of this framework, will reduce temporary staffing reliance and spend as a primary short term workforce driver whilst enabling a sustainable and inclusive workforce provision.

WORKFORCE SYSTEM TRANSFORMATION

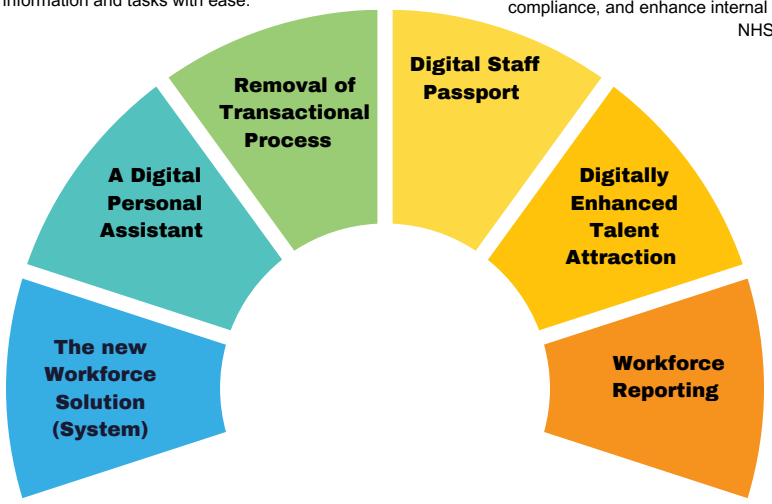
Strategic framework drivers.
1. Increased workforce mobility
2. Increased digital capability
3. Innovation and Change

Workforce Systems Transformation Framework - We will continue to innovate within the Workforce Systems Transformation space. We aim to create one digital estate were ease of access and streamlined workforce processes are the norm. All leaders will have access to meaningful workforce data with predictive capabilities. Colleagues will experience simplification and greater accessibility through smart devices.

3. Removal of Transactional Process through Digital Innovation. Simplify and streamline all digital interactions to improve user experience and reduce barriers in processes, enabling employees and core teams to access and manage information and tasks with ease.

4.Digital Staff Passport -to create a digital staff Passport within the Group that consolidates an employee's qualifications, training, certifications, performance history, career progression, and other key data points in one comprehensive, secure, and easily accessible digital profile. This will facilitate career development, improve workforce planning, support regulatory compliance, and enhance internal mobility across NHS organisations.

2. A Digital Personal Assistant AI/RPA Leverage Artificial Intelligence (AI) and Robotic Process Automation (RPA) to streamline HR processes and provide personal assistant capabilities for Employees and Managers. and tasks with ease.



5. Digitally enhanced Talent attraction - Use digital tools to enhance recruitment, attract diverse talent, and reduce time-to-hire.

1.The new workforce solution and maximising the use of ESR and E-roster - The new solution will build on the success of the current Electronic Staff Record (ESR) system in support of the NHS People Plan and the wider NHS workforce policies. Maximising the use of existing solutions such as ESR and E-roster will be a priority in achieving system efficiencies and realising workforce benefits.

6. Workforce Reporting. Provide actionable insights, real-time and predictive reporting of NHS Humber Health Partnership workforce to support better decision-making and planning.

1. Leaders will experience a new workforce system that builds on the strengths of and replaces the current ESR system, driving improvements in efficiency, accuracy, and user experience as we move toward a single digital estate. The introduction of the enhanced system, alongside maximising use of existing systems will streamline workforce management, improve data visibility, and empower leaders to make informed decisions, boost staff morale, and foster a more flexible, scalable, and sustainable workforce.

2. Leaders will experience the benefits of a Digital Personal Assistant powered by Artificial Intelligence (AI) and Robotic Process Automation (RPA), designed to streamline HR processes and enhance efficiency. This advanced solution will simplify tasks for both employees and managers, providing seamless support and enabling quicker, more accurate decision-making while reducing administrative burdens.

3. Leaders will experience the removal of transactional processes through digital innovation, simplifying and streamlining all digital interactions. This will enhance the user experience, reduce process barriers, and enable both employees and core teams to easily access and manage information and tasks, improving overall efficiency and satisfaction. Focus will be given to establishing innovation at a system level, working with partners to improve system efficiency.

4. NHS Humber Health Partnership will benefit from the introduction of a Digital Staff Passport, consolidating key employee data such as qualifications, training, certifications, performance history, and career progression into a single, secure, and easily accessible digital profile. This innovation will support mobility of health professionals between organisations and remove any duplication of processes where aligned to the same national standards. Introduction of digital passports at a regional level with integration to the national programme will foster a more agile workforce.

5. Leaders will experience digitally enhanced talent attraction, leveraging advanced and automated digital AI & VR tools to streamline recruitment processes and significantly reduce time-to-hire and human based bias. Introduction of this technology will enable quicker, more efficient hiring while improving the quality and validity of candidate assessment.

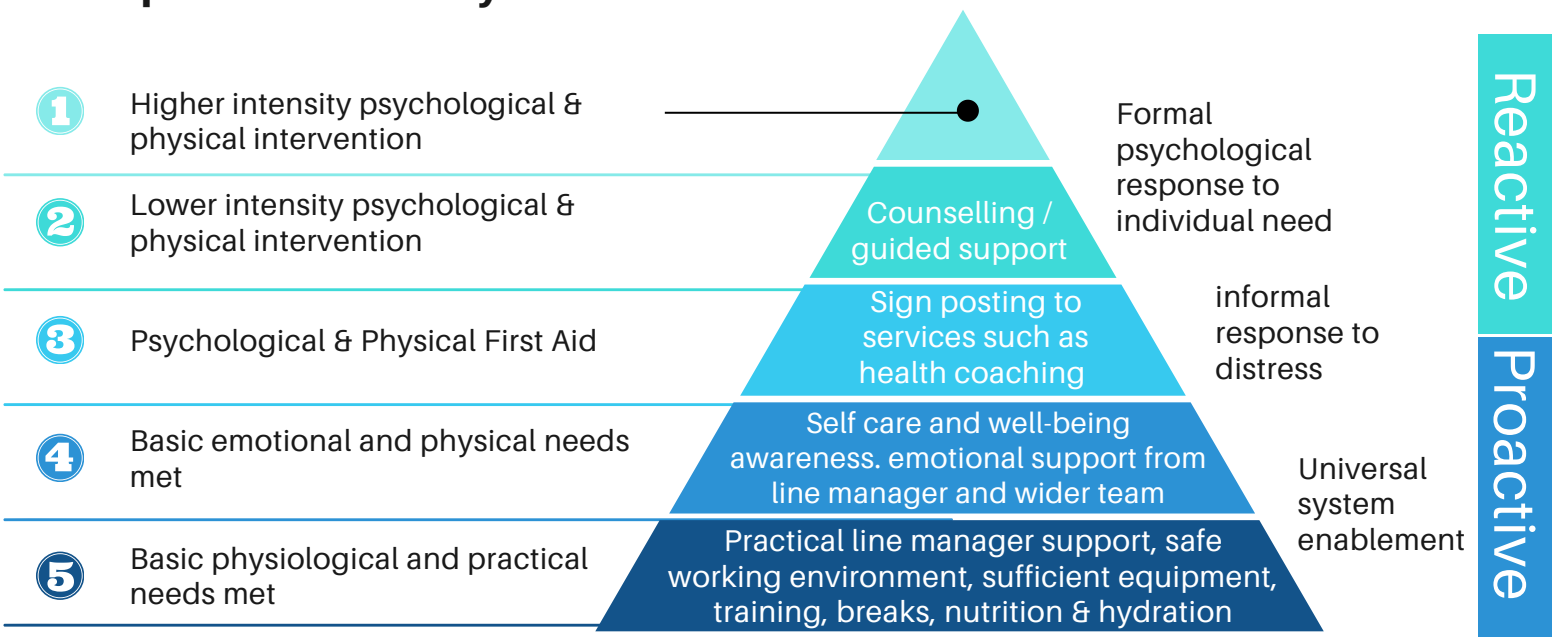
6. Leaders will gain access to real-time and predictive workforce reporting, providing actionable insights into the NHS Humber Health Partnership workforce. This data-driven approach will support better decision-making, improve planning, and ensure more informed, strategic management of resources.

HEALTH & WELL-BEING

Health & Well-being Framework (HWB)- the framework deals with the varying stages and support that colleagues may need throughout the employee lifecycle. Much of the framework deals with preventative and basics needs, these are not always experienced within the workplace. Having a greater sense and understanding of our own Health & Well-being enables us to support colleagues, family members and the wider community including our patients.

Strategic Framework Drivers.
We will look after the Health and well-being of our People
1. Increased Flexible Working
2. Healthier workforce, healthier communities

Group HWB Hierarchy



Colleagues will experience:

1. In times of crisis, colleagues will be able access rapid hyper specialised care. Line managers will be well trained and be equipped to support and signpost individuals into appropriate provision. Teams will have access to support immediate circumstances and ongoing support to heal.

2. Specialised help and support will be available whether because of individual circumstance or because of work based events. Colleague's will experience supportive employment policies and be able to access timely health care provision where possible to enable

3. Colleagues will have access to health coaches and a range off supportive groups that are tailored to their needs throughout the employee life cycle. This will include access to inclusive support for colleagues that feel isolated or discriminated against because of their circumstances or background. We will increase dedicated Health &Well-being spaces across the Group to enable break away space and Health & Well-being activities.

4. Colleagues will have 1:1's and PADR's with a line managers that protect and prioritise Health and Well-being. Teams will be more aware of their own physical and mental health and be given the tools to stay well at work. Partnership working will add value to the HWB offer.

5. Greater access to nutritious and affordable food and drink. Line managers who are accessible, are well trained and that enable healthy working lives. Colleagues will experience a more social work place where flexibility is the norm.

LEADERSHIP, LEARNING & TALENT DEVELOPMENT

Empowering Excellence in Every Role is at the heart of our approach. We will provide development opportunities for every leader to fully understand their core people management responsibilities and approach, whilst offering programmes to further enhance and challenge compassionate and inclusive leadership skills. Regardless of role, we are committed to providing our staff and students with access to high-quality teaching, courses, apprenticeships and programmes to help colleagues to reach their full potential and enable progression as per identified workforce requirements. Through strong partnerships with local schools, colleges, and higher education providers, we will offer a diverse range of accredited and non-accredited opportunities, ensuring continuous professional development and lifelong learning for all.

Strategic Framework Drivers.

1. Develop educational programmes that support innovation and change
2. Talent Development
3. Increasing digital capability

1. We will enable our leaders to embed personal development into our organisation through developing them to lead talent-focused appraisals, ensuring everyone acquires the skills needed for exceptional patient care. Managers will be given the skills to ensure that they can and will focus on their team's development needs, providing support for success. We will ensure that there is comprehensive offer for our staff to access coaching, mentoring, and restorative conversations to ensure that they can reach their potential in their role and career.

2. We will ensure our leaders and managers are compassionate and inclusive, creating a psychologically safe culture that encourages innovation and risk-taking without fear. By fostering open communication and mutual respect, we will empower staff to share ideas and collaborate effectively, enhancing our organisation's performance and wellbeing. We will provide development opportunities for all leaders to understand their core people management responsibilities and offer programs to enhance their compassionate and inclusive leadership skills.

3. We will place Continuous Professional Development (CPD) at the heart of our approach, making it accessible to everyone regardless of their role within our group. We will ensure that all staff can acquire the core functional skills necessary for job progression and future career aspirations. Our programs will be meticulously aligned with the latest healthcare advancements and patient care standards, ensuring that our training remains relevant and impactful. By fostering a culture of lifelong learning, we will empower our workforce to deliver the highest quality of care and continuously improve their professional practice.

4. We will prioritise equitable talent management, ensuring that all staff have access to personal and career development opportunities. We will implement the Scope for Growth model to facilitate open and transparent career conversations, helping to identify and nurture hidden talent within our organisation. By establishing clear and transparent processes for progression, we will support staff in achieving their career aspirations. Succession planning will be integral, ensuring that we have a robust pipeline of future leaders and critical role successors. This approach will not only enhance individual career development but also ensure the continuity and excellence of patient care.

5. We will commit to providing our staff and students with access to high-quality teaching, courses, and programmes, regardless of their role within our group. Our goal is to help everyone reach their full potential and ensure we deliver exceptional care to our patients. We will equip all our educators with the necessary skills and knowledge to provide top-tier education, enhancing the learning experience for all healthcare professionals. By forging strong partnerships with local schools, colleges, and higher education providers, we will offer our staff a diverse range of accredited and non-accredited opportunities.

CULTURE & ENGAGEMENT

Strategic Framework Drivers.
1. Inclusive cultures
2. Tackling discrimination
3. Getting the basics right

This framework represents the “How”. How will we achieve the deliverables as set out in the first four frameworks. Working with our colleuges across the Group, we will work towards a culture that puts our people first, underpinned by our Group values of Compassion, Respect, Honesty and Teamwork.

ONE WORKFORCE

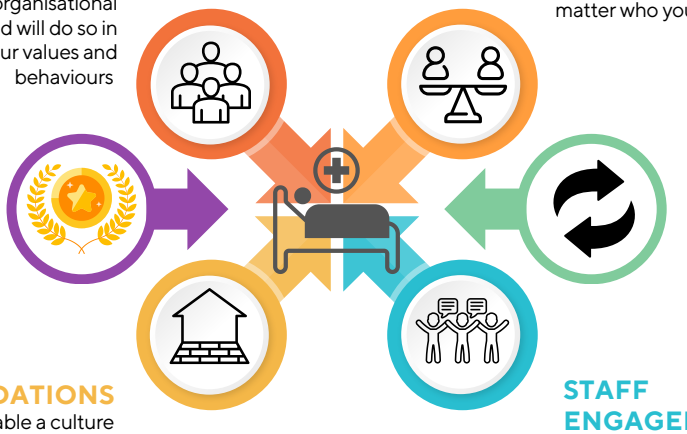
One team that is united by a common vision and purpose . All colleagues understand what their role is and how it contributes to our organisational objective and will do so in line with our values and behaviours

EQUITY, INCLUSION & BELONGING

We will be steadfast in ensuring equity in working standards, staff experience, and opportunities for all. We will act rapidly where this is not the case and work to remove systemic discrimination at all levels, so no matter who you are, you feel like you belong

REWARD AND RECOGNITION

We will recognise the contribution that our staff make each and every day. We will ensure that staff are rewarded for their efforts. Whether that is a simple thank you, improved and enabled employee experiences and staff benefits or being recognised on a local and national stage



MEANINGFUL AND WELL LED TRANSFORMATION

We recognise that improvement is part of our fabric as we continue to strive to the do the very best for our patients. Where change is required, we will do this well, engaging our colleuges with us on the journey whilst recognising the impacts of uncertainty that change can bring.

FOUNDATIONS

We will enable a culture where the core needs of colleagues are taken care of 100% of the time and as a priority. We lead with a just and learning cultural approach

STAFF ENGAGEMENT

We will actively listen, and facilitate a conversation that enables and empowers our colleagues with the trust and permission to act as part of our quality improvement ambitions

1. We will ensure clarity of organisational and strategic objectives and group values, so everyone understands our goals. Our staff will experience leaders who set clear, bite-sized objectives aimed at delivering group objectives. Roles and responsibilities will be clear, with an accountability framework understood by everyone. Leaders will value communication, making team meetings the norm, not the exception. Our processes and policies will be completely harmonised, ensuring we have one way of doing things.

2. We will ensure that getting to work is simple for all staff, who will have equal access to nutritious hot food 24/7 and easy access to areas where they can take a break. Our staff feel safe in their working environment, with low levels of bullying and harassment. By building solid foundations, we create an environment where staff feel happy, included, and safe at work.

3. We acknowledge that discrimination exists in our group and are committed to significantly improving staff experience over the next three years. With a steadfast, zero-tolerance approach to discrimination, our leaders will create a psychologically safe environment where everyone feels confident to speak up and assured that action will be taken. We will proactively educate all staff to reduce discrimination and work with our local communities to ensure they understand that discrimination or abuse towards our staff is completely unacceptable. Our local population recognises us as an equal opportunities employer, knowing they will be treated fairly. Our leaders are committed to ensuring that all staff, regardless of background, have equal access to career development and job opportunities and feel a strong sense of belonging within our organisation.

4. We will prioritise staff engagement to achieve excellence, expecting managers and leaders to connect an engaged team with high performance. Managers will dedicate time to one-on-one meetings, actively listening and empathising with staff. We will implement a staff-led improvement programme, ensuring everyone's voice is heard. Regular career development discussions with line managers will help staff grow and succeed. Teams will prioritise spending time together, fostering unity and fun. We are committed to continuous improvement, always striving to enhance our workplace and support our staff.

5. Transformation will be a constant across Health and Social Care in order for our systems of care to meet future patient demands. Where this is the case across our Group, our colleagues will experience processes of change that are engaging, informative and equitable. Leaders will be responsive to colleague needs including them in the case for change even when the outcome may be difficult. Change process will managed in a timely way avoid protracted processes that leave colleagues in limbo.

6. We deeply value and appreciate the dedication and hard work of our staff. We believe in recognizing and rewarding our employees in various ways, from a simple thank you to local and national awards. We will offer access to a comprehensive range of employee benefits designed to support colleagues well-being and life events. Colleague contributions are the cornerstone of our success, and we are committed to ensuring staff feel valued and supported every step of the way.

DELIVERY
YEAR 1 (2025-2026)

The People Strategy delivery will be informed by the associated thematic frameworks with activity prioritized against available delivery resource and organisational need. All identified actions will be split between year 1, 2 and 3 in delivery.

People and Partnerships: We will establish people resource focused on workforce transformation that will facilitate practical solutions to known workforce issues. Reduction of the medical vacancy position will be a primary focus. We will implement new roles including advanced practice in line with the developing national picture and will establish processes to facilitate the flexible deployment of substantive and peripheral workforces to meet short term needs. We will introduce dynamic and real time specialty level workforce planning as part of overarching Group level workforce planning processes. Alignment of leadership, learning and talent development processes to workforce needs will be implemented, and we will establish stronger workforce governance processes at an operational level to ensure compliance with NHS employment standards. We will focus on the development of ethical recruitment practices whilst reducing any direct or indirect discrimination in process. Will commence work towards establishing NHS HHP as an employer of choice. Outputs of the activity detailed will continue to reduce reliance on agency usage whilst reducing our vacancy position in critical areas. Harmonisation of employment frameworks will remove confusion in leadership approach across the Group.

Workforce Systems Transformation - Introducing a Group in-house system for establishment control, eliminating paperwork with Manager Self-Service, and improving data quality to meet workforce standards. A full ESR system assessment will align processes across the Group, standardizing reporting, and enhancing Power BI for better insights and decision-making as we move towards a single digital estate where possible. Full utilisation of Health Roster for areas in scope will enable clinical leaders and staff to ensure efficient workforce management and enhanced staff rostering capabilities. Digital innovation will be a primary driver for efficiency. Innovation will be developed in partnership with the system with shared service delivery in mind were appropriate to explore.

Health and Well-Being: Establish proactive foundations for health and well-being, including improved break spaces, flexible working policies, physical and mental health campaigns, and training initiatives like REACT mental health training for line managers. Year 1 programmes will focus on creating a healthier, more supportive work environment, aiming to reduce stress and absenteeism while enhancing overall well-being through proactive education and support.

Leadership, Learning and Talent Development - We will focus on laying the groundwork for inclusive and compassionate leadership by launching development programmes for leaders whilst promoting psychological safety through training sessions and team-building activities. We will enhance educator skills and ensure access to high-quality teaching and courses for all staff and students. Talent-focused appraisals will be implemented to identify individual development needs, and coaching and mentoring programmes will be extended to support personal and professional growth. We will also create specific appraisal processes for our leaders ensuring that feedback from their teams is inbuilt alongside other core people metrics. We will create a comprehensive learning needs analysis for the Group ensuring we have a clear plan for future education commissioning over the next 3 years.

Culture & Engagement - We will further embed and improve the impact of our zero tolerance frameworks so we see measurable reduction of discrimination. We will focus on creating a psychologically safe environment where staff feel confident to speak up through developing our leaders skillset and mindset. Teams will be encouraged to apply our Group values to their workplaces through a structure programme of development. We will provide easy access to break areas, and maintain a safe working environment. We will continue our group approach to civility to further reduce levels of bullying and harassment. We will explore a range of staff benefits that will enable both working and home lives of our colleagues.

DELIVERY

YEAR 2 (2026-2027)

People and Partnerships: We will further develop Talent Acquisition and recruitment methodologies utilising available technology to increase reach and sourcing capability, including further developing ethical recruitment and eliminating bias in selection so far as is reasonably possible. We will provide further growth opportunities through implementing additional development posts across a range of staff groups and expand our offer of early stage career opportunities including increased undergraduate placements, apprenticeships, T levels, and work experience placements. We will develop partnerships with regional providers to establish regional workforce solutions where desirable. We will establish and maintain partnerships with educational providers to design and implemented co-created career pathways and educational provision aligned to workforce needs. We will continue to fill all recruitable vacancies in line with workforce plans, including offering substantive opportunities to temporary workers. Temporary staffing requirements will be reducing, however where temporary staffing is required we will ensure appropriate governance is in place and the best value for money is obtained.

Workforce Systems Transformation - Launch of the Digital Staff Passport, modernising systems with People System apps, and selecting a platform for CoPilot. Implementation of real-time reporting and expanding on Culture Dashboard to enhance workforce insights and engagement.

Health and Well-being: Expand resources and integrate interventions into daily operations. This includes launching Menopause and Well Man programmes, health coaching, group therapy, and enhancing managerial support through the "8 Minutes Initiative." Dedicated HWB spaces and staff-led clubs will promote a positive, inclusive workplace culture. These initiatives aim to improve morale and create a more supportive and engaging work environment.

Leadership Learning and Talent Development - We will offer advanced leadership programmes to further enhance leadership skills and encourage innovation and risk-taking by recognising and rewarding creative ideas. Continuous Professional Development (CPD) will be embedded into the organisational culture, and partnerships with educational institutions will be strengthened to offer a wider range of learning opportunities. Personalised development plans will be created for each staff member, and managers will be trained to conduct restorative conversations to address challenges and support team members.

Culture and Engagement: We will have allyship programmes that proactively educate all staff to reduce instances of discrimination and work with local communities to ensure they understand that discrimination or abuse towards staff is unacceptable. Managers will dedicate more time to one-on-one meetings, actively listening and empathising with their staff with feedback about them built into appraisal processes. We will implement systems to ensure equal access to career opportunities for all staff, regardless of ethnicity, disability, or gender identity. We will launch a managed programme of staff-led improvement to ensure everyone's voice is heard and prioritise regular career development discussions with line managers to help staff grow and succeed.

DELIVERY

YEAR 3 (2027- 2028)

People and Partnerships: In addition to ongoing monitoring, we will review the impact of all workforce and partnerships framework elements and identify further opportunities. We will ensure that practices and processes relating to increasing diversity and inclusion and eliminating bias are embedded as an operational normal. We will continue with the implementation of further development roles and frameworks as required aligned to current and future forecasted workforce need. We will realize the benefits of of specialty level workforce planning, with the alignment to operational and financial planning. We will maintain NHS HHP as an employer of choice.

Workforce Systems Transformation: Auditing current systems, reviewing AI and RPA processes, and creating AI chatbots. We will pilot AI and RPA for an Employee Portal, explore virtual simulation, and enhance digital onboarding. The new Workforce Solution project will begin, transitioning users to a more advanced, integrated platform.

Health and Well-being: Evaluate and optimise the programme, focusing on long-term impact. Colleagues will benefit from refined policies, advanced interventions for complex health needs, and continued well-being practices. Tier 1 interventions like case management and clinical access will be fully operational, with expanded Tier 2 services. Regular HWB training and the annual HWB Excellence Awards will promote recognition, job satisfaction, and retention.

Culture and Engagement: We will continue to improve staff experience by addressing any remaining issues of discrimination and ensuring significant improvement which is measurable by our staff survey results. We will maintain a focus on continuous improvement, always striving to enhance our workplace and support our staff. Strengthening the connection between staff engagement and performance will be a priority, ensuring managers and leaders understand its importance with staff engagements scores inbuilt into our performance and accountability frameworks. We will build solid foundations for staff to feel happy, included, and safe at work. Our local population will recognise us as an equal opportunities employer, knowing they will be treated fairly.

Learning Leadership and Talent Development: We will conduct evaluations to assess the impact of leadership programmes and gather feedback for necessary adjustments. Sustainability plans will be developed to ensure continuous improvement in leadership practices, and an impact assessment will be conducted to evaluate the effectiveness of CPD programmes and partnerships. Talent management processes will be reviewed, and succession planning efforts will be strengthened to ensure a robust pipeline of future leaders and critical role successors.

MEASURING SUCCESS

The performance of the People Strategy will be measured against the below identified metrics. Performance reporting will be incorporated into the existing Workforce Integrated Performance Report. KPI's will link to enabling project delivery in the associated strategy delivery frameworks.

Strategic Pillar	KPI Measure	Source	Current	2026 target	2028 target
People & Partnerships	Consultant Vacancy Position %	ESR/ Finance	12%	10%	8%
	Overall Vacancy Position %	ESR/ Finance	4.3%	3.5%	2.5%
	Agency as % of gross staff costs	Finance	4.47%	4%	3.5%
	First Year Turnover %	ESR	21%	18%	15%
	Turnover %	ESR	9%	8%	8%
	Group Time to Hire Combined conditional to unconditional	Trac	24 days	22 days	<20 days
	Specialty Workforce Plans in Place	Workforce Planning	0%	80%	100%
	Satisfaction with Onboarding Experience	Recruitment KPis	N/A	80%	90%
Workforce Systems Transformation	Removal of paper based processes via introduction of ESR MSS across the Group	ESR	66%	90%	100%
	% of in scope departments utilising the Health Roster	Health Roster	90%	100%	100%
	Digital Staff Passport. Reducing Time to Hire for all staff	Recruitment KPI's	24 Days	20 Days	15-20 Days
	All group pay impacting changes to be administered through Establishment control processes	Establishment control system	50%	75%	100%
	Workforce Reporting - Real Time	Power BI	Monthly	Daily	Daily

Strategic Pillar	KPI Measure	Source	Current	2026 target	2028 target
Health & Well-being	NSS - We are Safe and Healthy	NSS	NLAG: 5.8 HUTH: 5.9	6	6.5
	Psychological related sickness % of overall sickness	ESR	21.69%	18%	15%
	% of Leaders completed REACT training	HEY 24/7 / ESR	15%	30%	50%
	NSS - Burnout (higher scores demonstrates improvement)	NSS	NLAG: 4.97 HUTH: 4.98	5	5.3
	NSS - Flexible Working	NSS	NLAG: 5.82 HUTH: 5.66	6	6.85
Culture & Engagement	Our Staff Engagement Score is above the average for NHS England Trusts	NSS	NLAG: 6.4 HUTH: 6.5	6.7	7.0
	Percentage of staff experiencing harassment, bullying and abuse (from a colleague or manager)	NSS	NLAG: 22.3% HUTH: 20%	16%	12%
	Recommend my organisation as place to work.	NSS	NLAG: 46.9% HUTH: 49.9%	55%	65%
	Experienced discrimination from a colleague or a manager	NSS	NLAG: 9.3% HUTH: 7.63%	4.5%	3.79%
Leadership, Learning & Talent Development	Appraisal %	ESR/Hey 247	80.9%	85%	85%
	Quality of Appraisal - left me feeling valued	NSS	NLAG: 29.2% HUTH: 28.8%	35%	42%
	Learning Needs Analysis Completed	Internal	0%	50%	90%
	We are always learning	NSS	NLAG: 5.39 HUTH: 5.69	5.8	6.07
Group	CQC Well-Led Review	CQC	Requires improvement	Good	Good

WORKFORCE GOVERANCE

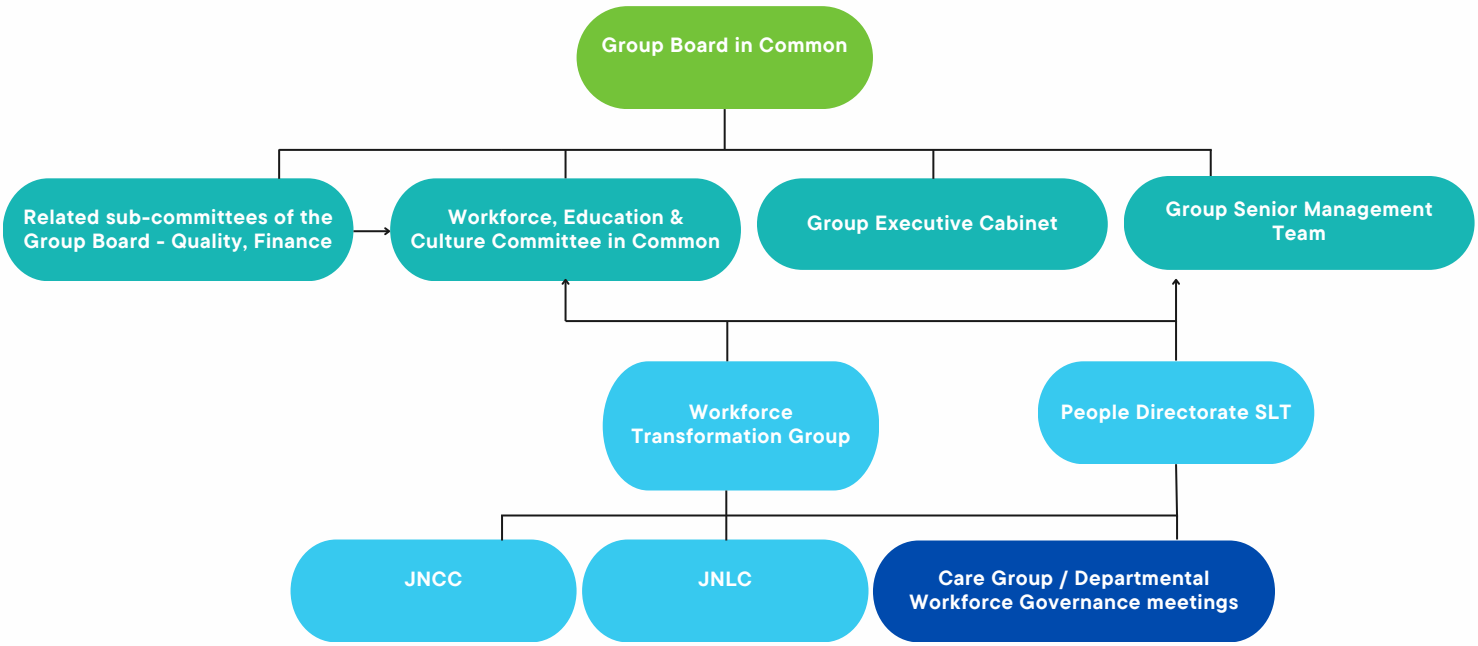
The People Strategy delivery will be monitored in a number of ways and at varying levels across the organisation.

Workforce Education & Culture Committee in Common
On a bi-monthly basis, the Workforce Integrated Performance Report (IPR) will be submitted to the Workforce Education and Culture Committee in common (WECC) which is a subcommittee of Group Board. This will include in-year People Strategy performance reporting in addition to the broader workforce programme of work and KPI's. Escalation will also be received from other Sub-committees into WECC where relevant to workforce. Escalations of assurance levels and any issues identified will be presented at Group Board.

Executive Cabinet / Group Senior Management Team
Executive Cabinet will set the People priorities and employment frameworks receiving escalations from operational workforce groups where appropriate. The Group Senior Management group will receive and approve annual operational planning submissions, inclusive of the workforce aspects of business planning as well as in year escalations of any emerging workforce issues. The Executive Cabinet will continue to manage the Vacancy Control process to ensure correct resource allocation and will also meet with Care Group management teams on a regular basis to ensure accountability for both performance and people issues.

Workforce Transformation Group
The Workforce Transformation Group is responsible for the operational delivery of the People Strategy. Member includes representation from all operational Care Groups as well as supporting departments and the People Directorate delivery leads. This group will focus on the dynamic co-delivery of the strategy making critical decisions as required.

JNCC and JLNC
Collaboration with our union partners will be cruical to the success of this strategy. Our union partners share our ambitions to provide excellence in patient care delivered through an engaged and valued workforce. JNCC and JLNC are the forums where policy and practice will be consulted upon and agreement reached where possible to do so.



3.4 - CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORT & BOARD CHALLENGE

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

REFERENCES

Only PDFs are attached

BIC(25)018 - Capital & Major Projects Commitees-in-Common Highlight Report & Board Challenge.pdf

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25) 018

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**13 February 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 Thursday 30 January 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:

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

Report for meeting of the Trust Boards to be held on:	Thursday 13 February 2025
Report from:	Capital and Major Projects Committees in Common
Report from meeting(s) held on:	30 January 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 30 January 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 January 2025

- Capital Plan delivery and expenditure against plan 2024/25
- Draft Capital Plan review 2025/26
- Post Capital Project Evaluation progress
- Humber Acute Services Review (HASR) Update
- Community Diagnostic Centre (CDC) Programme update
- Digital Plan Delivery 2024/25 Update including priorities for 2025/26

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:

Capital Plan 2024/25

a) The CIC were provided with an updated plan for the current year, which had been flexed to bring forward projects from 2025/26 to offset delays. All expenditure brought forward has been approved by Cabinet. The CIC were assured that spend for the year will be in line with plan and that there are no known omissions, albeit ongoing work around flow in the Emergency Departments may give rise to additional requirements.

a) Plans need to remain fluid in order to deal with changing landscapes, and as such the estates team ensure that future projects are planned early and ready to commence, including the Public Sector Decarbonisation Schemes (PSDS).
b) The Estates Team confirmed that, whilst the plan for Quarter 4 was extensive, that capacity existed to deliver all activities. The team noted that external support could be called upon to increase capacity as necessary. The CFO confirmed that the spend could be accommodated within the cash forecast.

Significant assurance was agreed due to the grip and control on the capital expenditure and planning processes. The efforts to flex and bring spend in line with plan were commended and there was clear evidence of strong teamwork in line with the staff charter.

Capital Plan 2025/26

a) Although the capital allocation is yet to be confirmed, Cabinet have carried out a prioritisation planning exercise based on reasonable assumptions and a draft capital plan was presented to the CIC. Whilst there are still allocations and accounting treatments to be confirmed, the CiC were assured that the plan was as complete as possible until capital allocations had been confirmed and that items had been appropriately prioritised. There was a £2m unallocated amount within the HUTH plan, although requirement to include the Daisy building (funded by Hull University) has not yet been concluded.

b) New schemes totalling £40m have been identified based upon emerging issues and will be evaluated alongside the development of a longer term capital strategy.

c) The clinical strategy once approved, would require cross reference against the plan.

d) A copy of the draft plan has been included as an appendix to this report.

Significant assurance was agreed, but the absence of a contextual strategic plan for timescales beyond 2025/26 was noted.

HASR

The local challenge process has concluded, which required significant input from colleagues across an 8week period, which was commended. The referral to the Secretary of State has not yet resulted in a call in, so planning for implementation continues.

Community Diagnostic Centres

a) The CIC received an update and despite delays outside of the Group's control, work was ongoing to ensure the CDCs opened as soon as possible. The Scunthorpe and Grimsby CDCs would be handed over mid-February although there had been a water ingress issue at Grimsby that is being investigated and a solution sought. It was confirmed that delays in opening would not adversely impact the financial plan for 2024/25 as activity mitigations had been put in place.

Revised tariffs for 2025/26 had been implemented by NHSE which resulted in a reduction in income for carrying out MRI and CT scans. This would create an adverse variance to business case of £2m for NLAG and £1m for HUTH, but it might be possible to offset some of this lost income by amending the activity and volume mix.

The CIC recorded their thanks to Ivan McConnell and team in conjunction with Estates colleagues for their hard work in trying to reach an optimal position. Limited assurance was given but this was due to the changing circumstances outside the Group's control.

Digital plan 2024/25 and 2025/26

The key focus of the Digital Plan would be the EPR Business Case and the CIC welcomed the confirmation of £15m of additional funding to close the shortfall in the Outline Business Case, which was still awaiting approval. The additional funds allocated would enable a range of potential suppliers to tender for the contract. The £14.5m forecast spend in 2025/26 related to infrastructure, staff and other enablement activity to ensure the procurement process could take place and a contract signed by 31 March 2026.

Significant assurance was maintained with regards to the overall digital plan and the CiC commended the team's level of engagement with colleagues.

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) Impact on the capital plans in relation to ICB activities, such as the creation of Regional Hubs for specialty and community services (details are not yet clear).

b) The CIC requested further clarity regarding the ED/IAAU Post Capital Evaluation (PCE)as the project spend had been reported as being on plan, however additional funding had been allocated. . The importance of undertaking the PCEs in a timely manner was reiterated. It was also agreed that a similar evaluation be undertaken for all major projects, whether revenue or capital in nature and irrespective of whether they fell in scope of the NHSE review process.

c) In the longer term the CIC requested visibility of 5 year + capital plans that are aligned with the overall strategy and illustrate allocation of spend into categories such as: strategic transformation, efficiency, replacement (equipment & digital etc), digital innovation, estates, PSDS (net zero), Legal & Compliance, Cultural. This would aid with prioritisation and flexing of plans in year and understanding whether allocations across the Group are balanced, aligned and risk based.

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 BAF was not presented at this meeting.

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

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Committees-in-Common Front Sheet

Agenda Item No: 4.2

Name of the Meeting	**Capital & Major Projects Committees-in-Common**
Date of the Meeting	30 January 2025
Director Lead	Emma Sayner; Group Chief Financial Officer
Contact Officer/Author	Alison Drury/Nicola Parker
Title of the Report	2025/26 Draft Group Capital Plan
Executive Summary	The draft capital programme for 2025/26 is attached, building on from previous Cabinet discussions in November. Based on the standard allocations, pre-commitments and approved business cases/investments, including a HASR provision in NLaG for commencing critical care, the capital programme is attached. This highlights that for the group, the capital programme could be fully committed, with only a small contingency, based on the assumptions of a similar ICB allocation to this year. There is also a list of schemes included that have been identified as emerging issues/priorities at the beginning of November, with no approved funding stream currently. These have been updated to capture any issues identified from the operational planning submissions. The Committee is asked to review and approve the latest draft programme and highlight any priority areas that could be missing from the development of the longer-term programme.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	Paper to cabinet in November and update paper for 21st January 2025 Cabinet meeting.
Financial implication(s) (if applicable)	The ICB capital allocation is to be confirmed – the assumptions are based on similar levels to 2024/25.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review X Assurance ☐ Other – please detail below:

NHS
Humber Health
Partnership

Capital & Major Projects Committees-in-Common

Capital Plan: Draft 25/26 Plan

1. 25/26 Draft Capital Plan

The Draft Capital Plan below was discussed briefly at Cabinet in November and remains work in progress. The ICB capital allocations are not yet confirmed and as advised we have worked on assumptions, similar to 2024/25 with any known PDC adjustments.

The draft plan includes: standard allocations for Equipment replacement, Building Maintenance and IM&T, (adjusted to reflect any schemes brought forward into 24/25 or slippage to 25/26); existing approved schemes scheduled for 25/26; and confirmed externally funded schemes (PDC and Grant funding).

		Current Status	NLaG 2025/26 £m	HUTH 2025/26 £m	Comments
Sources of Funding					
	Internally Generated	Estimated - tbc with ICB allocations	18.90	18.83	
	IFRS16 Right of Use Assets	Estimated - to be updated	2.13	3.85	
	Grants and Donations	Known schemes	19.24	0.78	
	PDC	Approved - EPR	6.71	5.34	
TOTAL FUNDING AVAILABLE FOR INVESTMENT			**46.968**	**28.798**	
Planned Allocations					
	Equipment replacement	Standard allocation	3.02	2.26	After adjustments for b/f to 24/25
	Building Maintenance and Compliance	Standard allocation	3.05	2.50	After adjustments for b/f to 24/25
	IM&T infrastructure/systems/hardware replacement	Standard allocation	3.50	1.50	HUTH - after £1m adj for EPR
	SGH Boiler/GDH Fire alarms	Approved	3.10		
	Digital Diagnostics c/f	Approved		0.54	
	CDC pads c/f	Approved		0.15	
	Ophthalmology Beverley CDC c/f	Approved		0.25	
	Hybrid Theatre building work	Business Case/scheme approved		0.47	Building work and residual equipment
	DPOW Audiology Booths	Approved	0.26		
	Kiosks for outpatients -self check-in	Approved BC (cabinet)	0.30	0.30	split 50/50 HUTH /NLaG
	Group Data warehouse	Approved BC (cabinet)	0.25	0.25	split 50/50 HUTH /NLaG
	EDMS	Approved in principle…BC ongoing	0.20	0.20	capital costs over 4 years (0.4m, 1.1m, 1.2m, 0.6m)
	HAS DPOW C Floor	Approved part of HASR	0.61		
	HAS DPOW Crit care B floor	HASR	3.84		scheme across 2 years
	Feasibility fees	Standard allocation	0.10	0.05	
	Spend to Save	Standard allocation		0.30	
Other Allocations					
	EPR	Externally funded	7.38	11.38	
	Rev/Cap transfers	Standard allocation		1.00	
	Remaining funds ACTIF ED scheme	Externally funded		0.79	
	PSDS Funded	Externally funded	19.14		
	Donated Assets (general)	Restricted allocation	0.10	0.30	
	Wellbeing Suite HRI (donated)	Restricted allocation		0.48	
	IFRS 16	Restricted allocation	2.13	3.85	
	University Daisy scheme	Cash funding stream but requires CDEL			*Could be 1.7m*
TOTAL ALLOCATIONS			**46.97**	**26.58**	
UNALLOCATED FUNDING			**0.00**	**2.22**	

The above highlights that for NLaG, the capital programme could be already fully committed based on the pre-commitments, previously approved business cases and standard allocations for backlogs and equipment replacement. This also includes provision for the commencement of the critical care development at DPoW, identified as part of the HASR Business Case.

For HUTH there is just over £2m uncommitted, however there is an issue regarding the partnership arrangements with the university and the Daisy building that requires more clarity as to whether this needs to be included as part of the Trusts capital allocation. Although funded by the university from a cash perspective, there may be an issue from a CDEL perspective if the scheme is required to be managed within the System Capital Envelope, reducing the spending power for HUTH by £1.7m and the unallocated to circa 0.5m.

Based on the above summary, the capital programme for the group could therefore already be fully committed, with only a small contingency.

2. Additional Capital Schemes identified as priorities with no current funding stream.

The table below includes the schemes that have been identified as emerging issues at the beginning of November and have been updated to capture any further issues/updates, as well as any issues identified from the operational planning submissions, noting these are indicative values. Further work is required to confirm likely timescales for these proposed schemes and where phasing is likely to cross into future years.

Priorities		**NLaG**	**HUTH**
New PSDS schemes - Trust contributions	Awaiting outcome of bids	3.40	3.90
SGH Day Surgery	Business case required	9.00	
Plastics Unit CHH	Business case required		
Rehabilitation 2	Business case required		12.00
Centralised therapies at CHH	Business case required - link to the above scheme		7.20
Offices/refurb old therapies block HRI	Business case required - link to the above scheme		
Oncology server replacement - urgent business case	Business case required		1.00
MRI cable HRI	More details required		0.30
Argyle St car park re-surface	Business case required		2.00
Mattress decontamination/Equipment library	Business case required		
Invest to save schemes		2.05	1.38
Plasma exchange service (Neurology) - needs machine	Business case required		0.03
Additional cranial navigation (Neurosurgery)	Business case required		0.15
		14.45	**27.96**
Funding gap against above priorities		**-14.45**	**-25.74**

The overall ICB allocations for 2025/26 are still to be confirmed and therefore the internal allocation within the capital programme is subject to change. In addition, there are often other opportunities to bid for capital funding in year and whilst at this stage there is limited opportunity in 2025/26 to progress any of the above schemes – consideration by the Committee on any omissions or views on the relative priorities and timelines would be helpful to focus the effort on the priority schemes.

3. Recommendation

The Committee is asked to review and approve the latest draft programme and highlight any priority areas that could be missing from the development of the longer-term programme.

3.5 - AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON HIGHLIGHT REPORT & BOARD CHALLENGE

Jane Hawkard & Simon Parkes, Non-Executive Directors Committee Chairs

REFERENCES

Only PDFs are attached

BIC(25)019 - Audit, Risk and Governance Committees-in-Common Highlight Report.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)019

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	13 February 2025
Director Lead	Jane Hawkard & Simon Parkes – Non-Executive Directors / Chairs of Audit, Risk and Governance Committees-in-Common
Contact Officer / Author	Jane Hawkard / Simon Parkes
Title of Report	**Audit, Risk and Governance Committees-in-Common Highlight / Escalation Report – January 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 meeting on 23 January 2025. The Trust Boards are asked to: • Note the public highlight report from the January 2025 Audit, Risk and Governance Committees-in-Common meeting.
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk and Governance Committees-in-Common Agenda Papers – 23 January 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:

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

Report for meeting of the Trust Boards to be held on:	13 February 2025 – Public
Report from:	Audit, Risk and Governance Committees-in-Common
Report from meeting(s) held on:	23 January 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 23 January 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:

- HUTH External Audit Progress Report
- HUTH External Audit Recommendations Action Plan Update
- NLAG External Audit Planning Report 2024/25
- Group Internal Audit Progress Report 2024/25 YTD
- Group Internal Audit Recommendations Status Report
- Group CIP / Waste Reduction Report
- Annual Review of Arrangements for Raising Concerns / Freedom to Speak Up – NLAG and HUTH
- Group EPRR Highlight Report
- Group Procurement Update
- Group HFMA Improving NHS Financial Sustainability Self-Assessment Checklist
- Group Board Assurance Framework
- Group Risk Register
- WISHH Charitable Funds Governance Arrangements
- Annual review of Policy for Engagement of External Auditor for Non-Audit Work – Group
- Results of ARG CiC Annual Self-Assessment Exercise 2025*
- Annual Review of ARG CiC Terms of Reference – NLAG and HUTH*
- Annual Review of ARG CiC Aligned Work Plan

*[*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) **Group Internal Audit (IA) Update** –The Committees received details of six finalised IA reports since the last meeting, with two receiving limited assurance – Group Cost Improvement Programme (CIP) / Waste Reduction and NLAG Lorenzo. The ARG CiC received **assurance** that the CIP recommendations had been met and that the setting up of a new programme management office (PMO) would provide more assurance in terms of accurately reporting against CIP targets and ensure that process of completing Equality and Quality Impact Assessments (EQUIAs) was robust and adhered to. A referral is being made to the Quality and Safety Committees-in-Common to understand how they receive assurance on the appropriate and compliant completion of EQIA's in relation to CIP projects.

The Committees received the latest reports on overdue IA recommendations and were only **reasonably assured**. All overdue recommendations for 2022/23 are now closed. However, the Committees were concerned that a number of recommendations for 2023/24 remained open and that implementation dates had moved a number of times. The ARG CiC will be routinely notified in future progress reports where recommendation implementation dates are moved more than once. The NLAG ARG CiC Chair will also write to all Executive Directors again to advise them of this, and that there needs to be a push on closing off recommendations before the April 2025 meeting. A review of overdue recommendations will also be made in advance of the April 2025 ARG CiC meeting and Executive Directors will be asked to attend the meeting to explain why recommendations have not been implemented in their respective areas where relevant.

b) **Freedom to Speak Up Arrangements** – The ARG CiC received **assurance** on the process arrangements for raising concerns / speaking up at both organisations. A referral is however being made to the Workforce, Education and Culture Committees-in-Common to understand how they 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 and obtain assurance that those who speak up are protected.

c) **Group Risk Register** - The ARG CiC were concerned that the report consisted of a significant number of high risks across the Trust and did not include mitigations. The Group Director of Assurance advised that he and the Group Director of Nursing were meeting with each of the Care Groups to discuss the risks in detail and the process that needed to be undertaken to mitigate and manage risks. The ARG CiC were **not assured** and requested that this matter be brought to the attention of the Group Risk and Assurance Cabinet (GRAC) as a matter of urgency.

d) **Policy for Engagement of External Auditor for Non-Audit Work** – The two existing documents have been combined into one Group policy document as part of the annual review process, and this Group document was approved by the ARG CiC.

e) **ARG CiC Governance Documents** – the Committees approved the results of the ARG CiC annual self-assessment exercise 2025 for submission to the Trust Boards for information. The Committees also reviewed their Membership and Terms of Reference (ToR) documents and agreed a limited number of minor additions. The ToR documents are provided to the Trust Boards for ratification as a separate agenda item.

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 The ARG CiC received its routine item on the Board Assurance Framework (BAF) and the Group Director of Assurance advised the Committees that Executive Director challenge meetings would commence on 24.1.2025. The ARG CiC discussed having realistic scores and mitigated scores.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to note the highlight report from the Audit, Risk and Governance Committees-in-Common.

Jane Hawkard
HUTH ARG CiC Chair / NED
23 January 2025

Simon Parkes
NLAG ARG CiC Chair / NED

3.6 - CHARITABLE FUNDS HIGHLIGHT REPORT

Jane Hawkard, Non-Executive Director

REFERENCES

Only PDFs are attached

BIC(25)020 - Charitable Funds Highlight Report - HUTH.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)020

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**13 February 2025**
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer / Author	Jane Hawkard on behalf of HUTH Charitable Funds Chair
Title of Report	HUTH Charitable Funds Committee
Executive Summary	The HUTH Charity is running down its fund balances with a view to transfer all remaining funds to the WISHH Charity (independent from the Hospital Trust) by the 31st March 2025. The Charitable Funds Committee met on 20 January 2025 to approve HUTH's Charity annual accounts. The accounts are attached for information. **Recommendation:** The Boards in Common are asked to: • ***Note*** *the approval by the CF Committee Trustees of the 2023/24 year-end HUTH Charity Accounts.* • ***Note*** *that a revised MOU is being produced with legal support from Capsticks to agree the relationship between HUTH and the WISHH Charity. The CG Committee will meet again on the 10th of February to review and sign off the MOU.* • *Formally minute the* ***approval*** *closure of the HUTH General Purpose Account and transfer to the WISHH Charity by the 31 March 2025.*
Background Information and/or Supporting Document(s) (if applicable)	A briefing paper is attached detailing the process of transferring the General Purpose Accounts to the WISHH Charity. The paper also highlights the next steps for the HUTH Charitable Funds Committee
Prior Approval Process	The HUTH Charitable Funds Committee held 20 February 2025
Financial Implication(s) (if applicable)	Financial implications are included in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A

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

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

Report for meeting of the Trust Boards to be held on:	13 February 2025
Report from:	HUTH Charitable Funds Committee
Report from meeting(s) held on:	20 January 2025
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Charitable Funds Committee at their meeting held on 20 January 2025 including those matters which the committee specifically wishes 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:

- *Financial Report at 31 December 2024*
- *General Purpose Summary of the Balances*
- *General Purpose Charity 2023-24 Final Accounts*
- *Letter of Representation*

3.0 Matters for reporting / escalation to the Trust Boards

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

a. Note the approval of the year-end 2023-24 HUTH Charity Accounts by the Trustees of the Committee.

b. That the Trust Board **formally approve** the closure of the General Purpose Accounts and transfer to the WISHH Charity (formal minute required) as at 31 March 2025.

c. Note that a revised Memorandum of Understanding regarding the transfer of the accounts process and continuing relationship between the WISHH Charity and the Trust following the transfer of funds.

4.0 Matters on which the committees have requested additional assurance:

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

a. The likely amount of final balances to be transferred to WISSH once the current expenditure commitments have been actions, including the recompense of the Trust for the costs in relation to the Allam donations towards buildings.
b. Sight of the MOU for approval prior to the transfer.

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

4.2 N/A

6.0 Trust Board Action Required

5.1 The Trust Boards are asked to:

- Approve closure of the HUTH General Purpose Account and transfer to the WISHH Charity
- Note the contents of this report

Tony Curry, Chair of the HUTH Charitable Funds Committee

20 January 2025

TRUST BOARDS-IN-COMMON
MERGER OF NHS CHARITY WITH THE WISHH CHARITY

1. PURPOSE OF REPORT

The purpose of this paper is to seek formal approval on the closure of the Hull and East Yorkshire Hospitals NHS Trust General Purposes Charity (GP Charity) and its conversion to independent status / merger with the Hull and East Yorkshire Hospitals Health Charity, also known as the WISHH Charity. Subject to formal approval by the Trust Boards-in-Common, a final notification will be sent to the Department of Health and Social Care (DHSC) for its approval.

2. BACKGROUND

At its meeting held on 8th February 2024, the Trust Boards-in Common was appraised of the work that was being undertaken by the HUTH Charitable Funds Committee to run down the GP Charity fund balances with a view to transferring any remaining funds to the WISHH Charity, subject to the necessary approvals being obtained from the DHSC and Charity Commission. This has been a strategic objective following the creation of the WISHH Charity, as has previously been referenced.

There is a formal procedure which has to be followed to achieve this outcome and requires approval by the:

- Charity Commission
- Department of Health and Social Care

Whilst this process was commenced some 12 months ago, with the required notification letters being sent to both organisations above, the time taken has been longer than originally anticipated.

In respect of the dialogue with the Charity Commission, this was relatively straight forward, once issues relating to several linked NHS charities which had been merged over the years were clarified. These are now detailed in the required Memorandum of Understanding - see item 3 and Appendix 1 of the attached MoU. The Charity Commission has subsequently corresponded and approved the proposed merger.

In respect of securing DHSC approval, it has been necessary to consult with our legal services provider who has advised that a follow up letter along with the following be submitted.

- Copy of the initial letter sent to DHSC.
- Copy of the final agreed MOU.
- Copy of the Trust Board minutes approving the MOU.
- Copy of the Articles of Association of the WISHH Charity.

It is expected that provision of the above to the DHSC will be deemed as meeting their requirements.

3. DRAFT MEMORANDUM OF UNDERSTANDING

Attached to this report at Appendix A is a draft Memorandum of Understanding (MoU), the document which sets out the principles and requirements placed on each party as a consequence of the proposed merger. Both organisations have had legal advice in formulating and considering this document. It has been updated to reflect comments received from the WISHH Charity.

Prior to finalisation it will be necessary to complete the MoU with the addition of the resources to be transferred, any liabilities that the NHS Charity has and a Service

Level Agreement (SLA) setting out the facilities and services provided by the Trust in support of the WISHH Charity – Appendix 3 of the MoU refers.

4. FINANCIAL IMPLICATIONS

A summary breakdown of the financial position as at 31st December 2024 is provided at Appendix B.

At this date, total funds (cash at bank and investments) amounted to £5,760k.
While £69k was due from HUTH, a total of £404k was owed to HUTH, WISHH and trade suppliers.
After taking account of the above, in addition to funds already committed (£4,573k), there will be a net funds balance of circa £852k. Clearly, there will be some movement on this balance between now and the point of funds transfer.

Instructions to liquidate investments were issued to CCLA during the second half of January 2025. It is likely that there will have been some market value movement in the interim which will impact the net funds balance reported above.

All outstanding commitments existing at the point of conversion to independent status will transfer to WISHH and will be honoured.

5. NEXT STEPS

Assuming there are no significant issues arising from the Board's consideration of this paper, work will be undertaken to finalise the MoU and arrangements made for its completion in March, for subsequent sign-off by both the HUTH Charitable funds Committee and WISHH Charity Committee. The overall aim being to complete the conversion to independent status / merger process by no later than the 31st March 2025.

Key MoU sign off dates will be as follows.

- Monday 10th March 2025 – HUTH Charitable funds Committee
- Tuesday 11th March 2025 – WISHH Charitable funds Committee

6. RECOMMENDATION

The Boards-in Common is recommended to:

6.1 Consider and comment on the contents of this paper, the attached Memorandum of Understanding and summary financial details set out in Appendix B.
6.2 Acknowledge that the draft MoU, subject to any changes, will be signed off by Trustees of both charities.

Tony Curry
Chair – HUTH Charitable Funds Committee

Paul Webster
Senior Financial Accountant

Jane Hawkard – Trustee, HUTH Charitable Funds Committee

February 2025

APPENDIX A

MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING is made 2025

BETWEEN

(1) HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST of Trust Headquarters, Hull Royal Infirmary, Alderson House, Anlaby Road, Hull, HU3 2JZ (the "**Trust**"); and

(2) THE HULL AND EAST YORKSHIRE HOSPITALS HEALTH CHARITY a company limited by guarantee registered in England and Wales with company number 09594274 and a registered charity with charity registration number 1162414 having its registered office at Alderson House, Hull Royal Infirmary, Anlaby Road, Hull HU3 2JZ, also known as WISHH ("**Independent Charity**").

BACKGROUND

(A) The Trust is the corporate trustee of its NHS charity; Hull and East Yorkshire Hospitals NHS Trust General Purpose Charity (Charity Number 1052035) and the related charities as detailed in Appendix 1 of this Memorandum of Understanding (together the "**NHS Charity**").

(B) The Independent Charity (The Hull and East Yorkshire Hospitals Health Charity, also known as WISHH – Charity Number 1162414) was incorporated on 16 May 2015 as a charitable company limited by guarantee.

(C) In 2018, discussions took place between the Trust (as corporate trustee of the NHS Charity) and the Independent Charity for the development of the Independent Charity as the primary fundraising organisation supporting and managing fundraising activities related to the Trust. The proposed arrangements were approved in July 2018.

(D) On 11 September 2021, the Trust and the Independent Charity entered into a memorandum of understanding to set out the arrangements between the Trust and the Independent Charity ("**Initial Agreement**").

(E) Pursuant to the terms of the Initial Agreement, from October 2018, all newly received charitable donations received by the Trust were agreed to be paid into the Independent Charity for management of the funds. All charitable funds held by the NHS Charity at the date of the Initial Agreement continued to be held by NHS Charity to be applied in accordance with NHS Charity's objects. There

was no transfer to the Independent Charity of charitable funds received prior 1 October 2018.

(F) Following the successful conclusion of the Initial Agreement, the Trust acting as corporate trustee of the NHS Charity has agreed to convert the NHS Charity to independent status.

(G) As required by the guide 'NHS Charities – Conversion to Independent Status, February 2020' published by the Department of Health and Social Care, the Parties are entering into this agreement ("**Memorandum of Understanding**") to set out terms on which they will work together from the Completion Date.

OPERATIVE PART

1. DEFINITIONS AND INTERPRETATION

1.1 In this Memorandum of Understanding (including, where relevant, the Recitals), and unless the context otherwise requires, the following words or expressions will have the following meanings:

"Assets"	all assets of the NHS Charity, including but not limited to those assets described in Clause 5;
"Bank Accounts"	the bank accounts operated by the Trust in respect of the NHS Charity;
"Completion Date"	31st March 2025
"Debts"	all debts (including prepayments) owed to the Trust in respect of the NHS Charity on the Completion Date;
"Intellectual Property"	all patents, know-how, registered and unregistered trademarks and service marks (including any trade, brand or business names), any registered domain name, registered designs, design rights, utility models, copyright (including all such rights in computer software, business information and any databases), moral rights and topography rights (in each case for their full period and all extensions and renewals of them), applications for any of the foregoing in any part of the world and any similar rights situated anywhere in the world in each case owned by the Trust in respect of the NHS Charity;

"Recitals"	paragraphs (A) to (G) above under the heading 'Background';
"Restricted Funds"	those assets held by the Trust in respect of the NHS Charity as restricted funds, in particular those detailed in Appendix 2 (*Restricted Funds*);
"Regulatory or Supervisory Body"	those government departments and regulatory, statutory and other entities, committees and bodies which, whether under statute, rules, regulations, codes of practice or otherwise, are entitled by any legislation to supervise, regulate, investigate or influence the matters (or some of the matters) dealt with in this Memorandum of Understanding or the affairs (or some of the affairs) of the Trust, which as at the Completion Date includes NHS England, the Department of Health and Social Care and the Charity Commission (and the term "**Regulatory or Supervisory Bodies"** shall be construed accordingly.
"Termination Notice"	notice to terminate this Memorandum of Understanding in accordance with Clause 11.

2. COMMENCEMENT

2.1 This Memorandum of Understanding will commence on the Completion Date.

3. OBJECTS AND PURPOSE

3.1 The objects of the Independent Charity are:

"to relieve sickness and promote and improve the health of the public" (Article 5 of WISHH's articles of association).

3.2 The NHS Charity's object are:

"any charitable purpose or purposes relating to the National Health Service".

3.3 The Trust and the Independent Charity agree that the Trust will transfer:

(a) the Assets to the Independent Charity in accordance with Clause 5; and

(b) the gifts (whether of money or other assets), received by the Trust after the Completion Date, to the Independent Charity in accordance with Clause 6,

on terms that the Assets and/or the gifts (as relevant) may be applied only for any charitable purpose or purposes relating to the National Health Service and specifically the Hull University Teaching Hospitals NHS Trust or its successors.

3.4 The Independent Charity shall not transfer any funds held by the Independent Charity under this Memorandum of Understanding without prior written consent from the Trust.

3.5 This Memorandum of Understanding sets out how the Trust and the Independent Charity will work together to ensure:

(a) that the Trust and the Independent Charity are actively involved with each other in a collaboration of independent entities with mutually beneficial objectives;

(b) that the Trust provides the Independent Charity with carefully considered recommendations for charitable support;

(c) the maximum efficiency and effectiveness of the Independent Charity in support of the Trust patients, employees, facilities, services and research through the application of charitable funds in pursuit of its charitable objects.

4. THE INDEPENDENT CHARITY TRUSTEES

4.1 From the Completion Date and at all times when this Memorandum of Understanding is in force, the Trust shall be entitled to nominate two (2) trustees to the board of trustees of the Independent Charity, provided that the number of trustees nominated by the Trust shall never form a majority of the

board of trustees of the Independent Charity, and the Trust's nominee(s) shall become trustees of the Independent Charity on receipt of a confirmation nomination by the Independent Charity from the Trust and in accordance with the Independent Charity's articles of association.

4.2 The Independent Charity agrees that it shall not, at any time whilst this Memorandum of Understanding is in force, take any action that would result in the termination or removal of the Trust's right to appoint trustees to the board of the Independent Charity in accordance with this Clause and the articles of association of the Independent Charity as they apply at the date of this Memorandum of Understanding.

4.3 If any trustee appointed pursuant to this Clause 4 retires, resigns or otherwise ceases to act as a trustee of the WISHH Charity, the WISHH Charity will promptly notify the Trust. The Trust shall be entitled to nominate an appropriate replacement in accordance with the terms of this Clause 4.

5. TRANSFER OF ASSETS

5.1 The Trust hereby transfers to the Independent Charity, with effect from the Completion Date, all of the rights, title and interest of the Trust in the assets held by the Trust as trustee for the NHS Charity, including, without limitation:

(a) all amounts standing to the credit of the Bank Accounts;

(b) the Restricted Funds;

(c) the Debts;

(d) all other assets, property or rights of the NHS Charity owned by the Trust in its capacity as corporate trustee of the NHS Charity,

for them to be held by the Independent Charity on the terms of Clause 3.3 (above) and subject to the restrictions of the objects of the Independent Charity and in the case of the Restricted Funds, on the terms applicable to those funds.

6. FUTURE TRANSFER OBLIGATIONS

6.1 The Trust hereby undertakes to transfer to the Independent Charity all gifts (whether of money or other assets) received by the Trust after the Completion Date to be held on trust for the benefit of the Trust and its services in accordance with Clause 3.3 (above).

7. RESTRICTED FUNDS

7.1 The Independent Charity undertakes that, with effect from the Completion Date, it shall hold and shall apply the Restricted Funds on and subject to the terms applicable to them immediately prior to the Completion Date.

8. REVIEW MEETINGS

8.1 The Trust and the Independent Charity shall meet, at least once in each calendar year, to discuss the Trust's strategic aims and objectives and to discuss the Independent Charity's role in achieving the Trust's strategic aims and objectives ("**Review Meeting**").

8.2 The Parties shall, from time to time, agree the attendees to the Review Meeting. The Trust shall ensure that at least one representative, at director level, attends each Review Meeting on behalf of the Trust. The Independent Charity shall ensure that at least one trustee attends each Review Meeting on behalf of the Independent Charity.

8.3 The Parties shall agree the agenda for each Review Meeting in advance of each meeting.

9. APPROVALS

9.1 The Trust warrants and represents that it has passed the necessary resolutions to approve the terms and authorise the execution of this Memorandum of Understanding.

9.2 The Independent Charity warrants and represents that it has passed the necessary resolutions to approve the terms and authorise the execution of this Memorandum of Understanding.

10. DISSOLUTION

10.1 In the event that the Independent Charity is considering dissolution in accordance with its Articles of Association, the Independent Charity must promptly provide written notice to the Trust and shall consult with the Trust on the application of the assets held under this Memorandum of Understanding. The Independent Charity shall co-operate with the Trust and shall have regard to the Trust's decision in relation to replacement arrangements for the holding of assets held under this Memorandum of Understanding and the charitable gifts donated to the Trust.

11. TERMINATION

11.1 Without prejudice to its other rights and remedies, the Trust may terminate this Memorandum of Understanding, immediately or on the expiry of the notice

period specified in the Termination Notice (whichever is earlier), by giving written notice to the Independent Charity in any one or more of the circumstances set out below:

(a) the Independent Charity is in material breach of this Memorandum of Understanding, provided that (if capable of remedy) such breach has not been remedied within the time period specified by the Trust;

(b) the Independent Charity is in material breach of this Memorandum of Understanding and such breach is not capable of remedy;

(c) notice that the Independent Charity is proposing to wind up or dissolve;

(d) a Regulatory or Supervisory Body having jurisdiction over the Trust requires this Memorandum of Understanding to be terminated.

11.2 Following the service of a Termination Notice for any reason:

(a) the Independent Charity shall, until termination of this Memorandum of Understanding, continue to hold charitable funds transferred to it pursuant to the terms of this Memorandum of Understanding;

(b) the Independent Charity shall, from the date of the Termination Notice, hold charitable funds transferred to it pursuant to the terms of this Memorandum of Understanding on trust for the benefit of the Trust and shall, promptly, upon written notice from the Trust transfer such charitable funds to a charity nominated by the Trust;

(c) the rights granted to the Independent Charity pursuant to the terms of this Memorandum of Understanding shall cease.

11.3 In the event of termination of this Memorandum of Understanding the Parties shall co-operate acting reasonably to determine an appropriate replacement arrangement for the holding of charitable gifts donated to the Trust including by consulting with Regulatory and Supervisory Bodies and by continuing the arrangements provided for in this Memorandum of Understanding for such period as may be required to ensure the orderly transfer of such arrangements.

11.4 Termination of this Memorandum of Understanding shall not affect any rights or liabilities of either Party hereunder or at law, not shall it affect the coming

into force or the continuance in force of any provision hereof which is expressly or by implication intended to come into or continue in force.

12. DISPUTE RESOLUTION

12.1 If any dispute arises in connection with this Memorandum of Understanding, or the performance, validity or enforceability of it ("**Dispute"),** then the Parties shall follow the procedure set out in this Clause 12.

12.2 Either Party shall give to the other written notice of the Dispute, setting out its nature and full particulars, together with the relevant supporting documents.

12.3 If the Dispute relates to circumstances which entitle the Trust to terminate this Memorandum of Understanding pursuant to Clause 11 (above), before taking any action to terminate this Memorandum of Understanding the Parties shall first use their reasonable endeavours acting in good faith to resolve the Dispute so that the Independent Charity may continue as the recipient of charitable gifts donated to the Trust.

12.4 In the event that the Parties are unable to resolve any Dispute then before serving notice to terminate the Parties shall notify and consult with the Charity Commission and the Department of Health and Social Care in respect of the Dispute and shall consider in good faith such proposals as those Parties may make.

12.5 In the event the Parties are unable to resolve the Dispute following notification and consultation with the Charity Commission and the Department of Health and Social Care, or, if the Dispute is not related to circumstances which entitle the Trust to terminate this Memorandum of Understanding, the parties will attempt to settle it by mediation in accordance with the Centre for Effective Dispute Resolution ("**CEDR**") Model Medication procedure. Unless otherwise agreed by the parties within 14 days of notice of the dispute, the mediator will be nominated by CEDR. To initiate the mediation a party must give notice in writing ("**ADR Notice**") to the other parties to the dispute requesting a mediation. A copy of the request should be sent to CEDR. The mediation will start no later than 28 days after the date of the ADR Notice.

13. GOVERNING LAW AND JURISDICTION

13.1 This Memorandum of Understanding and any disputes or claims arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) will be governed by and construed in accordance with the laws of England.

13.2 The English courts shall have jurisdiction over any disputes or claims arising out of or in connection with this Memorandum of Understanding or its subject matter or formation (including non-contractual disputes or claims).

This Memorandum of Understanding is duly executed on the date first written above

Executed by **THE HULL AND EAST YORKSHIRE HOSPITALS HEALTH CHARITY** acting by a director, and a director/ secretary	)) …… Director) …….. Director/Secretary
SIGNED by **HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST**	)) …… Authorised signatory ……. Authorised signatory

APPENDIX 1 - LINKED CHARITIES

Charity name	Charity number	Date of Declaration	Object	Registration history
The Beverley Westwood and Castle Hill Hospital Patients Fund	1052035-2	28 May 1996	For the relief of sickness and disability of patients or its effects, who are or have been treated at the Beverley Westwood Hospitals or Castle Hill Hospital.	10 June 1996: Standard registration
The Beverley Westwood and Castle Hill Hospitals Medical Equipment Fund	1052035-3	28 May 1996	For the provision of medical equipment for the relief of sickness and disability or its effects of patients who are or have been treated at Beverley Westwood or Castle Hill Hospitals	10 June 1996: standard registration
The Beverley Westwood and Castle Hill Hospitals Staff Fund	1052035-1	28 May 1996	For the relief of sickness at the Beverley Westwood Hospital and Castle Hill Hospital by promoting the efficient performance of their duties by the staff at those hospitals.	10 June 1996: standard registration
The Hull and East Yorkshire Hospitals NHS Trust Clinical Research and Amenities Charitable Trust	1052035-8	17 March 1997	For any charitable purposes principally (but not exclusively) at or in connection with the hospitals under the control of Hull and East Yorkshire Hospitals NHS Trust	6 December 2000: standard registration
The Hull and East Yorkshire Hospitals NHS Trust	1052035-6	17 March 1998	To combine the investments and money belonging to the charities and representing expendable funds	8 May 1998: standard registration

(Expendable Funds) Common Investment Fund			into one pooled fund (for further details of charities involved see scheme)	
The Hull and East Yorkshire Hospitals NHS Trust General Purpose Charity	1052035-5	20 January 1998	For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by East Yorkshire Hospitals NHS Trust.	23 February 1998: standard registration
The Hull and East Yorkshire Hospitals NHS Trust Medical Research Charitable Fund	1052035-4	28 May 1996	For any charitable purpose or purposes, principally (but not exclusively) at or in connection with the East Yorkshire Hospitals NHS Trust, which will further the following aims: (a) the investigation of the causes of sickness and disability and the prevention, treatment, cure and defeat of sickness and disability in all its forms; (b) the advancement of scientific and medical education and research in topics related to sickness and disability (provided that the useful results of any research must be published); (c) the furtherance of any other charitable purposes for the relief of persons suffering from sickness and disability	10 June 1996: standard registration

The Hull and East Yorkshire Hospitals NHS Trust Patient welfare and Amenities' Charitable Trust	1052035-9	17 March 1997	For the relief of sickness or patients who are or have been treated in hospitals under the control of Hull and East Yorkshire Hospitals NHS Trust	6 December 2000: standard registration
The Hull and East Yorkshire Hospitals NHS Trust Staff Welfare and Amenities Charitable Trust	1052035-10	17 March 1997	For the relief of sickness at the hospitals under the control of Hull and East Yorkshire Hospitals NHS Trust by promoting the efficient performance of their duties by the staff of those hospitals	6 December 2000

APPENDIX 2 – RESTRICTED FUNDS

Fund number	Fund Name
F50200	Hth Gp Educational Fund
F79993	Hth Allam Developments
F00002	Hth Irene Hardy Legacy

APPENDIX 3 – SUMMARY SERVICE LEVEL AGREEMENT
BETWEEN
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
AND
HULL AND EAST YORKSHIRE HOSPITALS HEALTH CHARITY

1. PURPOSE OF DOCUMENT

This document forms part of the Memorandum of Understanding which governs the merger of the Hull and East Yorkshire Hospitals NHS Trust General Purposes Charity and the Hull and East Yorkshire Hospitals Healthy Charity. Specifically, it sets out the services and facilities which are provided by the Trust at no cost to the Charity.

2. FACILITIES PROVIDED

2.1 Office Accommodation and Facilities

Provision of fully serviced furnished office facility which form the Charity's base currently in the Administration Building on the Castle Hill hospital site. Any relocation of office accommodation to be agreed by both parties.

Occasional use of a hot desk facility on the Hull Royal Infirmary site to enable staff to work on projects/activities specific to the site, subject to availability and booking.

Use of meeting rooms, subject to availability.

The Trust also allows the Charity use of the Trust's IT systems and support services.

2.2 Financial Matters

Assistance and support from the Cashiers office in terms of the collection and banking of funds, petty cash requirements etc.

2.3 Employment Matters

Use of the Trust's employment systems and processes relating to the Charity's staff, who are paid for by the Charity but employed on NHS Terms and Conditions, including advice and assistance on related employment matters.

This arrangement also facilitates Charity staff to undertake all mandatory and other training provision facilitating working in a hospital environment.

2.4 Communication

Whilst the Charity produces the majority of its own publicity, it engages with and receives support from the Trust's Communication Department to ensure effective coordination, liaison, advice, and guidance in respect of relevant publicity matters.

This working arrangement also facilitates the communication of charity publicity material via the Trust's intranet.

2.5 Other General Support

The Trust also facilitates the use of other specific assistance required from time to time e.g. inclusion of Charity logo on Trust vehicles, display of publicity materials throughout the hospital site.

3. Review Process

The Trust and the Charity will ensure that the above arrangements are reviewed at regular intervals to ensure that they still are both relevant and meet the needs of both parties.

Signed…… **Signed**……

Designation…… **Designation**……

Date…… **Date**……

Appendix B

Hull and East Yorkshire Hospitals NHS Trust General Purposes Charity

Residual funds as at 31st December 2024

	Total at 31/12/2024 £000
Funds	
Investments - long term	1,952
Investments - short term	440
Cash at bank	3,368
Total funds	**5,760**
Plus	
Amounts due from HUTH (debtor)	69
Less	
Funds already committed*	(4,573)
Amounts owed to WISHH (creditor)	(320)
Amounts owed to HUTH (creditor)	(45)
Amounts owed to suppliers (trade creditors)	(39)
Residual / unallocated funds to transfer to WISHH	**852**

* Includes £4m contribution towards HUTH capital schemes

3.7 - HEALTH TREE FOUNDATION TRUSTEES' HIGHLIGHT REPORT

Gill Ponder, Non-Executive Director

REFERENCES

Only PDFs are attached

BIC(25)042 - Health Tree Foundation Trustees' Highlight Report.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)042

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	13 February 2025
Director Lead	**Emma Sayner Group CFO**
Contact Officer / Author	**Neil Gammon – Independent Health Tree Foundation Trustees' Meeting Chair**
Title of Report	**The Health Tree Foundation Bi-annual Report to Trust Board**
Executive Summary	This report, presented bi-annually, provides Trust Board with update on current Health Tree Foundation (HTF) issues. No Trust Board decisions required at this time, although Trust Board is asked to note impending contract expiry in June 2025
Background Information and/or Supporting Document(s) (if applicable)	Minutes of Quarterly Health Tree Foundation Trustees' Meetings
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:

Funding Activities and Challenges

Charities across the UK are facing significant challenges in fundraising amidst the ongoing cost-of-living crisis. Rising inflation and economic pressures have led to reduced disposable income, impacting individual donations and corporate sponsorships. In response, the Health Tree Foundation (HTF) has implemented cost-effective fundraising strategies, focusing on targeted events and corporate partnerships.

Despite these challenges, HTF continues to make progress.

HTF addresses these challenges by diversifying income streams, applying for grants, and securing corporate collaborations. Efforts are underway to secure additional funding for strategic projects, such as the CDC Garden and NICU simulation doll.

Successful Christmas Campaign and Activities

HTF's Christmas 2024 initiatives successfully engaged communities and supported hospital patients and staff. Key highlights include:

- **Patient Gifts:** Distribution of branded blankets to all inpatients and personalised baubles for new babies in NICU and Maternity Wards.
- **Community Events:** HTF organised Christmas Light Switch-Ons at SGH and DPOW sites, hosted by Trust Chairman Sean Lyons. Despite the weather conditions, these events were executed seamlessly.
- **Fundraising Events:** The Keelby Santa Run and Christmas Market raised over £3,400 for the Little Lives Appeal, demonstrating strong community participation, again despite adverse weather conditions.
- **Visits to Wards:** Partnerships with local organisations including Grimsby Town Football Club and The Scunny Bikers, brought festive cheer to children's wards.

These activities not only raised significant funds but also strengthened community relations and enhanced the patient experience.

Performance Against KPIs

HTF continues to meet many of its Key Performance Indicators (KPIs). Notable achievements include:

- **Grant Applications:** Submission of multiple grant funding applications with, amongst other smaller ones, one significant success—the ICCM Woodlands Crematorium grant of £11,600 for bereavement services.
- **Community Engagement:** Enhanced visibility through regular attendance at Business Hive networking events and local community fairs.

- **Circle of Wishes:** The automated system, introduced in October 2024, has improved tracking and fulfilment of charitable initiatives, with over 142 active wishes and 34 fulfilled in November 2024 alone.
- **Fundraising Impact:** In current FY, at AP9 actual income of £399k was £291k below budgeted income of £690K. Main reason is that donations and legacies have been less than expected when budget was set.
- **Expenditure:** Expenditure of £91k is £188k below budget of £279k at same stage. Main reasons are delays in approvals and ordering processes, together with a period of downtime for about 2 months in summer 2024, of the HTF website. During this time, 'Wishes' had to be submitted via email.

While HTF has faces challenges engaging new fundraisers and corporate partners, these efforts remain ongoing, with promising leads for 2025.

At each quarterly Trustees' Meeting, performance against KPIs is rigorously reviewed and priorities adjusted accordingly.

NLAG's Contract with Smile Foundation: Review due June 2025

The HEY Smile Foundation (Smile) has partnered with Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) to manage the Health Tree Foundation (HTF) since 2015. Smile was engaged to transform the management of NLAG's charitable funds, shifting from passive administration to a proactive, strategic approach. Leveraging its infrastructure and expertise, Smile rapidly implemented tailored systems, recruited experienced staff, and enhanced the utilisation of charitable funds to maximise patient benefits.

Smile's Role

Smile has sought, through the contract, to add value to HTF's output through focussing on operational efficiency, fundraising expertise, community engagement and crisis management. Whilst this has not always managed to overcome the downturn in HTF's income, there is much untapped potential in the relationship, which Trustees are seeking to maximise.

Strategic Impact

Smile's integration within the regional healthcare framework enhances HTF's alignment with Integrated Care Board (ICB) priorities. By brokering relationships across health, local authority, and voluntary sectors, Smile amplifies HTF's impact while driving cost-effective interventions, such as supporting hospital discharges, reducing waiting list pressures, and expanding green social prescribing initiatives.

2025 and Beyond

Trustees are currently considering best way forward with the HTF contract.

Charity Patron

Following the departure in 2024 of Sir Reginald Sheffield as HTF Patron, efforts to attract another suitable candidate have not borne fruit; work continues.

4 - GOVERNANCE & ASSURANCE

4.1 - BOARD ASSURANCE FRAMEWORK & STRATEGIC RISK REGISTER - NLAG & HUTH

David Sharif, Group Director of Assurance

REFERENCES

Only PDFs are attached

BIC(25)021 - Board Assurance Framework (BAF) & Strategic Risk Register - NLaG & HUTH.pdf

Hull University Teaching Hospitals NHS Trust

Trust Boards-in-Common Front Sheet

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(25)021

Meeting name	Trust Boards-in-Common
Meeting date	13 February 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 risk ratings for: • BAF risk 1 – Staff Support – Current risk score = **20** • BAF risk 2 – Performance – Current risk score = **20** • BAF risk 8 – Finance – Current risk score = **20** There are 5 actions underway for the Group Culture and Leadership risk and there are no proposed changes to the risk rating or risk appetite. There are 10 actions underway for the Performance risk and there are no proposed changes to the risk rating or risk appetite. There are 6 actions underway in total addressing the Finance risks with a range of owners (two for the finance related risk). The Group Chief Financial Officer reviewed the financial sustainability risk on 24 January 2025. As a result of the ongoing mitigation which includes the development of a financial strategy, Care Group transformation and PA Consultancy assistance, the risk has been downgraded from 25 to 20 (Likelihood 4, Consequence 5). 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. **Recommendations:** The BiC is asked to: • Note and review the BAF risks noted in this report • Consider the recalibrated Finance risk score • Note that the risks have been recalibrated

Background information and/or Supporting Document(s) (if applicable)	BAF risks 1, 2 and 8 have been updated following discussion between the Group Chief Financial Officer, CEO North, the Group Chief People Officer 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
Group Cabinet Risk and Assurance Committee

NHS Humber Health Partnership

Purpose of the report

The purpose of the report is to update the Committee regarding the Group's strategic Finance and Performance risks. The Board assurance framework is designed to help drive the Boards' agenda, achieve its strategic objectives and ensure that the Group's reputation and credibility for patients and broader stakeholders is preserved and nurtured.

Structure of the report

Overleaf, a table summarises the current assessment for 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):

- The strategic risk description;
- #1
- The last review date;
- The current risk score in a 5 by 5 matrix applicable to the risk appetite for this risk category; and
- The risk appetite statement relevant to the matrix (for information).

#2

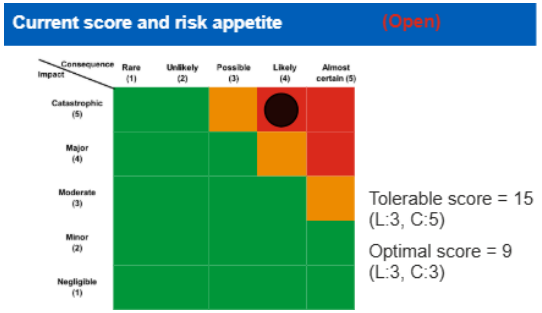
- The controls and assurances and their respective gaps

#3

- The actions being taken to mitigate the current gaps;
- An estimated completion date; and
- The lead officers involved.

Risk appetite

Risk category	Current risk appetite level	Risk appetite statement
Clinical Quality and Safety	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.
Financial / Value for Money	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.
Partnership	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.
Transformation delivery	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.
Workforce	Balanced	Our staff are the most important aspect is delivering safe, effective care and a good experience to our patients. Our willingness to accept workforce risks is balanced and open in nature. Whilst we have the highest levels of ambition for our workforce and their development, we will accept some level of likelihood or range of negative consequences to our workforce in the pursuit of better patient care, more local decision-making, improved productivity, innovation and better ways of working.



Board Assurance Framework
Current assessment – Finance Risk

The table below summarises the current assessment for each risk.

ID	Heading	CiC	Strategic risk	Risk owner/s	Latest score	Score change	Scored date	Appetite	Max target score	Optimal risk
1	Staff support	WEC	We aim to support our staff. However, if we fail to embed 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		07/10/24	Balanced	12	8
2	Performance	PEF	We aim to achieve upper quartile performance through transformational change and by harnessing the energy of the organisation and creating a culture of improvement.	Clive Walsh, Interim Site Chief Executive - North, Sarah Tedford, Interim Site Chief Executive - South	20		23/10/24	Open	16	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	20	-5	23/10/24	Open	15	9

The following pages provide further detail.

Board Assurance Framework
Risk #1 – Group Culture and Leadership(1)

The tables below and opposite provides score and further details for the above risk.

Strategic objective

Group Culture and Leadership

Strategic risk category	Current score
Staff support	20

Strategic risk

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.

Committee

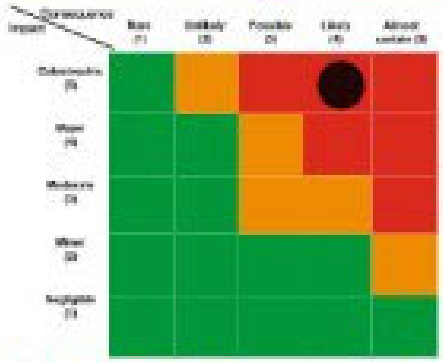
Workforce, Education and Culture

Lead

Simon Nearney, Group Chief People Officer

Last review date - of strategic risk	of risk score
Monday, 7 October 2024	10/7/2024

Current score and risk appetite (Balanced)



Tolerable score = 12 (L:4, C:3)

Optimal score = 8 (L:4, C:2)

Appetite statement

Our staff are the most important aspect is delivering safe, effective care and a good experience to our patients. Our willingness to accept workforce risks is balanced and open in nature. Whilst we have the highest levels of ambition for our workforce and their development, we will accept some level of likelihood or range of negative consequences to our workforce in the pursuit of better patient care, more local decision-making, improved productivity, innovation and better ways of working.

Board Assurance Framework
Risk #1 – Group Culture and Leadership (2)

The tables below and opposite set out the controls and assurances for the above risk and their respective gaps. The numbers shown in the gap tables reference an action ID given overleaf.

Control
Workforce Transformation Committee
Talent management team for international recruitment
Required Learning Steering Group
NLAG People Strategy (2024 expiry)
International recruitment drives
HUTH People Strategy (2024 expiry)
Group Senior Management Team (was EMC) will receive escalation reports from the Group Workforce Transformation Committee
Group Leadership Strategy (in development)
E-Rostering for clinical staff
EDI Steering Group
CESR Programme
Care Group Performance and Accountability
Annual Care Group Workforce plans

Gaps in control (and Action ID)	5	6	7	8	Total
Hard to recruit roles in medical specialities	1	1	1		3
Healthcare Assistant issues and high turnover	1	1			2
Sufficient attraction, to recruit and retain staff to work in the area	1	1	1	1	4
Total	3	3	2	1	9

See over for Action ID detail

Source and assurance
⊖ External
Workforce Report to HNY and Care Partnership ICB Workforce Board
Workforce Report to Pay and Agency meetings
⊖ Internal
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

Board Assurance Framework
Risk #1 – Group Culture and Leadership (3)

The table below sets out the actions being taken for the above risk. The ID number reference to the gap tables from the previous page.

ID	Action	Completion date	Update	Update date	Action owner/s
5	Group People Strategy 2025-28 to be developed and launched 2025	01/01/25	WECC Endorsed	29/01/25	Simon Nearney, Group Chief People Officer
6	Recruitment drives using the Group name to attract high calibre candidates	31/10/24		29/01/25	Simon Nearney, Group Chief People Officer
7	Cultural Transformation action plan development	31/10/24	Care Groups March Performance meetings - Apr/May 2025	29/01/25	Simon Nearney, Group Chief People Officer
8	Group Leadership network and training programme - November 2024	30/11/24	New competencies for leaders - comments from Care Groups - May 2025	29/01/25	Simon Nearney, Group Chief People Officer
38	Launched Group Well-being platform	28/02/25		29/01/25	Simon Nearney, Group Chief People Officer

Board Assurance Framework
Risk #2 Performance (1)

The tables below and opposite provides score and further details for the above risk.

Strategic objective

Achieving upper quartile performance

Strategic risk category	Current score
Performance	20

Strategic risk

We aim to achieve upper quartile performance through transformational change and by harnessing the energy of the organisation and creating a culture of improvement.

Committee

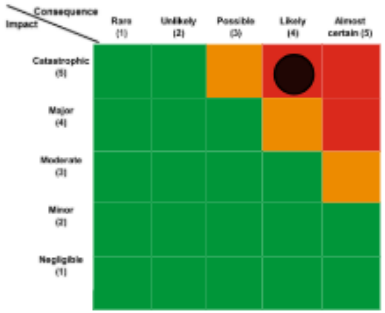
Performance, Estates and Finance

Lead

Clive Walsh, Interim Site Chief Executive - North
Sarah Tedford, Interim Site Chief Executive - South

Last review date - of strategic risk	of risk score
Wednesday, 23 October 2024	1/24/2025

Current score and risk appetite (Open)



Tolerable score = 16 (L:4, C:4)

Optimal score = 4 (L:2, C:2)

Appetite statement

Our willingness to accept transformation delivery risks is open and entrepreneurial in nature. We wish our local leaders to make changes for the benefit of their patients without routine recourse to executive permission. We accept the potential consequences because we recognise the need to change and capability of our workforce to make the right decisions.

Board Assurance Framework
Risk #2 – Performance (2)

The tables below and opposite set out the controls and assurances for the above risk and their respective gaps. The numbers shown in the gap tables reference an action ID given overleaf.

Control
Unplanned Care Board
Planned Care Board
Financial Planning Improvement Board
Care Group Performance and Accountability

Gaps in control (and Action ID)	19	20	21	28	31	37	Total
Absence of a comprehensive demand and capacity model		1					1
Data quality issues in supporting metrics					1		1
Lack of timely / realtime performance reporting (eg weekly dashboard)	1						1
Lack of trajectory setting to support robust performance management	1			1			2
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	2	1	1	1	1	2	8

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**
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)	31	Total
Absence of routine data quality monitoring	1	1
Total	1	1

See over for Action ID detail

Board Assurance Framework
Risk #2 - Performance (3)

The table below sets out the actions being taken for the above risk. The ID number reference to the gap tables from the previous page.

ID	Action	Completion date	Update	Update date	Action owner/s
19	Closer working with BI to produce performance reports				Clive Walsh, Interim Site Chief Executive - North, Adam Creeggan, Group Director of Performance
20	Strategic Bed Review (based on optimum LoS)	30/06/25			Ivan McConnell, Group Chief Strategy & Partnerships Officer, Clive Walsh, Interim Site Chief Executive - North
21	Embed QI Methodology	31/01/25			Ivan McConnell, Group Chief Strategy & Partnerships Officer, Amanda Stanford, Group Chief Nurse
22	Develop five-year long term financial model	31/03/25		23/10/24	Emma Sayner, Group Chief Financial Officer
23	Develop comprehensive finance strategy	31/03/25		23/10/24	Emma Sayner, Group Chief Financial Officer
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				Neil Rodgers, North Bank Managing Director, Ashy Shanker, South Bank Managing Director
31	Delivery of BI investment and data quality strategy	31/05/25			Adam Creeggan, Group Director of Performance
33	Business Case Review Group	31/01/25	Started w/c 20/1/25	24/01/25	Emma Sayner, Group Chief Financial Officer
34	Creating and linking a prioritisation Framework to strategy	31/03/25		24/01/25	Emma Sayner, Group Chief Financial Officer
35	Utilising Care Group Performance and Accountability Groups to focus and deliver on transformation	31/03/26		24/01/25	Emma Sayner, Group Chief Financial Officer, Simon Nearney, Group Chief People Officer, Kate Wood, Group Chief Medical Officer, Amanda Stanford, Group Chief Nurse, Clive Walsh, Interim Site Chief Executive - North, Sarah Tedford, Interim Site Chief Executive - South

Board Assurance Framework
Risk #8 – Achieving financial sustainability(1)

The tables below and opposite provides score and further details for the above risk.

Strategic objective

Achieving financial sustainability

Strategic risk category	Current score
Financial sustainability	20

Strategic risk

We aim to achieve financial sustainability through strong financial stewardship. However, if we fail to agree and communicate clear, balanced finance plans that are mutually beneficial to the Group and system partners, with aligned activity and workforce actions, then a failure to engage with teams and to set controls that are consistent and / or appropriately delegated, will result in overspent budgets and little change in practice

Committee

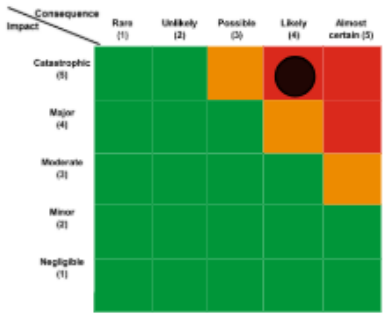
Performance, Estates and Finance

Lead

Emma Sayner, Group Chief Financial Officer

Last review date - of strategic risk	of risk score
Wednesday, 23 October 2024	1/24/2025

Current score and risk appetite (Open)



Tolerable score = 15 (L:3, C:5)

Optimal score = 9 (L:3, C:3)

Appetite statement

Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.

Board Assurance Framework
Risk #8 – Achieving financial sustainability (2)

The tables below and opposite set out the controls and assurances for the above risk and their respective gaps. The numbers shown in the gap tables reference an action ID given overleaf.

Control
Long term Financial Model
ICS finance model
High functioning Finance department advice and guidance
Financial Strategy
Financial Planning Improvement Board
Financial management education for directors and budget holders
Cost Improvement Programme
Cash management controls
Care Group Performance and Accountability
Business cases
Budgetary control system
Board capability and education

Gaps in control (and Action ID)	22	23	33	34	35	36	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	2
Total	**1**	**1**	**1**	**1**	**1**	**1**	6

See over for Action ID detail

Source and assurance
⊟ **External**
Internal audit review of key financial systems
⊟ **Internal**
Budget control reports
Exception reporting on Standing Financial Instructions and Standing Orders compliance
In-year operational plan progress

Board Assurance Framework
Risk #8 – Achieving financial sustainability (3)

The table below sets out the actions being taken for the above risk. The ID number reference to the gap tables from the previous page.

ID	Action	Completion date	Update	Update date	Action owner/s
22	Develop five-year long term financial model	31/03/25		23/10/24	Emma Sayner, Group Chief Financial Officer
23	Develop comprehensive finance strategy	31/03/25		23/10/24	Emma Sayner, Group Chief Financial Officer
33	Business Case Review Group	31/01/25	Started w/c 20/1/25	24/01/25	Emma Sayner, Group Chief Financial Officer
34	Creating and linking a prioritisation Framework to strategy	31/03/25		24/01/25	Emma Sayner, Group Chief Financial Officer
35	Utilising Care Group Performance and Accountability Groups to focus and deliver on transformation	31/03/26		24/01/25	Emma Sayner, Group Chief Financial Officer, Simon Nearney, Group Chief People Officer, Kate Wood, Group Chief Medical Officer, Amanda Stanford, Group Chief Nurse, Clive Walsh, Interim Site Chief Executive - North,
36	Developing positive challenge culture within Finance e.g. to query why we do things and where we need value	31/03/26		24/01/25	Emma Sayner, Group Chief Financial Officer

Board Assurance Framework
Next steps and recommendations

Next steps

Each CiC will receive a quarterly update on the BAF for review and approval.

The management of the high-level risks will continue to be assessed through the Care Groups, the Risk and Compliance Group and the escalation processes in place.

The Executive Team will continue to review their strategic risks between CICs and the Group Cabinet Risk and Assurance Committee will recommend any changes to risk ratings or BAF risks to the CICs. Final decisions will be made at the Boards-in-Common.

Recommendations

The Committee is asked to:

- Note and review the BAF risks relating to Performance, Finance and Staff Support
- Consider the recalibrated Finance risk score

4.2 - TRUST BOARD REPORTING FRAMEWORK

David Sharif, Group Director of Assurance

REFERENCES

Only PDFs are attached

BIC(25)022 - Trust Board Reporting Framework.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)022

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	13 February 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	David Sharif, Group Director of Assurance
Title of the Report	Trust Board Reporting Framework
Executive Summary	The Group has a Board Reporting Framework which forms the basis for setting each agenda for each board meeting. The Framework (attached) details: • Purpose of the report (column B) • Method of Reporting (written or verbal, column C) • Committee Oversight (column D) • Report Lead (column E) • Frequency (e.g. annual, quarterly, in column F) • Month of meeting (column G to M) • Action (e.g. approval, assurance, in column N) The current Board Reporting Framework contains around 120 items. Work is underway with Cabinet and Non-Executive colleagues to refresh its contents to: • Reflect changes to the boards' membership; • Align business items to the strategic objectives of the Group and the Board's key responsibilities; • Better reflect the development of the Group partnership – thereby replacing or removing items in the Group Development section; and • Reference the associated risks maintained as part of the board assurance framework - thereby giving a perspective on the scale and nature of risks to achieving the strategic objectives and assurances, that members can expect to receive during the period. Working in parallel with the development of the Group's strategies, this work aims to complete by May 2025. The Framework presented today reflects a number of minor changes, including the contribution to Report Lead made by the Group Site Chief Executives and the removal of Group Brand item. Members are invited to note the contents of the current Board Reporting Framework and the work underway to refresh its content for 2025-26.
Background Information and/or Supporting Document(s) (if applicable)	Board Reporting Framework – February 2025
Prior Approval Process	Cabinet discussion on 21 January 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 ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other – please detail below:

As at 2.2.2025

Northern Lincolnshire & Goole NHS Foundation Trust and Hull University Teaching Hospital NHS Trust

Aligned Board Reporting Framework 2025/26

Agenda Item	Purpose of the report	Method of Reporting	Committee Oversight	Report Lead	Frequency	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Core / Standing Business													
Board Site Visits	To receive feedback on board member site visits & issues for escalation	Verbal	N/A	Group Chair	Bi-monthly	√	√	√	√	√	√	√	Assurance
Group Chair's Opening Remarks	To welcome board members to the meeting and to note any apologies for absence	Verbal	N/A	Group Chair	Bi-monthly	√	√	√	√	√	√	√	Noting
Declarations of Interest	To note any conflicts of interest on specific agenda items or any changes to Directors' Interests	Verbal	N/A	Group Chair	Bi-monthly	√	√	√	√	√	√	√	Assurance
Declarations of Interest Annual Report	To review and note any changes to the Register of Directors' Interests over the last 12 months	Written	N/A	Group Chair	Annually			√					Assurance
Fit & Proper Person Test: Annual Declaration	To receive assurance that all board members remain compliant with the Fit & Proper Person requirements	Written	Remuneration Committees	Group Chair	Annually			√					Assurance
Minutes of the Previous Meetings	To approve and / or amend the minutes of the previous meeting ensuring an accurate corporate record of the meeting is maintained	Written	N/A	Group Chair	Bi-monthly	√	√	√	√	√	√	√	Approval
Matters Arising & Action Tracker	To ensure all agreed board actions are completed	Written	N/A	Group Chair	Bi-monthly	√	√	√	√	√	√	√	Noting
Patient Story	To receive direct feedback on the experience of patients including both good practice and areas for improvement	Verbal	N/A	Group Chief Nurse	Bi-monthly	√	√	√	√	√	√	√	Assurance
Group Chief Executive's Briefing ***(Note 1)***	To brief the boards on local and national topical matters, risk issues & mitigations and good news & communication updates	Written	N/A	Group Chief Executive	Bi-monthly	√	√	√	√	√	√	√	Assurance
Integrated Performance Report ***(Note 1)***	To brief the boards on key performance metrics & priorities, risks to delivery & mitigations	Written	All Committees	Group Chief Strategy & Partnerships Officer / Group Director of Performance	Bi-monthly	√	√	√	√	√	√	√	Assurance

Agenda Item	Purpose of the report	Method of Reporting	Committee Oversight	Report Lead	Frequency	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Group Development													
Group Vision, Strategy & Objectives	To approve the Group Vision, Strategy & Objectives & any relevant sub-strategies **(see later section)** and to receive regular updates on the delivery of the expected benefits of moving to a Group model and the integration of clinical and corporate services (the latter as part of the Group Chief Executive's Briefing)	Written	N/A	Group Chair & Group Chief Executive	Initial approval June / July 2024 / Bi-monthly updates thereafter			√					Approval
Group Values	To approve the Values for the Group and any subsequent changes	Written	Workforce, Education & Culture Committees-in-Common	Group Chief Executive	Initial approval/ As required thereafter		√						Approval
Group Operating Model / Care Group Structure	To approve the Group Operating Model & any subsequent changes including changes to the group governance arrangements and assurances in respect of the effectiveness of these arrangements (the latter to also come via the audit committee route and reporting)	Written	N/A	Group Chief Executive & Group Site Chief Executive	Initial approval February 2024 / As required thereafter	√ (Final)	**To be added to the agenda as required thereafter**						Approval
Group Memorandum of Understanding	To approve the Memorandum of Understanding for the Group & any subsequent changes	Written	N/A	Group Director of Assurance	Initial approval April 2024 / As required thereafter			√					Approval
Group and Trust Priorities	To agree the annual priorities for each trust and wider group	Written	N/A	Group Chief Executive	Annually		√						Approval
Group Data Sharing Agreement & Privacy Notice	To agree the data sharing agreement and privacy notice for the group	Written	N/A	Group Chief Strategy & Partnerships Officer	Annually	√						√	Approval
Engagement with External Stakeholders ***(Note 2)***	To receive updates from engagement with stakeholders to include HASR etc	Written	N/A	Group Chief Executive	Bi-monthly	√	√	√	√	√	√	√	Assurance
Audit, Risk & Governance													
Trust Boards' Aligned Business Reporting Framework	To ensure the boards' consideration of all relevant items of business and, in turn, continued compliance with their statutory and regulatory requirements	Written	N/A	Group Director of Assurance	Annually	√ (Final)						√	Approval
Trust Board & Committee Meeting Cycle	To approve the Trust Board & Committee meeting cycle	Written	N/A	Group Director of Assurance	Annually	√						√	Approval
Trust Boards' Development Programme	To agree and approve the Board Development Programme in response the outcome of the board skills assessment	Written	N/A	Group Chair	Annually		√						Approval
NHS Provider Licence Self Certification	To undertake and agree the annual Trust Board self certification of compliance with the NHS Provider Licence	Written	N/A	Group Director of Assurance	Annually			√					Assurance

Agenda Item	Purpose of the report	Method of Reporting	Committee Oversight	Report Lead	Frequency	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Trust Boards' Annual Review of Effectiveness	To undertake an annual review of effectiveness and agree the need for any additional external assurance and / or development needs	Written	N/A	Group Chair	Annually			√					Assurance
Trust Board Committees' Annual Review of Effectiveness	To receive the outcome of the annual review of committee effectiveness and any changes or improvements required including any required changes to Terms of Reference & Work Plans	Written	All Committees	NED Committee Chairs	Annually	√							Assurance
Trust Board Committees Terms of Reference &	To approve the changes to board committee terms of reference and work plans following	Written	All Committees	NED Committee Chairs	Annually		√						Approval
Board Assurance Framework & Strategic / High Level Risk Register	To receive assurance in relation to the management & mitigation of the risks to the achievement of the Trusts' strategic objectives and ensure that the BAF is reflective of the	Written	All Committees	Group Director of Assurance	Bi-monthly	√	√	√	√	√	√	√	Assurance
Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report ***(Note 3)***	To note the matters considered by the committees-in-common and the issues which the committee wish to escalate to the Trust Board and to agree the actions required	Written	Audit, Risk & Governance Committees-in-Common	NED Committee Chairs	Quarterly + Annual Report & Accounts	√		√	√		√	√	Assurance
Standards of Business Conduct Policy	To approve the Trusts' policies on standards of business conduct ensuring that guidance is available to all staff across the two trusts and that conflicts of interests are minimised	Written		Group Director of Assurance	3 Yearly			√					Approval
Annual Accounts - Delegation of Authority, if	To delegate authority to the Audit Committee for the preparation of the Annual Accounts	Written		Group Chief Financial Officer	Annually							√	Approval
Annual Report & Accounts including Going Concern and Audit Letter	To approve and adopt the Annual Report & Accounts	Written		Group Chief Financial Officer	Annually			√ (NLaG)	√ (HUTH)				Approval
Annual Governance Statement (including HoIA Opinion)	To approve the Annual Governance Statement and note the assurances in support of that statement and any significant risks & planned mitigations	Written		Group Director of Assurance	Annually			√ (NLaG)	√ (HUTH)				Approval
Trust Constitution & Standing Orders	To approve amendments to the Trust Constitution & Standing Orders (and any requirement to vary or suspend Standing Orders)	Written		Group Director of Assurance	3 Yearly (or as required)			√					Approval
Scheme of Delegation & Powers Reserved for the Trust Board / Standing	To approve the Scheme of Delegation including the Schedule of Powers Reserved to the Trust Boards and those delegated to committees	Written		Group Chief Financial Officer	3 Yearly (or as required)			√					Approval
Emergency Preparedness, Resilience and Response (EPRR) Regulatory Report	To receive and approve the Trusts' annual submission to NHSE on EPRR including any required improvement actions	Written		Group Chief Site Chief Executive	Annually						√		Approval

Agenda Item	Purpose of the report	Method of Reporting	Committee Oversight	Report Lead	Frequency	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
External reviews & inspections e.g. CQC, royal college, governance reviews, development reviews against the well led	To receive reports from external reviews & inspections including where there are significant quality & safety concerns in respect of any of the Trusts' clinical services and progress against the agreed improvement actions	Written	Relevant Committees	Group Chief Executive / Group Executive Leadership Team	As required								Assurance
Quality & Safety													
Quality & Safety Committees-in-Common Highlight / Escalation	To note the matters considered by the committees-in-common and the issues which the committee wish to escalate to the Trust Board	Written	Quality & Safety Committees-in-Common	Committee Chairs	Bi-monthly	√	√	√	√	√	√	√	Assurance
Quality Priorities	To approve the annual quality priorities	Written		Group Chief Nurse			√						Approval
Maternity & Neonatal Safety Assurance Report (including Ockenden, CNST	To maintain oversight and receive assurance in respect of the quality & safety of the Trusts' maternity and neonatal services	Written		Group Chief Nurse	Bi-monthly	√	√	√	√	√	√	√	Assurance
Maternity Safety: NED Safety Champions Report	To provide reporting and assurance to the Trust Boards, independent of the executive, on the quality & safety of the trusts' maternity services including risks and concerns requiring escalation as well as good practice, improvement and	Written		NED Safety Champions	Bi-monthly	√	√	√	√	√	√	√	Assurance
Maternity Safety: CNST Maternity Incentive Scheme (MIS)	To approve the Trusts' CNST MIS submissions	Written		Group Chief Nurse + Heads of Midwifery	Annually						√		Approval
Establishment Review of Safe Staffing	To approve the outcome of the bi-annual review of safe staffing and any recommended changes to the establishment	Written		Group Chief Nurse	Bi-annually		√				√		Approval
CQC Statement of Purpose	To approve any required changes to the CQC Statement of Purpose / changes to Trust services	Written		Group Chief Executive	Annually			√					Approval
Annual Quality Account	To approve the Annual Quality Accounts	Written		Group Chief Nurse	Annually			√					Approval
Performance, Estates & Finance													
Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report **(Note 3)**	To note the matters considered by the committees-in-common and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Written	Performance, Estates & Finance Committees-in-Common	NED Committee Chairs	Bi-monthly	√	√	√	√	√	√	√	Assurance
Annual Plan: Operational & Financial Plan	To approve the Annual Plan	Written		Group Chief Financial Officer / Group Site Chief Executive	Annually			√					Approval
Winter Plan	To approve the Winter Plan	Written		Group Chief Delivery Officer	Annually					√			Approval

Agenda Item	Purpose of the report	Method of Reporting	Committee Oversight	Report Lead	Frequency	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Premises Assurance Model (PAM)	To approve the PAM submission & note the areas requiring improvement	Written		Group Director of Estates	Annually				√				Approval
Capital & Major Projects													
Capital & Major Projects Committees-in-Common Highlight / Escalation Report **(Note 3)**	To note the matters considered by the committees-in-common and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Quarterly	Capital & Major Projects Committees-in-Common	Group Chief Financial Officer	Quarterly	√	√	√	√	√	√	√	Assurance
Capital Plan	To approve the Capital Plan	Written		Group Chief Financial Officer	Annually							√	Approval
Business Cases	To approve relevant Business Cases in accordance with the Trusts' Schemes of Delegation	Written		Group Chief Financial Officer	**To be added to the agenda as required**								Approval
Workforce, Education & Culture													
Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report ***(Note 3)***	To note the matters considered by the committees-in-common and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Written	Workforce, Education & Culture Committees-in-Common	NED Committee Chairs	Bi-monthly	√	√	√	√	√	√	√	Assurance
Freedom to Speak Up Guardian Quarterly report - HUTH	To receive the FTSU Guardians report including progress with the implementation of the Freedom to Speak Up Strategy and the outcome of relevant audits and other assurances	Written		FTSU Guardian	Quarterly	√ (Q3)		√ (Q4)	√ (Q1)		√ (Q2)	√ (Q3)	Assurance
Freedom to Speak Up Guardian Quarterly report - NLAG	To receive the FTSU Guardians report including progress with the implementation of the Freedom to Speak Up Strategy and the outcome of relevant audits and other assurances	Written		FTSU Guardian	Quarterly	√ (Q3)		√ (Q4)	√ (Q1)		√ (Q2)	√ (Q3)	Assurance
Gender Pay Gap	To approve the Gender Pay Gar report	Written		Group Chief People Officer	Annually	√							Approval
Modern Slavery Statement	To approve the Modern Slavery Statement	Written		Group Chief People Officer	Annually				√				Approval
National Staff Survey	To receive the results from the annual staff survey & note the planned improvement actions and monitoring arrangements	Written		Group Chief People Officer	Annually		√						Assurance
Workforce Disability Equality Standard (WDES)	To approve the annual WDES submission	Written		Group Chief People Officer	Annually					√			Approval
Workforce Race Equality Standard (WRES)	To approve the annual WRES submission	Written		Group Chief People Officer	Annually					√			Approval
NHS Equality Delivery System (EDS) Submission	To approve the annual EDS submission	Written		Group Chief People Officer	Annually		√						Approval

Agenda Item	Purpose of the report	Method of Reporting	Committee Oversight	Report Lead	Frequency	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Employee Relations: MHPS & Other Capability & Conduct Cases	To note the current capability & conduct cases / activity	Written (via the Workforce, Education & Culture Committee Highlight / Escalation Report)		Group Chief People Officer / Group Chief Medical Officer	Bi-annually			√			√		Assurance
Charitable Funds													
Charitable Funds / Health Tree Foundation Committees Highlight / Escalation Report **(Note 3)**	To note the matters considered by the committees and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Written	Charitable Funds / Health Tree Foundation Committees	NED Committee Chairs	Bi-monthly	√			√			√	Assurance
Health Tree Foundation Annual Report & Accounts	To receive the HTF Annual Report & Accounts	Written						√					Assurance
Remuneration													
Remuneration Committees-in-Common Highlight / Escalation Report ***(Note 3)***	To note the matters considered by the committees and the issues which the committees wish to escalate to the Trust Board and to agree any actions required	Written	Remuneration Committees	Group Chair	Quarterly	√							Assurance
Pay Framework for Group Executive Directors	To approve the framework & any subsequent changes	Written		Group Chief People Officer	Three Yearly	√		√	√		√	√	Approval
Strategy													
Quality Strategy	To approve the Quality Strategy & any subsequent changes	Written	Quality & Safety Committees-in-Common	Group Chief Nurse	3 Yearly								Approval
Quality Improvement Strateg	To approve the Quality Improvement Strategy & any subsequent changes	Written		Group Chief Nurse	3 Yearly								Approve
Clinical Strategy	To approve the Clinical Strategy & any subsequent changes	Written		Group Chief Medical Officer / Development lead: Group Chief Strategy & Partnerships Officer	3 Yearly								Approval
Mental Health Strategy	To approve the Mental Health Strategy & any subsequent changes	Written		Group Site Chief Executive	3 Yearly								Approval
Research, Development & Innovation Strategy	To approve the Research & Innovation Strategy & any subsequent changes	Written		Group Chief Medical Officer	3 Yearly								Approval
People Strategy	To approve the People Strategy & any subsequent changes	Written	Workforce, Education & Culture Committees-in-Common	Group Chief People Officer	3 Yearly								Approval
Equality, Diversity & Inclusio	To approve the Equality & Diversity Strategy & any subsequent changes	Written		Group Chief People Officer	3 Yearly								Approval
Freedom to Speak Up Strate	To approve the Freedom to Speak Up Strategy & any subsequent changes	Written		Group Chief People Officer	3 Yearly								Approval

Agenda Item	Purpose of the report	Method of Reporting	Committee Oversight	Report Lead	Frequency	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Digital Strategy	To approval the Digital Strategy & any subsequent changes	Written	Capital & Major Projects Committees-in-Common	Group Chief Medical Officer / Group Chief Information Officer	3 Yearly								Approval
Financial Strategy	To approve the Financial Strategy & any subsequent changes	Written	Performance, Estates & Finance Committees-in-Common	Group Chief Financial Officer	3 Yearly								
Estates Strategy	To approve the Estates Strategy & any subsequent changes	Written		Group Chief Financial Officer / Group Director of Estates	3 Yearly								Approval
Green, Carbon and Travel Plans	To approve the Green, Carbon and Travel Plans	Written		Group Director of Estates	3 Yearly								Approval
Risk Management Strategy (including Risk Appetite)	To approve the Risk Management Strategy & any subsequent changes	Written	Audit, Risk & Governance Committees-in-Common	Group Chief Nurse / Group Director of Assurance	3 Yearly								Approval
Other Board Approved Policies / Documents													
Protocol for Reserving Matters to a Private Board Meeting	To approve the protocol and any required changes	Written	N/A	Group Director of Assurance	3 Yearly			√					Approval
Division of Responsibilities Between the Group Chair and the Group Chief Executive	To approve the schedule outlining the division of responsibilities between the Group Chair and Group Chief Executive	Written	N/A	Group Director of Assurance	3 Yearly / As Required			√					Approval
Fit & Proper Person Test Policy	To approve the Fit & Proper Person Test Policy and any required changes	Written	N/A	Group Director of Assurance	3 Yearly		√						Approval
Policy on Handling Inventions and Intellectual Property	To approve the Policy on Handling Inventions and Intellectual Property and any required changes	Written	N/A	Group Director of Assurance	3 Yearly				√				Approval
Health & Safety Policy Statement	To approve any required changes to the Health & Safety Policy Statement	Written	Audit, Risk & Governance Committees-in-Common	Group Chief Financial Officer	3 Yearly			√					Approval
Notes:													
1. The Group Chief Executive's Briefing and the Integrated Performance Report will be the route for 'routine' group executive reporting on key operational issues, priorities and metrics. **2. 'Engagement with stakeholders' will be a standing agenda item and will capture updates, developments and board actions, as required, in resect of HASR, CAP / ICS, PLACE etc.** **3. Where items are submitted to the Trust Boards for discussion and / or approval (e.g. strategy, policy or external submission), having first been considered at one of the committees-in-common, there is an expectation that the committee's highlight / escalation report will include the committees' endorsement or any specific concerns.**													
Items for Information (Where relevant referenced in committee highlight / escalation reports)													
Safeguarding & Vulnerabilities Annual Report			Quality & Safety Committees-in-Common	Group Chief Nurse							√		
Infection Control Annual				Group Chief Nurse						√			

Agenda Item	Purpose of the report	Method of Reporting	Committee Oversight	Report Lead	Frequency	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Patient Experience Annual Report (incorporating	To note the annual reports including assurances that the trusts are meeting the relevant obligations and / or risks & planned mitigations and, where relevant, to provide the work plans / activity for the following year	Written		Group Chief Nurse	Annually						√		Information & Assurance
Research, Innovation & Development Annual				Group Chief Medical Officer			√						
Medicines Management Annual Report				Group Chief Medical Officer					√				
End of Life Annual Report				Group Chief Nurse							√		
Organ Donation Annual Report				Group Chief Medical Officer					√				
PSIRF / Serious Incident Annual Report				Group Chief Nurse							√		
Medical Appraisal & Revalidation Annual Report			Workforce, Education & Culture Committees-in-Common	Group Chief Medical Officer					√				
Guardian of Safe Working Hours Annual Report				Group Chief Medical Officer						√			
Audit Committee Annual Report			Audit, Risk & Governance Committees-in-Common	Group Chief Financial Officer					√				
FTSU Guardian Annual Report			Workforce, Education & Culture Committees-in-Common	Group Chief People Officer				√					
Security / LSMS Annual Report & Work Plan				Group Chief Finance Officer / Group Director of Estates						√			
Fire Annual Report & Work Plan				Group Chief Finance Officer / Group Director of Estates & Facilities						√			
Health & Safety Annual Report & Work Plan				Group Chief Financial Officer / Group Director of Estates				√					
Documents Signed Under Seal	To receive the record of documents signed under the Trusts' seals	Written	N/A	Group Director of Assurance	Quarterly		√		√	√		√	
Executive and NED Statutory Roles	To note any changes to Executive and Non-Executive Director statutory roles	Written	N/A	Group Director of Assurance	Annually / As required		√						

Agenda Item	Purpose of the report	Method of Reporting	Committee Oversight	Report Lead	Frequency	Feb	Apr	Jun	Aug	Oct	Dec	Feb	Action
Committee Minutes	To receive the record of business conducted by the Trust Board committees	Written	All Committees	Group Director of Assurance	Bi-monthly / Quarterly		√	√	√	√	√	√	
Guardian of Safe Working Hours	To note the Guardian of Safe Working Hours Report	Written	Workforce, Education & Culture Committees-in-Common	Group Chief Medical Officer	Quarterly		√ (Q3)	√ (Q4)		√ (Q1)	√ (Q2)		

5 - OTHER ITEMS FOR APPROVAL

5.1 - AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON TERMS OF REFERENCE- NLAG & HUTH

David Sharif, Group Director of Assurance

REFERENCES

Only PDFs are attached

BIC(25)023 - Audit, Risk and Governance Committees-in-Common Terms of Reference - NLAG HUTH.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)023

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	13 February 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	Sally Stevenson, Assistant Director of Finance – Compliance and Counter Fraud
Title of Report	**Audit, Risk and Governance Committees-in-Common Terms of Reference – NLAG and HUTH**
Executive Summary	The annual review of the Audit, Risk and Governance Committees-in-Common (ARG CiC) Membership and Terms of Reference (ToR) is scheduled for January each year on its annual work plan. The ARG CiC's ToR were last updated for minor amendments following discussions at the April and July ARG CiC meetings, which were subsequently approved at the August 2024 Trust Boards-in-Common meeting. As a result of this latest review a limited number of minor changes were proposed and approved by the ARG CiC at its meeting on 23 January 2025 and are tracked for ease of reference on the attached. **The Trust Boards-in-Common are asked to approve the proposed changes to the Audit, Risk and Governance Committees-in-Common Terms of Reference for both organisations.**
Background Information and/or Supporting Document(s) (if applicable)	Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2024)
Prior Approval Process	Audit, Risk and Governance Committees-in-Common – 23 January 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:

Northern Lincolnshire and Goole NHS Foundation Trust

Group Directorate of Corporate Assurance

AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON

(NLAG)

Membership and Terms of Reference

Reference:	DCT302
Version:	1.1
This version issued:	~~12/09/24~~
Result of last review:	Minor Changes
Date approved by owner (if applicable):	N/A
Date approved:	~~08/08/24~~
Approving body:	Trust Boards-in Common
Date for review:	~~August, 2025~~
Owner:	Sean Lyons, Group Chair
Document type:	Terms of Reference
Number of pages:	18 (including front sheet)
Author / Contact:	~~Lee Bond~~Emma Sayner, Group Chief Financial Officer / David Sharif, Group Director of Assurance

Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

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

United by Compassion:
Driving for Excellence

1.0 Purpose

1.1 The role of the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) **Audit, Risk & Governance Committee-in-Common** is to review the establishment and maintenance of the Trust's systems of internal governance, risk management and internal control and for providing assurance to the Trust Board as to the effectiveness of those arrangements and / or for escalating risk issues.

1.2 These terms of reference have been produced in line with guidance contained within the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2024).

2.0 Authority

2.1 In accordance with the NHS Act 2006 and the Trust's Constitution, the board may make arrangements for the exercise, on behalf of the trust, of any if its functions by a committee of directors.

2.2 The NLaG Trust Board has established a committee to be known at the **Audit, Risk & Governance Committee-in-Common**. The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3 Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust ~~(NLaG)~~ and Hull University Teaching Hospitals NHS Trust (HUTH) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Audit, Risk & Governance Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Audit, Risk & Governance Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.

2.5 The **Audit, Risk & Governance Committee-in-Common** is authorised by the NLaG Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The **Audit, Risk & Governance Committee-in-Common** is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the committee. The committee is also authorised by the board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

3.0 Accountability & Reporting Arrangements

3.1 The **Audit, Risk & Governance Committee-in-Common** is accountable to the NLaG Trust Board and shall report to the board on how it discharges its responsibilities.

3.2 The minutes of each meeting shall be submitted to the next meeting for formal approval as a true record of that meeting. The approved minutes will be submitted to the next meeting of the board for information.

3.3 The **Audit, Risk & Governance Committee-in-Common** will provide a highlight / escalation report to the NLaG Trust Board after each meeting highlighting issues that require disclosure to the board or require executive action.

3.4 The committee shall report to the board annually on its work in support of the Annual Governance Statement specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the effectiveness of governance arrangements, the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

3.5 The annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed. The report will also outline its workplan for the coming year.

3.6 The committee's annual report and workplan will also be submitted to the Council of Governors for information.

4.0 Responsibilities

4.1 The specific duties & responsibilities of the committee are categorised as follows:

4.2 Governance, Risk Management and Internal Control

4.2.1 The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

4.2.2 In particular, the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board.

- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications, including the NHS Code of Governance, NHS Provider Licence and Fit and Proper Persons Test.

- The organisations policy (Standards of Business Conduct Policy), systems and processes for the management of conflicts (including gifts and hospitality and bribery) to satisfy itself they are effective, including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

- The policies and procedures for all work related to counter fraud and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

4.2.3 In carrying out this work the committee use the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers, as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

4.2.4 This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

4.2.5 As part of its integrated approach, the committee will have effective relationships with other Trust Board committees (which may include reciprocal membership) to provide an understanding of processes and linkages and particularly to enable review and oversight of the other committee's governance of risk. This will include the exchange of their chair's action trackers and highlight reports to the Trust Board.

4.3 Internal Audit

4.3.1 The committee shall assure itself that there is an effective internal audit function that meets ~~Public Sector~~Global Internal Audit Standards (~~PS~~GIAS, effective from 9.1.2025) and provides independent assurance to the committee, Chief Executive and board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.

- Reviewing and approving the internal audit strategy, the annual internal audit plan and more detailed programme of work, which is consistent with the audit needs of the Trust as identified in the assurance framework.

- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.

- Monitoring the implementation of agreed internal audit recommendations in line with agreed timescales, and where concerns exist in relation to the lack of implementation in a particular area the committee can request the relevant operational manager to attend a meeting and give explanation.

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

- Reviewing the Internal Auditor's annual report before its submission to the Board.

- Monitoring the effectiveness of internal audit and carrying out an annual review and obtaining independent assurance that Internal Audit complies with ~~PSG~~IAS.

4.4 External Audit

4.4.1 The committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Assisting and advising the Council of Governors in their appointment of the External Auditors (and make recommendations to the Board when appropriate).

- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.

- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.

- Reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

- Reviewing and monitoring the External Auditor's independence and objectivity and the effectiveness of the audit process.

- Establishing a clear policy for the engagement of external auditors to supply non-audit services, and for scrutinising and where appropriate approving uses of, or exceptions to, this policy.

4.5 Financial Reporting

4.5.1 The committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

4.5.2 The committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

4.5.3 The committee shall review the annual report and financial statements before submission to the board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Explanations for significant variances.

4.6 Risk Management

4.6.1 The committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks the committee considers it is appropriate to do so. This will include:

- Reviewing the Trust's information governance and cyber security arrangements, in order to provide assurance to the Board that the organisation is properly managing its information and cyber risks and has appropriate risk mitigation strategies.
- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks.
- Overseeing actions plans relating to regulatory requirements in terms of the NHS Oversight Framework and Use of Resources.
- Providing the Board with assurance over developing partnership arrangements (e.g., integrated care systems) and mitigation of risks which may arise at the borders between such organisations. The Health and Care Act 2022 introduced new requirements for NHS bodies to work

together to meet joint financial objectives and duties, and as such the Audit Committee will need to take a wider view when considering audit and assurance. Organisations need to agree together how best to recognise and manage risk across a system, including what assurances the Audit Committee will need and where these will come from.

4.7 The Board will however retain the responsibility for routinely reviewing specific risks.

4.8 Counter Fraud

4.8.1 The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud that meet the NHS CFA's standards and shall review the outcomes of work in these areas. The committee shall receive the annual report and annual work plan from the Local Counter Fraud Specialist and shall also receive regular progress reports on counter fraud activities.

4.9 System for Raising Concerns

4.9.1 The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensures that any such concerns are investigated proportionately and independently and in line with relevant policies.

4.9.2 The Trust's Freedom to Speak Up Guardian, or his or her nominated deputy shall attend the committee at least annually to provide assurance on the design and operation of the function.

4.10 Management

4.10.1 The committee shall request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

4.10.2 The committee may also request specific reports from individual functions within the organisation (e.g., compliance reviews or accreditation reports).

4.11 Other Assurance Functions

4.11.1 The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation. These may include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g., the Care Quality Commission, NHSE, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g., Royal Colleges, accreditation bodies, etc.).

4.11.2 In addition, the committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the committee's own areas

of responsibility. In particular this will include any committees covering safety / quality, for which assurance from clinical audit can be assessed, and risk management. The committee shall receive the action trackers and highlight reports to the Trust Board of the following Board committees for information:

- Performance, Estates & Finance Committees-in-Common
- Quality and Safety Committees-in-Common
- Workforce, Education & Culture Committees-in-Common
- Health Tree Foundation Trustees' Committee
- Capital & Major Projects Committees-in-Common
- Remuneration Committee – Annual Summary report only
- Ethics Committee (when in operation)

4.11.3 The committee will review Standing Financial Instructions, Scheme of Delegation and those elements of the Trust Constitution (Standing Orders) that provide assurances on the internal management of procurement and financial matters.

4.11.4 The committee will receive the Board Assurance Framework (BAF) and the High-Level Risk Register on a routine basis, to gain assurance that it is operating as part of the Trust's overarching governance / control systems.

4.11.5 The committee will ensure escalation of issues requiring action or decision by the Trust board or other groups within NLAG, as appropriate.

4.12 Summary Scope

4.12.1 In summary, to cover the following areas of scope:

- Annual Report and Accounts / Annual Governance Statement
- Charitable Funds governance arrangements
- Counter Fraud
- Data Quality
- Debt Management
- Document Control
- Engagement of External Audit for Non-Audit Work
- Emergency Preparedness Resilience & Response and Business Continuity
- Financial Reporting and Control
- Freedom to Speak Up (Annual Review of Arrangements)
- Going Concern Review
- Governance / Risk
- Information Governance (IG) / IG Toolkit / Cyber Security
- Internal Audit / External Audit
- Losses and Compensation

- Management and Internal Control Systems
- Oversight of Work of Other Board Committees
- Procurement Key Performance Indicators
- Salary Over / Under Payments
- Standards of Business Conduct
- Standing Orders, Standing Financial Instructions and Scheme of Delegation
- Waiving Standing Orders

5.0 Membership

5.1 Core Membership

5.1.1 The committee shall be appointed by the board from amongst its independent, Non-Executive Directors and shall consist of not less than three members (including the committee chair). One of the members shall have recent relevant financial experience. One of the members will be nominated as vice chair of the committee.

5.1.2 The chair of the Trust and the Group Chief Executive shall not be members of the committee. However, they may be invited to attend a meeting by the committee Chair – see 5.3.1.

5.2 In Attendance (all meetings)

5.2.1 The following shall normally attend meetings:

- Group Chief Financial Officer
- Group Director of Assurance
- Internal Audit Representative(s)
- External Audit representative(s)

5.2.2 The Local Counter Fraud Specialist will attend to report upon and discuss counter fraud matters.

5.2.3 An invitation to join the committee as an attendee in an observer capacity with will be extended to a governor.

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 At the invitation of the committee chair, the Trust Chair and Group Chief Executive may attend meetings. The Trust Chair (or Vice Chair) may attend to ensure that the committee is operating as expected and that the non-executives are carrying out their tasks appropriately. The Group Chief Executive would be expected to attend for items around the annual report and accounts, including the Annual Governance Statement, for which they are directly accountable.

5.3.2 Other Non-Executive / Associate Non-Executive Directors may be requested to attend specific meetings of the committee, as the agenda dictates.

5.3.3 The committee may, from time to time and as the agenda dictates, require attendance from other senior officers of the Trust not mentioned above, particularly when the committee is discussing areas of risk or operation that are the responsibility of that individual. Such attendance will normally be for their item(s) only.

5.3.4 Representatives from other organisations (e.g. NHS Counter Fraud Authority (NHS CFA) and other individuals (e.g. Local Security Management Specialist) may be invited to attend on occasion.

5.3.5 At least once a year, ~~usually at its Audited Accounts meeting,~~ members of the committee shall meet privately with the External and Internal Auditors, either separately or together. Other meetings will take place at the request of members or auditors. The Head of Internal Audit and representatives from External Audit and the Local Counter Fraud Specialist have a right of direct access to the chair of the committee.

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 The committee will normally meet at least five times per year at appropriate times in the audit cycle to allow it to discharge all of its responsibilities in line with its annual work plan. Where required and in agreement with the committee chair and executive lead for the committee, additional meetings may be convened to consider matters that require urgent attention. The committee will review the meeting schedule annually.

6.1.2 The committee will maintain a twelve-month rolling workplan capturing its main items of business at each scheduled meeting. This will be updated throughout the year as the committee sees fit. Ad-hoc reports, in addition to those set out in its workplan, may also be requested by the committee as necessary.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of each committee will be the chair of the respective committee and jointly chair the **Audit, Risk & Governance Committee-in-Common.** [In line with agreed CiC principles agreed between NLaG and HUTH, both Non-Executive Director chairs will attend the agenda setting meeting with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of one or both Non-Executive Director chairs, the vice chair Non-Executive Director member(s) of the committee of the respective trust(s) will jointly chair the meeting.]

6.3 Secretary

6.3.1 The **Audit, Risk & Governance Committee-in-Common** will be supported administratively by the Assistant Director of Finance – Compliance and Counter Fraud. Their duties in this respect will include agreement of agenda's with both chairs of the committee; ensuring papers are collated and circulated in good time; that those invited to each meeting attend; maintaining the action tracker; preparing the draft highlight / escalation reports for review and agreement by both chairs; advising the committees on pertinent issues / areas of interest and enabling the development and training of committee members.

6.3.2 Secretarial support for the taking and production of minutes will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members and regular attendees (as listed at 5.2) is required at a minimum 75% of meetings.

6.4.2 In the absence of group executive regular attendees, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 A quorum shall be two of the three members. Associate Non-Executive Directors will not form part of the quorum.

6.5.2 A quorum must be maintained at all meetings.

6.5.3 If quoracy cannot be achieved from the committee members, and the reason for lack of quoracy is short term and the papers have already been read, other Non-Executive Directors can be invited to attend for a single meeting (excluding the Trust Chair) or the meeting can go ahead and any actions or decisions (dependent upon the nature) could be ratified at the next meeting, or by the next Trust Board.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than 5 clear working days prior

to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 In addition to the circulation of minutes, the 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.3 Minutes of meetings, once approved as true and accurate by the committee, will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation / self-assessment of its performance and attendance levels.

6.8.2 A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference and is based on the good practice guide found in the HFMA Audit Committee Handbook **(Appendix A refers)**, will be used for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.3 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties. The committee will recommend any changes to the Trust Board for approval.

7.0 Equality Act (2010)

7.1 Northern Lincolnshire and Goole NHS Foundation Trust is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

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

7.3 The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

7.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

8.0 Freedom to Speak Up

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with these terms of reference, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to the Freedom to Speak Up Policy for the NHS (DCP126) which has been adopted by the Trust in line with national guidance. Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact the Trust's Freedom to Speak Up Guardian in confidence by email to nlg-tr.ftsuguardian@nhs.net or telephone 07892764607. More details about how to raise concerns with the Trust's Freedom to Speak Up Guardian can be found on the Trust's intranet site.

Appendix A

HFMA NHS Audit Committee Handbook Extract (2024)

This checklist can be completed by the secretary to the committee, along with the chair of the committee, and the results shared with the whole committee. The value of this checklist is that it should be a simple (yes /no) check against the standard requirement. Where the answer is 'no' then the committee should consider whether it should comply (or explain why not).

Area/ Question	Yes	No	Comments/Action
1.0 Composition, establishment and duties			
1.1 Does the audit committee have written terms of reference and have they been approved by the governing body?			
1.2 Are the terms of reference reviewed annually?			
1.3 Has the committee formally considered how it integrates with other committees that are reviewing risk?			
1.4 Are committee members independent of the management team?			
1.5 Does at least one committee member have a financial background?			
1.6 Are all executive officers that you would expect to attend present at meetings?			New question 2024
1.7 Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?			
1.8 Does the committee prepare an annual report on its work and performance for the governing body?			
1.9 Has the committee established a plan of matters to be dealt with across the year?			

1.10 Are committee papers distributed in sufficient time for members to give them due consideration?			
1.11 Has the committee been quorate for each meeting this year?			
1.12 Is there a succession plan in place for the chair of the audit committee?			New question 2024
1.13 Are there clear arrangements in place in terms of how the committee works within the integrated care system?			New question 2024
2.0 Internal control and risk management			
2.1 Has the committee reviewed the effectiveness of the organisation's risk management framework?			New question 2024
2.2 Has the committee reviewed the effectiveness of the organisation's assurance framework?			
2.3 Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?			
2.4 Has the committee reviewed the accuracy of the draft annual governance statement?			
2.5 Has the committee reviewed key data against the data quality dimensions?			
3.0 Annual report and accounts and disclosure statements			
3.1 Does the committee receive and review a draft of the organisation's annual report and accounts?			
3.2 Does the committee specifically review: • changes in accounting policies			

• changes in accounting practice due to changes in accounting standards • changes in estimation techniques • significant judgements made in preparing the accounts • the going concern assessment • significant adjustments resulting from the audit • explanations for any significant variances?			
3.3 Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?			
3.4 Does the committee ensure that it receives explanations for any unadjusted errors in the accounts found by the external auditors?			
4.0 Internal audit			
4.1 Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?			
4.2 Does the committee review and approve the internal audit plan, and any changes to the plan?			
4.3 Is the committee confident that the audit plan is derived from a clear risk assessment process?			
4.4 Does the committee receive periodic progress reports from the head of internal audit?			
4.5 Does the committee effectively monitor the implementation of management actions arising from internal audit reports?			

4.6 Does the head of internal audit have a right of access to the committee and its chair at any time?			
4.7 Does the committee hold periodic private discussions with the internal auditors?			New question 2024
4.8 Does the committee assess the performance of internal audit?			New question 2024
4.9 Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?			
4.10 Has the committee evaluated whether internal audit complies with the *Public sector internal audit standards*?			
4.11 Does the committee receive and review the head of internal audit's annual opinion?			
5.0 External audit			
5.1 Are appropriate external audit procurement arrangements in place?			New question 2024
5.2 Do the external auditors present their audit plan to the committee for agreement and approval?			
5.3 Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?			
5.4 Does the committee review the external auditor's value for money conclusion?			
5.5 Does the external audit representative have a right of access to the committee and its chair at any time?			New question 2024
5.6 Does the committee hold periodic private discussions with the external auditors?			
5.7 Does the committee assess the performance of external audit?			

5.8 Does the committee require assurance from external audit about its policies for ensuring independence?			
5.9 Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?			
6.0 Clinical audit [Note: this section is only relevant for providers]			
6.1 If the committee is not responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?			
7.0 Counter fraud			
7.1 Does the committee review and approve the counter fraud work plans and any changes to the plans?			
7.2 Is the committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?			
7.3 Does the audit committee receive periodic reports about counter fraud activity?			
7.4 Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?			
7.5 Do those working on counter fraud activity have a right of direct access to the committee and its chair?			
7.6 Does the committee receive and review an annual report on counter fraud activity?			
7.7 Does the committee receive and discuss reports arising from quality inspections by NHSCFA?			

Hull University Teaching Hospitals NHS Trust

Group Director of Corporate Assurance

AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON

(HUTH)

Membership and Terms of Reference

Reference:	DCT302HU
Version:	1.1
This version issued:	~~12/09/24~~
Result of last review:	Minor Changes
Date approved by owner (if applicable):	N/A
Date approved:	~~08/08/24~~
Approving body:	Trust Boards-in-Common
Date for review:	~~August, 2025~~
Owner:	Sean Lyons, Group Chair
Document type:	Terms of Reference
Number of pages:	18 (including front sheet)
Author / Contact:	Emma Sayner, Group Chief Financial Officer / David Sharif, Group Director of Assurance

Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

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

United by Compassion:
Driving for Excellence

1.0 Purpose

1.1 The role of the Hull University Teaching Hospitals NHS Trust (HUTH **Audit, Risk & Governance Committee-in-Common** is to review the establishment and maintenance of the Trust's systems of internal governance, risk management and internal control and for providing assurance to the Trust Board as to the effectiveness of those arrangements and / or for escalating risk issues.

1.2 These terms of reference have been produced in line with guidance contained within the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2024).

2.0 Authority

2.1 In accordance with the NHS Trusts Membership and Procedures Regulations 1990 an NHS Trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, subject to any restrictions and conditions as the trust thinks fit. An NHS trust may also appoint committees of the trust consisting wholly or partly of directors of the trust or wholly or partly of persons who are not directors of the trust.

2.2 The HUTH Trust Board has established a committee to be known at the **Audit, Risk & Governance Committee-in-Common**. The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust ~~(HUTH)~~ and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Audit, Risk & Governance Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

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3.4 The committee shall report to the board annually on its work in support of the Annual Governance Statement specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the effectiveness of governance arrangements, the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

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4.2 Governance, Risk Management and Internal Control

4.2.1 The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

4.2.2 In particular, the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board.
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the

management of principal risks and the appropriateness of the above disclosure statements.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications, including the NHS Code of Governance, NHS Provider Licence and Fit and Proper Person Test.

- The organisations policy (Standards of Business Conduct Policy), systems and processes for the management of conflicts (including gifts and hospitality and bribery) to satisfy itself they are effective, including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

- The policies and procedures for all work related to counter fraud and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

4.2.3 In carrying out this work the committee use the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers, as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

4.2.4 This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

4.2.5 As part of its integrated approach, the committee will have effective relationships with other Trust Board committees (which may include reciprocal membership) to provide an understanding of processes and linkages and particularly to enable review and oversight of the other committee's governance of risk. This will include the exchange of their chair's action trackers and highlight reports to the Trust Board.

4.3 Internal Audit

4.3.1 The committee shall assure itself that there is an effective internal audit function that meets ~~Public Sector~~Global Internal Audit Standards (~~PS~~GIAS, effective from 9.1.2025) and provides independent assurance to the committee, Chief Executive and board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.

- Reviewing and approving the internal audit strategy, the annual internal audit plan and more detailed programme of work, which is consistent with the audit needs of the Trust as identified in the assurance framework.

- Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.

- Monitoring the implementation of agreed internal audit recommendations in line with agreed timescales, and where concerns exist in relation to the lack of implementation in a particular area the committee can request the relevant operational manager to attend a meeting and give explanation.

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

- Reviewing the Internal Auditor's annual report.

- Monitoring the effectiveness of internal audit and carrying out an annual review and obtaining independent assurance that Internal Audit complies with ~~PSG~~IAS.

4.4 External Audit

4.4.1 The committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Recommending to the Trust Board the appointment of the External Auditor. The committee will act as the Auditor Panel, as per the Trust's Standing Financial Instructions. The Auditor Panel's function is to oversee the selection and appointment of the External Auditor by agreeing and overseeing a robust procurement process, making a recommendation to the Board and ensuring any conflicts of interest are dealt with effectively. It will also advise the Board on any decision involving the removal or resignation of the External Auditor.

- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.

- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.

- Reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

- Reviewing and monitoring the External Auditor's independence and objectivity and the effectiveness of the audit process.

- Establishing a clear policy for the engagement of external auditors to supply non-audit services, and for scrutinising and where appropriate approving uses of, or exceptions to, this policy.

4.5 Financial Reporting

4.5.1 The committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

4.5.2 The committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

4.5.3 The committee shall review the annual report and financial statements before submission to the board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letters of representation.
- Explanations for significant variances.

4.6 Risk Management

4.6.1 The committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks the committee considers it is appropriate to do so. This will include:

- Reviewing the Trust's information governance and cyber security arrangements, in order to provide assurance to the Board that the organisation is properly managing its information and cyber risks and has appropriate risk mitigation strategies.
- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks.
- Overseeing actions plans relating to regulatory requirements in terms of the NHS Oversight Framework and Use of Resources.
- Providing the Board with assurance over developing partnership arrangements (e.g., integrated care systems) and mitigation of risks which may arise at the borders between such organisations. The Health and Care Act 2022 introduced new requirements for NHS bodies to work

together to meet joint financial objectives and duties, and as such the Audit Committee will need to take a wider view when considering audit and assurance. Organisations need to agree together how best to recognise and manage risk across a system, including what assurances the Audit Committee will need and where these will come from.

4.7 The Board will however retain the responsibility for routinely reviewing specific risks.

4.8 Counter Fraud

4.8.1 The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud that meet the NHS CFA's standards and shall review the outcomes of work in these areas. The committee shall receive the annual report and annual work plan from the Local Counter Fraud Specialist and shall also receive regular progress reports on counter fraud activities.

4.9 System for Raising Concerns

4.9.1 The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensures that any such concerns are investigated proportionately and independently and in line with relevant policies.

4.9.2 The trust's Freedom to Speak Up Guardian, or his or her nominated deputy shall attend the committee at least annually to provide assurance on the design and operation of the function.

4.10 Management

4.10.1 The committee shall request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

4.10.2 The committee may also request specific reports from individual functions within the organisation (e.g., compliance reviews or accreditation reports).

4.11 Other Assurance Functions

4.11.1 The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation . These may include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g., the Care Quality Commission, NHSE, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g., Royal Colleges, accreditation bodies, etc.).

4.11.2 In addition, the committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the committee's own areas

of responsibility. In particular this will include any committees covering safety / quality, for which assurance from clinical audit can be assessed, and risk management . The committee shall receive the action trackers and highlight reports to the Trust Board of the following Board committees for information:

- Performance, Estates & Finance Committees-in-Common
- Quality and Safety Committees-in-Common
- Workforce, Education & Culture Committees-in-Common
- Health Tree Foundation Trustees' Committee
- Capital & Major Projects Committees-in-Common
- Remuneration Committees-in-Common – Annual Summary report only
- Ethics Committee (when in operation)

4.11.3 The committee will review Standing Financial Instructions, Scheme of Delegation and those elements of the Trust Constitution (Standing Orders) that provide assurances on the internal management of procurement and financial matters.

4.11.4 The committee will receive the Board Assurance Framework (BAF) and the High-Level Risk Register on a routine basis, to gain assurance that it is operating as part of the Trust's overarching governance / control systems.

4.11.5 The committee will ensure escalation of issues requiring action or decision by the Trust Board or other groups within HUTH, as appropriate.

4.12 Summary Scope

4.12.1 In summary, to cover the following areas of scope:

- Annual Report and Accounts / Annual Governance Statement
- Charitable Funds governance arrangements
- Counter Fraud
- Data Quality
- Debt Management
- Document Control
- Engagement of External Audit for Non-Audit Work
- Emergency Preparedness Resilience & Response and Business Continuity
- Financial Reporting and Control
- Freedom to Speak Up (Annual Review of Arrangements)
- Going Concern Review
- Governance / Risk
- Information Governance (IG) / IG Toolkit / Cyber Security
- Internal Audit / External Audit
- Losses and Compensation

- Management and Internal Control Systems
- Oversight of Work of Other Board Committees
- Procurement Key Performance Indicators
- Salary Over / Under Payments
- Standards of Business Conduct
- Standing Orders, Standing Financial Instructions and Scheme of Delegation
- Waiving Standing Orders

5.0 Membership

5.1 Core Membership

5.1.1 The committee shall be appointed by the board from amongst its independent, Non-Executive Directors and shall consist of not less than three members (including the committee chair). One of the members shall have recent relevant financial experience. One of the members will be nominated as vice chair of the committee.

5.1.2 The chair of the Trust and the Group Chief Executive shall not be members of the committee. However, they may be invited to attend a meeting by the committee chair – see 5.3.1.

5.2 In Attendance (all meetings)

5.2.1 The following shall normally attend meetings:

- Group Chief Financial Officer
- Group Director of Assurance
- Internal Audit Representative(s)
- External Audit representative(s)

5.2.2 The Local Counter Fraud Specialist will attend to report upon and discuss counter fraud matters.

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 At the invitation of the committee chair, the Trust Chair and Group Chief Executive may attend meetings. The Trust Chair (or Vice Chair) may attend to ensure that the committee is operating as expected and that the non-executives are carrying out their tasks appropriately. The Group Chief Executive would be expected to attend for items around the annual report and accounts, including the Annual Governance Statement, for which they are directly accountable.

5.3.2 Other Non-Executive / Associate Non-Executive Directors may be requested to attend specific meetings of the committee, as the agenda dictates.

5.3.3 The committee may, from time to time and as the agenda dictates, require attendance from other senior officers of the Trust not mentioned above, particularly when the committee is discussing areas of risk or operation that are the responsibility of that individual. Such attendance will normally be for their items(s) only.

5.3.4 Representatives from other organisations (e.g. NHS Counter Fraud Authority (NHS CFA) and other individuals (e.g. Local Security Management Specialist) may be invited to attend on occasion.

5.3.5 At least once a year~~, usually at its Audited Accounts meeting,~~ members of the committee shall meet privately with the External and Internal Auditors, either separately or together. Other meetings will take place at the request of members or auditors. The Head of Internal Audit and representatives from External Audit and the Local Counter Fraud Specialist have a right of direct access to the chair of the committee.

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 The committee will normally meet at least five times per year at appropriate times in the audit cycle to allow it to discharge all of its responsibilities in line with its annual work plan. Where required and in agreement with the committee chair and executive lead for the committee, additional meetings may be convened to consider matters that require urgent attention. The committee will review the meeting schedule annually.

6.1.2 The committee will maintain a twelve-month rolling workplan capturing its main items of business at each scheduled meeting. This will be updated throughout the year as the committee sees fit. Ad-hoc reports, in addition to those set out in its workplan, may also be requested by the committee as necessary.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of each committee will be the chair of the respective committee and jointly chair the **Audit, Risk & Governance Committee-in-Common.** [In line with agreed CiC principles agreed between HUTH and NLaG both Non-Executive Director chairs will attend the agenda setting meeting with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of one or both Non-Executive Director chairs, the vice chair Non-Executive Director member(s) of the committee of the respective trust(s) will jointly chair the meeting.]

6.3 Secretary

6.3.1 The **Audit, Risk & Governance Committee-in-Common** will be supported administratively by the Assistant Director of Finance – Compliance and Counter Fraud. Their duties in this respect will include agreement of agenda's with both

chairs of the committee; ensuring papers are collated and circulated in good time; that those invited to each meeting attend; maintaining the action tracker; preparing the draft highlight / escalation reports for review and agreement by both chairs; advising the committees on pertinent issues / areas of interest and enabling the development and training of committee members.

6.3.2 Secretarial support for the taking and production of minutes will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members and regular attendees (as listed at 5.2) is required at a minimum 75% of meetings.

6.4.2 In the absence of group executive regular attendees, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 A quorum shall be two of the three members.

6.5.2 A quorum must be maintained at all meetings.

6.5.3 If quoracy cannot be achieved from the committee members, and the reason for lack of quoracy is short term and the papers have already been read, other Non-Executive Directors can be invited to attend for a single meeting (excluding the Trust Chair) or the meeting can go ahead and any actions or decisions (dependent upon the nature) could be ratified at the next meeting, or by the next Trust Board.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will see to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than 5 clear working days prior to each meeting. No later papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 In addition to the circulation of minutes, the ‘action tracker’ of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action ‘lead’ and will assist in ensuring that actions are completed within the agreed timescale.

6.7.3 Minutes of meetings, once approved as true and accurate by the committee, will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation / self-assessment of its performance and attendance levels.

6.8.2 A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference and is based on the good practice guide found in the HFMA Audit Committee Handbook **(Appendix A refers)**, will be used for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.3 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties. The committee will recommend any changes to the Trust Board for approval.

7.0 Equality Act (2010)

7.1 Northern Lincolnshire and Goole NHS Foundation Trust is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

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

7.3 The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

7.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

8.0 Freedom to Speak Up

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with these terms of reference, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to the Freedom to Speak Up Policy for the NHS (DCP126) which has been adopted by the Trust in line with national guidance. Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact the Trust's Freedom to Speak Up Guardian in confidence by email to nlg-tr.ftsuguardian@nhs.net or telephone 07892764607. More details about how to raise concerns with the Trust's Freedom to Speak Up Guardian can be found on the Trust's intranet site.

Appendix A

HFMA NHS Audit Committee Handbook Extract (2024)

This checklist can be completed by the secretary to the committee, along with the chair of the committee, and the results shared with the whole committee. The value of this checklist is that it should be a simple (yes /no) check against the standard requirement. Where the answer is 'no' then the committee should consider whether it should comply (or explain why not).

Area/ Question	Yes	No	Comments/Action
1.0 Composition, establishment and duties			
1.1 Does the audit committee have written terms of reference and have they been approved by the governing body?			
1.2 Are the terms of reference reviewed annually?			
1.3 Has the committee formally considered how it integrates with other committees that are reviewing risk?			
1.4 Are committee members independent of the management team?			
1.5 Does at least one committee member have a financial background?			
1.6 Are all executive officers that you would expect to attend present at meetings?			New question 2024
1.7 Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?			
1.8 Does the committee prepare an annual report on its work and performance for the governing body?			
1.9 Has the committee established a plan of matters to be dealt with across the year?			

1.10 Are committee papers distributed in sufficient time for members to give them due consideration?			
1.11 Has the committee been quorate for each meeting this year?			
1.12 Is there a succession plan in place for the chair of the audit committee?			New question 2024
1.13 Are there clear arrangements in place in terms of how the committee works within the integrated care system?			New question 2024
2.0 Internal control and risk management			
2.1 Has the committee reviewed the effectiveness of the organisation's risk management framework?			New question 2024
2.2 Has the committee reviewed the effectiveness of the organisation's assurance framework?			
2.3 Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?			
2.4 Has the committee reviewed the accuracy of the draft annual governance statement?			
2.5 Has the committee reviewed key data against the data quality dimensions?			
3.0 Annual report and accounts and disclosure statements			
3.1 Does the committee receive and review a draft of the organisation's annual report and accounts?			
3.2 Does the committee specifically review: • changes in accounting policies			

• changes in accounting practice due to changes in accounting standards • changes in estimation techniques • significant judgements made in preparing the accounts • the going concern assessment • significant adjustments resulting from the audit • explanations for any significant variances?			
3.3 Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?			
3.4 Does the committee ensure that it receives explanations for any unadjusted errors in the accounts found by the external auditors?			
4.0 Internal audit			
4.1 Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?			
4.2 Does the committee review and approve the internal audit plan, and any changes to the plan?			
4.3 Is the committee confident that the audit plan is derived from a clear risk assessment process?			
4.4 Does the committee receive periodic progress reports from the head of internal audit?			
4.5 Does the committee effectively monitor the implementation of management actions arising from internal audit reports?			

4.6 Does the head of internal audit have a right of access to the committee and its chair at any time?			
4.7 Does the committee hold periodic private discussions with the internal auditors?			New question 2024
4.8 Does the committee assess the performance of internal audit?			New question 2024
4.9 Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?			
4.10 Has the committee evaluated whether internal audit complies with the *Public sector internal audit standards*?			
4.11 Does the committee receive and review the head of internal audit's annual opinion?			
5.0 External audit			
5.1 Are appropriate external audit procurement arrangements in place?			New question 2024
5.2 Do the external auditors present their audit plan to the committee for agreement and approval?			
5.3 Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?			
5.4 Does the committee review the external auditor's value for money conclusion?			
5.5 Does the external audit representative have a right of access to the committee and its chair at any time?			New question 2024
5.6 Does the committee hold periodic private discussions with the external auditors?			
5.7 Does the committee assess the performance of external audit?			

5.8 Does the committee require assurance from external audit about its policies for ensuring independence?			
5.9 Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?			
6.0 Clinical audit [Note: this section is only relevant for providers]			
6.1 If the committee is not responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?			
7.0 Counter fraud			
7.1 Does the committee review and approve the counter fraud work plans and any changes to the plans?			
7.2 Is the committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?			
7.3 Does the audit committee receive periodic reports about counter fraud activity?			
7.4 Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?			
7.5 Do those working on counter fraud activity have a right of direct access to the committee and its chair?			
7.6 Does the committee receive and review an annual report on counter fraud activity?			
7.7 Does the committee receive and discuss reports arising from quality inspections by NHSCFA?			

6 - ITEMS FOR INFORMATION / SUPPORTING PAPERS

REFERENCES

Only PDFs are attached

- BIC(25)024 - Quality & Safety Committees-in-Common Minutes - October & November 2024.pdf
- BIC(25)025 - Performance, Estates & Finance Commitees-in-Common Minutes - November & December 2024.pdf
- BIC(25)026 - Workforce, Education & Culture Committees-in-Common Minutes - November 2024.pdf
- BIC(25)027 - Capital & Major Projects Committees-in-Common Minutes - November 2024.pdf
- BIC(25)028 - Audit, Risk and Governance Committees-in-Common Minutes - October 2024.pdf
- BIC(25)029 - Results of Audit, Risk & Governance Committees-in-Common Annual Self-Assessment Exercise 2025.pdf
- BIC(25)030 - Integrated Performance Report (IPR).pdf
- BIC(25)031 - Documents Signed Under Seal.pdf
- BIC(25)032 - Trust Boards & Committees Meeting Cycle - 2025 & 2026.pdf

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)024

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 13 February 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 – October and November 2024
Executive Summary	The Quality & Safety Committees in Common Minutes from the meetings held on 24 October 2024 & 28 November 2024
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Quality & Safety Committees in Common held on 28 November 2024 and 17 December 2024
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday, 24 October 2024, at 9.00am to 12.30pm at Boardroom DPoW

For the purpose of transacting the business set out below:

Present:

Core Members:

David Sulch	Non-Executive Director (Chair)
Julie Beilby	Non-Executive Director
Paul Bytheway	Interim Group Chief Delivery Officer
Rob Chidlow	Interim Group Director of Quality Governance
Tony Curry	Non-Executive Director
Sue Liburd	Non-Executive Director (Chair)
Dr Pete Sedman	Deputy Group Chief Medical Officer
David Sharif	Group Director of Assurance
Amanda Stanford	Group Chief Nurse

In Attendance:

Richard Dickinson	Associate Director of Quality Governance
Stuart Hall	Non-Executive Director
Lesley Heelbeck	NHSE Maternity Support Team
Michela Littlewood	Associate Director of Quality Governance
Jonathan Lofthouse	Group Chief Executive
Yvonne McGrath	Group Director of Midwifery
Corrin Manaley	Governor Representative
Jo Palmer	PA to Board Committees in Common (Minute taker)
Vicky Thersby	Group Head of Safeguarding
Rebecca Thompson	Deputy Director of Assurance

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

David Sulch welcomed those present to the meeting. The following apologies for absence were noted: Dr Kate Wood, Group Chief Medical Officer, Kevin Allen, Governor, Dr Ashok Pathak, Associate Non-Executive Director, Debbie Bray, Group Head of Midwifery, Jo Ledger, Deputy Chief Nurse HUTH and Mel Sharpe,

Deputy Chief Nurse NLAG.

1.2 **Declarations of Interest**

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

1.3 **To approve the minutes of the meeting held on 29 August 2024**

The minutes of the meeting held on the 29 August 2024 were accepted as a true and accurate record.

1.4 **Matters Arising**

The committee chair invited committee members to raise any matters requiring discussion not captured on the agenda. No items were raised.

1.5 **Review of Action Tracker**

The following updates to the Action Tracker were noted:

The item on Domestic Abuse Co-ordinator future funding issues was agreed to be closed as it had been referred to the Workforce, Education & Culture Committees in Common following the July meeting.

The final item on the Maternity Positioning Paper was agreed to be closed as it had been presented to the Board in October 2024.

1.6 **Operational Pressures/Industrial Action update**

Paul Bytheway reported that there was now increased pressure on the Emergency Department (ED) and that measures already in place were being tested. There was no large increase with ambulances but there was a significant increase in Type 3 attendances ie. walk ins to around 30 per day, many with a 'Dear Doctor' letter and this was being investigated. They were being filtered through to the urgent care centre or SDEC. The Winter Plan needed to be based around the expectation that the situation would be no better but certainly no worse. There was a plan to improve escalation responses and this would be presented to Performance, Education & Funding Committees in Common (PEF). David Sulch queried whether there was a cost issue.

Stuart Hall referred to reports in the national press where certain trusts were experiencing issues with ambulances leaving patients without a handover and whether there was a risk of this in the Group. Paul Bytheway replied that there was always a risk with 'duty to rescue' in that the ambulance service should give notice to the ED that they are to leave the patient. From 4 November, there was to be a plan for a 45 minute maximum time for ambulances to leave the ED before a

patient is boarded to the ward, for additional consultants and nurses, working on an 8am-8pm timescale.

Sue Liburd asked for clarification on whether the increase in Type 3 patients was on all sites, to which Paul Bytheway replied it was, however less so on the South bank. Amanda Stanford advised that she had asked the Director of Nursing to inform on a clear escalation process as the random boarding needed to stop. There were risks on the North bank at HRI tower block where not all wards have suction and oxygen and this needed to be managed daily. Paul Bytheway noted that the presence of Executives seemed to generate focus on improvements to good practice, but that this needed to be the case going forward in general. Conversations were taking place with site tri's with a view to alternating responsibility for oversight in forming a structure and to establish stability. Tony Curry questioned the flow through the ED, Paul Bytheway stated that the 'no criteria to reside' figures had dropped, and there was a positive trajectory in improved efficiency in the use of beds. It was felt that a strategic bed review at some point in the future would be a good idea. David Sulch asked whether medical outliers in surgical beds was a significant issue, to which Paul Bytheway responded it was not.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

The committee chair reported that there were no matter(s) referred by the Trust Board(s) or other Board Committees-in-Common for consideration by the committees.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

David Sharif reported that the BAF was in its legacy state with not a great deal of movement since the previous report. Table 2 indicated the high level of overdue risks and Appendix 3 noted the draft progress on the refreshed BAF, with work ongoing on addressing the gaps. For the next meeting, the BAF would be in its new format. Tony Curry asked why these risks were overdue and Rob Chidlow responded that three were operational, and going through individual care groups, the function of risk reporting was beginning to gain structure. Rob Chidlow advised that a risk and compliance meeting had been set up, which was to meet in November and would be Executive-led, from which staff would be chased for timely updates. The risk to patient care due to the inability to deliver extension of a regional Mechanical Thrombectomy service was discussed in that the funding was available for working hours. The Breast service risk was being looked at, due to the workforce depletion. The last two risks were being managed, ie. Delays in Children being reviewed in the cardiac clinic – this was being mitigated by the consultant in clinic and finally the E-Radiology Results System, the risk had been addressed by ensuring the results had been updated promptly, with high risks to be updated within a month. Work was ongoing with Care Groups with regards to promoting good practice. Tony Curry referred to the reduction in breast service staff and

whether this was in danger of becoming an issue. Rob Chidlow replied that a culture had been inherited whereby staff were quick to add issues onto the risk register, but Paul Bytheway updated that a walk round had been carried out in the breast service and the situation was being monitored as to whether staffing issues were a risk to affecting service.

David Sulch asked for reassurance that if the risk had not been dealt with that an internal process was in place for monitoring. Amanda Stanford advised that conversations were taking place with teams to encourage progress.

Julie Beilby referred to Point 1.1 and why the strategy and risk register were different to each other, Rebecca Thompson responded in that it related to NLAG. Going forward, it would relate to the Group. With regards to BAF 6 there was a gap in control and assurance linked to the demand for IT and digital innovation and it seemed to be a recurring theme. Sue Liburd queried whether the risk was moderate or high as table 1 and appendix relating to NLAG quality of care were different. David Sharif to investigate.

ACTION: David Sharif to investigate discrepancy on Table 1 and Appendix risks

David Sulch questioned what the NEDs could do to influence spec comm. Amanda Stanford voiced that it was very difficult to work with NHS England and do what they asked when the funding was insufficient.

3.2 **EQIA Report**

Amanda Stanford took the report as read. A lot of work had been done on the template but more work to be done on embedding. It was under external consultancy review for advice on best use. Training was needed on completion for a true picture. Dr Kate Wood, Paul Bytheway and Amanda Stanford currently meet to go through the EQIA, but Amanda Stanford felt that more structure and feedback was needed. Ultimately, the report will be fed quarterly through to the Committees in Common. Sue Liburd questioned the initial period of 6 weeks for the external consultancy review and Jonathan Lofthouse updated that PA Consulting had been brought in to look at best ways to close the gaps. It was currently undecided as to whether to use the firm long term and onsite to help deliver the 2025/26 plan on a gainshare basis.

3.3 **TAVI RCP Update**

Dr Pete Sedman advised that this item was for assurance to the Board and that a large amount of work had been carried out over the last 4 years which was considered to be quite transformational. The mortality rate had decreased significantly over the past couple of years; working practices had changed dramatically. The two outstanding issues were related to having a dedicated TAVI clinic; currently awaiting the appointment of a second cardiac surgeon and finally, work on the background culture. Jonathan Lofthouse advised that there had been a notable increase in the number of procedures undertaken. Tony Curry referred to

the RCP report and questioned the degree of confidence in the stability of the team, the processes in place etc; Dr Sedman felt that could be assured.

Stuart Hall was pleased to see good progress and it was advised that the issue around retentions had been addressed. Sue Liburd noted that this item was to be closed, but wanted to check that following regular feedback meetings, whether this was still applicable or whether there were still concerns. Dr Sedman replied that there appeared to be no further concerns. Jonathan Lofthouse suggested that the Committee took a capacity and demand report in 12 months' time just to ensure that activity was proceeding as planned. Rob Chidlow pointed out that it had been under separate scrutiny by NHS England, and the frequency of meetings had dropped to monthly which was reassuring, but that the topic would still be monitored by Quality Governance for a while longer.

David Sulch confirmed that the Committee in Common was happy to refer the matter to Business as Usual, with the caveat of Jonathan Lofthouse's suggestion of a capacity and demand report. All agreed. Jonathan Lofthouse had a final request that if any reportable deaths arose in the meantime, then this would necessitate the matter being brought back for discussion.

ACTION: Capacity & demand report to be presented to the Committee in Common in 12 months' time.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Integrated Performance Report (IPR): quality & safety metrics

Rob Chidlow took the paper as read. There was a general improvement in data across the Group. Regarding Duty of Candour; this matter had been raised to Cabinet with regards poor compliance at HUTH and the steps taken to improve this, including weekly monitoring at Care Group level. HUTH reported four Never Events. Jonathan Lofthouse asked how long it would take to show visible improvement, to which Rob Chidlow replied that he expected it to be January.

Sue Liburd noted that the C.Difficile rate was static at above the target trajectory and asked whether anything was being done to mitigate this. Amanda Stanford felt it was important to look at early sampling and logging and updated the Committee that work was being done on improving hand hygiene with soap and water. The Group were at a low position against the national standard but last year a good performance had been reported, but this year, its position had slipped; this was thought to be related to high levels in the community.

Tony Curry referred to the backlog of complaints at HUTH and queried whether it was procedural related. Richard Dickinson reported that whilst still high, it had decreased drastically since last year. There was a plan in place for the Group to hit 40% and it was clear that the process at NLAG was significantly better and this was to be rolled out in Hull. Amanda Stanford questioned how the issue would be

addressed to then have an impact on reduction of cases. It was important to respond in a timely way and in good quality. Jonthan Lofthouse voiced that the HUTH statement was poorly worded and needed to be rephrased.

Julie Beilby asked whether the CEO signoff was reducing follow up complaints, to which Jonathan Lofthouse replied that for NLAG, the quality was very high and that at HUTH a different format was used and was not personable. It clearly needed to be of high standard on both sites.

David Sulch referred to the Patient Safety Alert and whether the ICB working group was achieving. Amanda Stanford felt it would but that there was still work to do. Richard Dickinson advised that there was slight progress in complying with alerts in the next six weeks but regarding equipment replacement, the situation would not change.

4.2 **CQC Oversight Update**

Amanda Stanford took the paper as read. Meetings had been held with Care Groups to ensure consistency at core service level. Compliancy was not being sustained. A quarterly review of CQC actions was being carried out with the site tris at core service level. Jonathan Lofthouse was unhappy with a quarterly review as he felt that those highlighted in red had been present for too long. Amanda Stanford was happy for the reviews to be more frequent.

David Sulch queried the amount of detail needed and Amanda Stanford replied that the action plan could be included as an appendix. Jonthan Lofthouse asked that it be presented to Cabinet and then back to the Committee.

Assurance was noted as Limited.

ACTION: CQC Oversight Update to be presented to Cabinet and then back to this Committees in Common

4.3 **Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, incidents/MNSI)**

Yvonne McGrath advised that work was ongoing with mapping topics relevant to the Committees. For CNST/MIS, there were two primary risks ie. the misuse of NPMRT and around training, which is being reviewed on a daily basis. Good progress was being made on Saving Babies Lives. Service user feedback was being developed and there were deep dives into booking rates as compliance was not at target level.

Sue Liburd referred to Place of Safety and, for assurance purposes, asked what the outcomes were. Yvonne McGrath replied that if the parental area was not considered safe then the babies were moved to the neonatal area.

Tony Curry referred to the introduction of Badgernet and Yvonne McGrath was pleased to report it had been well received at NLAG, and a lot had been learned following the HUTH rollout.

Stuart Hall asked about the new obstetric and maternity improvement advisor and how she would link into existing support. Yvonne McGrath replied that she would help support the obstetric side and interact on safety meetings.

Lesley Heelbeck confirmed that she would be working with Dr Clark and Yvonne McGrath looking at the key recommendations in the diagnostic report to be shared with the Board next month, particularly the maternity and neonatal improvement plan, safe staffing in obstetrics and midwifery. She emphasised the desire to dovetail into existing key meetings. Jonathan Lofthouse would be happy to receive an update at the next Board meeting, to be deferred until after Christmas due to the involvement of the national team. Amanda Stanford confirmed that conversations had taken place and there were key pieces of work forthcoming, focussing a great deal on obstetrics.

Yvonne McGrath raised the risk of secondments ending, and a need to consider mitigations due to staffing issues. Amanda Stanford to bring to Cabinet.

Stuart Hall was mindful of positive news with resourcing triage, but there was a need for more substantial communications. Yvonne McGrath felt that there was an issue with staff moving into posts and Jonathan Lofthouse felt that funding for roles could be looked into at Cabinet and for those roles that are agreed as needed, a robust case be made for further funding. Lesley Heelbeck advised that there was to be a meeting with the national obstetric lead to discuss role descriptors and planning work on the obstetric workforce and also reiterated that for the midwifery workforce, there were still significant risks on the delivery suite and postnatal wards around leadership which is becoming apparent in patient and staff experiences. Midwifery staff on triage was at a good level but for obstetric triage, there was still a gap evident. Yvonne McGrath gave reassurance that meetings with care groups were in place to look at all issues raised.

Sue Liburd pointed out that the Maternity Support Workers were still in dispute and asked whether there were any resultant risks to patient safety. Yvonne McGrath responded in that sickness levels had increased, so it could be an issue to backfill positions should there be more strike action. There were also issues on the HUTH side relating to Band 2 working at Band 3. Sue Liburd asked if these issues were on the risk register and Yvonne McGrath replied that they were but would need to be .

Sue Liburd referred to the LMNS of the previous week in that there was an increasing lack of confidence by midwives, in physiological labour births particularly in a pool birth setting. Yvonne McGrath responded that work was being done with staff around monitoring and safety in order to build confidence and capability.

Sue Liburd commended the work that had been done around reducing smoking in pregnancy and Yvonne McGrath was pleased to also advise that the RSV vaccine had been rolled out on both sites and that additional funding was currently being sourced for additional clinics.

ACTION: Lesley Heelbeck to provide update for February Board meeting

ACTION: Amanda Stanford to inform Cabinet of risk to staffing due to secondments ending

Assurance was noted as limited, although there was evidence of some good work in progress and although the issues were understood, the trajectory was not.

10.48am: Running order of discussion was changed to enable Vicky Thersby to present Item 4.5 on Safeguarding including MCA & DOLS

4.4 **PSIRF/Serious Incidents (including Duty of Candour and lessons learned)**

Richard Dickinson highlighted the Never Events. Check processes and actioning of the action plans were now in place which was increasing awareness. For HUTH the numbers had reduced and it was being considered how to ensure continued focus. Amanda Stanford felt work needed to concentrate around culture and whether safety culture was effective. Methods of improving proactiveness needed to be considered.

Stuart Hall felt that it was important to share lessons learned on Never Events. Michela Littlewood felt it was important to have NED and patient involvement and that Scan for Safety was an important process to adopt.

It was felt that it was inappropriate to give a level of assurance on this topic.

4.5 **Safeguarding including MCA & DOLS**

Vicky Thersby took the paper as read. The report noted work ongoing across both North and South bank sites and each site had a named safeguarding professional, however services were configured differently each site. The Domestic Abuse Co-ordinator role on the South bank would end in February 2025 due to a lack of funding and Sue Liburd noted that this had been referred to the Workforce, Education & Culture Committee. The possibility of white ribbon accreditation against Domestic Abuse was being explored. Support was being received for Domestic Abuse Champion training but it was noted that this would default to safeguarding if funding becomes unavailable.

Stuart Hall referred to the Navigator roles in ED and how they were to be maximised. Amanda Stanford agreed they needed to be more visible and the Group to be more responsive. Oliver McGowan training was now in place.

Julie Beilby referred to the South bank partnership with local authority areas and for some detail on whether it was positive and proactive. Amanda Stanford to investigate and feedback.

It was noted that a SEND inspection was due to take place in January on the South Bank and that a trainer was now in post so issues could be addressed immediately.

Assurance was noted as reasonable.

ACTION: Amanda Stanford to feed back on South bank partnership with local authority areas

Highlight to Board: The Domestic Abuse Co-ordinator role on the South bank is to end in February 2025 due to the expiration of funding

The Committee paused for a break at 11am

4.6 **Register of External Agency Visits**

Rob Chidlow took the paper as read. The aim was for a single register but referring to both sites. The CQC IR(ME)R inspection was proving to be proactive with work ongoing. David Sulch queried whether the action plans were effectively managing the delivery of quality; Michela Littlewood felt they were and Amanda Stanford replied that GIRFT was managed by the Care Groups and site triumvirate and was brought to the Committee more for information purposes. Paul Bytheway questioned should the central team be disbanded, how would awareness be generated on the work taking place. The workplan for GIRFT should be managed centrally but the delivery by the Care Groups. Michela Littlewood advised that the compliance team would be involved in this but agreed the problem lies in how the how the Committee should receive that information. She agreed to look at this and feedback. Rob Chidlow admitted that the paper was currently too detailed and Amanda Stanford reassured that the risk and compliance team would hold care groups to account.

Tony Curry felt that a level of assurance was emerging but it needed triangulation with other reports. Stuart Hall agreed the report needed to be less informative. David Sulch confirmed that this item would be taken for information.

ACTION: Michela Littlewood to review process

4.6.1 **Regulatory Update 003/2024 – Unannounced inspections for the post mortem sector**

Dr Pete Sedman advised that an inspection took place a few days previous in Lincoln with a few items to be addressed but nothing of significance. Rob Chidlow noted that Dr Kate Wood wanted this item to be noted for information.

4.7 **Clinical Effectiveness Report (including clinical audit, NICE compliance and deviations, GIRFT, PROMS etc)**

Richard Dickinson gave an overview of the report, which covered several areas of clinical effectiveness work, covering national audit outliers, compliance and the issues identified through monitoring on both sites. There were no negative outliers at NLAG or HUTH. For NLAG, there was continuing difficulty obtaining timely patient samples from Information Services and at HUTH, oversight of the National Audit programme was to be overseen by a central Audit team, as currently there were differences between the two original Trusts. Some Care Groups within HUTH are currently not participating in national audits, partly due to staffing issues. Richard Dickinson noted that resource allocation was indeed a national issue. Work was ongoing with regards to bringing tracking of all audits in line across the Group.

Sue Liburd referred to oxygen prescription practice and documentation for Thoracic Surgery patients and queried why the issue was persisting. Richard Dickinson highlighted that there was a problem in ensuring that the decision was documented and Amanda Stanford felt there was a lack of understanding of the safety issues around this. David Sulch emphasised this was mandatory and Richard Dickinson noted the onus was on capturing the decision and that any issues with this should be managed by the Care Groups and to be listed on the risk register after a gap analysis if compliance was not achievable.

Richard Dickinson highlighted that although there were gaps, there were plans in place to work with the Care Groups to address this. There were no alerts identified. He asked whether the Committee would prefer the data to be broken down into individual issues and the plans to resolve them. David Sulch felt there needed to be more focus on the evidence of action taken in response to the gaps. Rob Chidlow noted that this should be evident in the Highlight report to Board.

Stuart Hall felt that going forward, the next update needed to detail why the Committee gave limited assurance and what had been done to address that, with Tony Curry stating this could be included in the Executive Summary. David Sulch referred to discussions at the Timeout day in September regarding flexibility of matters to be discussed and if there were any major issues noted, then the paper to be brought for discussion earlier.

Assurance was taken as limited, due to the amount of detail but no clear outcomes. Amanda Stanford felt triangulation was needed with the Care Groups to which Stuart Hall agreed. Amanda Stanford also commented that there is a risk that CQC may ask why there is continued limited assurance and what actions the Committee are taking to increase this. Tony Curry felt it was important to indicate why there was only limited assurance.

4.8 **Children & Young People Assurance (to include update on medication errors)**

Item was deferred to the November meeting.

5. ANNUAL REPORTS

There were no annual reports to discuss.

6. ANY OTHER URGENT BUSINESS

6.1 Sue Liburd referred to the Timeout day and it was agreed that the overview notes could now be circulated. Sue Liburd asked if it could be made clearer whether an agenda item was for information or assurance.

David Sharif advised that Committee effectiveness reviews were currently taking place and a questionnaire would be circulated after the meeting to be completed as soon as possible.

Tony Curry asked about the challenge around CQC reporting. Amanda Stanford confirmed that Jonathan Lofthouse had asked for a report to be provided to Cabinet in November but she was keen for the site tri's to take responsibility, rather than sitting at Group level. She confirmed that the reports would continue to be quarterly but monitoring with the teams to be more frequent and an action plan to be included within the report. David Sulch reiterated that if any matters were urgent in the meantime, they could still be brought for discussion.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

The Domestic Abuse Co-ordinator post had previously been referred to the Workforce, Education & Culture Committee in Common. Stuart Hall felt it was important to know that once a matter had been referred to another Committee, how this was followed up and ultimately closed off. Amanda Stanford replied that this was picked up at safeguarding and at Cabinet. David Sulch added to ensure that the matter was noted on the action tracker.

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:

- Winter planning and financial constraints
- Good work achieved on the TAVI but to be brought back for discussion in 12 months to ensure sufficient embedding
- IPR Duty of Candour compliance to be monitored weekly and to be brought back for discussion in January
- Good work achieved on the South bank maternity Stop Smoking scheme
- Domestic Abuse Co-ordinator post referred to Workforce, Education & Culture Committees in Common
- HUTH complaints backlog and the use of the South bank process
- CQC outstanding actions review
- CNST risks
- Obstetric model deferred for Board discussion from December to February
- NLAG Maternity Support Worker issues
- Never events, limited assurance with regards the national audit, gap analysis was being done but more triangulation needed on the key issues
- BAF- any changes or updates

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next Quality & Safety CiC meeting:

Thursday 28 November 2024 at 9.00am-12.30pm
Nightingale Room, Education Centre, SGH

The committee chair closed the meeting at 12.15 hours.

Cumulative Record of Attendance at the Quality & Safety Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	Ma	Jun	Jul	Au	Sep	Oct	No	Dec	Jan	Feb	Mar
CORE MEMBERS													
Julie Beilby	Non-Executive Director							Y					
Rob Chidlow	Interim Group Director of Quality Governance	Y	Y	N	Y	Y	Y	Y					
Amanda Stanford	Group Chief Nurse	Y	Y	Y	Y	Y	Y	Y					
David Sharif	Group Director of Assurance	Y	Y	Y	N	Y	Y	Y					
Sue Liburd	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y					
David Sulch	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y					
Dr Kate Wood	Group Chief Medical Officer	Y	N	Y	Y	D	Y	D					
REQUIRED ATTENDEES													
Paul Bytheway	Interim Group Chief Delivery Officer			N	Y	Y		Y					
Tony Curry	Non-Executive Director	Y	N	Y	Y	Y	Y	Y					
Richard Dickinson	Associate Director of Quality Governance	Y	Y	Y	Y	Y	Y	Y					
Stuart Hall	Non-Executive Director	N	N	Y	N	Y		Y					
Dr Ashok Pathak	Associate Non-Executive Director	Y	N	Y	N	Y	N	N					
Yvonne McGrath	Group Director of Midwifery	N	N	N	Y	Y		Y					
Michela Littlewood	Associate Director of Quality Governance	Y	Y	Y	Y	Y	Y	Y					
Alison Hurley		N	N	N	N	N		Y					
Sean Lyons	Trust Chairman	N	N	N	N	Y		N					
Linda Jackson	Vice Chair	N	N	N	Y	N	Y	N					
Rebecca Thompson	Deputy Director of Assurance	Y	Y	Y	Y	Y	Y	Y					

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday 28 November 2024 at 9.00am to 12.30pm at Nightingale Room, Education Centre SGH

For the purpose of transacting the business set out below:

Present:

Core Members:

Sue Liburd	Non-Executive Director (NLaG)
David Sulch	Non-Executive Director (HUTH)
Julie Beilby	Non-Executive Director (NLaG) (via MS Teams)
Tony Curry	Non-Executive Director (HUTH)
Rob Chidlow	Interim Group Director of Quality Governance
Amanda Stanford	Group Chief Nurse
Clive Walsh	Interim Site Chief Executive North
Dr Kate Wood	Group Chief Medical Officer

In Attendance:

Richard Dickinson	Associate Director of Quality Governance (NLaG)
Stuart Hall	Non-Executive Director (HUTH)
Ashok Pathak	Non-Executive Director (HUTH)
Yvonne McGrath	Group Director of Midwifery
Rebecca Thompson	Deputy Director of Assurance
Kevin Allen	Governor
Marie Stern	Patient representative (via MS Teams)
Augustine (Austin) Smithies	Consultant in A&E (HUTH)
Jo Palmer	PA to Board Committees in Common (Minute taker)

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The committee Chair welcomed those present to the meeting. Apologies for absence were noted from David Sharif, Group Director of Assurance and Michela Littlewood, Associate Director of Quality Governance (HUTH).

1.2 Staff Charter and Values

The committee Chair reminded those present to conduct themselves accordingly during 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 24 October 2024**

The minutes of the meeting held on the 24 October 2024 were accepted as a true and accurate record.

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 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

31/07/24 Item 4.1 – on Agenda for discussion therefore item to be closed
24/10/24 Item 3.3 – update to be submitted in 12 months' time
24/10/24 Item 4.2 - report submitted, therefore item to be closed
24/10/24 Item 4.3 – action on track
24/10/24 Item 4.3 – report submitted, therefore item to be closed
24/10/25 Item 4.5 – action on track
24/10/24 Item 4.6 – action completed, therefore item to be closed

1.7 **Review of Effectiveness**

Rebecca Thompson informed the meeting that questionnaires had been sent out after each of the Committees in Common (CiC) in October 2024 but there had been a poor uptake, however the information submitted consisted of some rich data to work with. It had been decided at the Performance, Estates & Finance CiC (PEF) that another review would be requested in 6 months' time. A report had been sent to Chairs and would be submitted to the Board also.

Stuart Hall questioned why it would be passed on to the Board if there had been a lack of response, but it was deemed worthwhile due to the constructive comments received.

1.8 **Operational Pressures Update**

Sue Liburd welcomed Clive Walsh to the meeting. He proceeded to provide an overview to the end of October 2024. There had been an improvement in elective surgery waiting times; there were 19 patients waiting over 65 weeks, against a national target of 0 with a further target of 8 by the end of March 2025. On diagnostics, there have been improvements overall. There was a concern with audiology, which is a potential for a Quality & Safety concern and an investigation had begun into the possible mis-recording of some pathways relating to software and the outcome would be brought to this Committee if deemed necessary. On cancer, there had been an improvement in the 28-day Faster Diagnosis standard, although this had not yet been reported, but it was not currently having any impact

on the 62-day pathway. On the emergency pathway, the numbers seen within four hours within the Emergency Department was a good indicator of flow. Improvements were noted for both HUTH and NLaG, performance had been maintained at NLaG but had declined at HUTH in October, continuing into November. There were concerns from the ambulance service with regards to offload times, concerns from our staff regarding the management of patients with dignity. This was being addressed on the North bank in particular; firstly, with a Multi-Agency Discharge Event (MADE) event with some engagement from external agencies, with a great deal of useful information available. Secondly, a significant programme of improving flow has commenced, which was supported by Jenny Hinchcliffe with assistance in the project management of that by the QI team and also by PA Consulting. Clive Walsh advised that there was now a draft winter plan which included the flow programme and there was some financial investment in some modest programmes that could be quickly switched on to gain quick benefit. A challenging winter was expected, to which Amanda Stanford agreed. It had been discussed at the PEF CiC regarding the anticipated impact on staff wellbeing and how we keep our staff healthy during this time. There had already been noted an increase in respiratory incidents amongst staff ie flu and RSV. Amanda Stanford noted that there needed to be a bigger and better process for the Discharge Lounge and updated that there was some work being done around language and being community ready as soon as a patient comes in.

David Sulch noted that year after year, there was a mismatch of demand and capacity. He asked the question of whether this was recognised nationally or at ICB level and whether the Group were at risk of being penalised for only looking at the figures and not the fundamental issues behind them. He also noted that Emergency Department performance had been discussed at the PEF CiC but that no overview had been provided to the Quality & Safety CiC. This could be seen as a gap as neither Chair sat on the PEF CiC and be a potential risk if there was an extended period of time in the ED waiting for a bed in terms of mortality rates, incidents and so forth. Amanda Stanford advised that she had attended the PEF CiC for the first time and had noted that the waiting times were going up, therefore, she wondered whether a deep dive into performance data and an analysis of that be undertaken on behalf of the Quality & Safety CiC**.** Clive Walsh felt that the GP collaborative action this year was resulting in higher numbers of patients coming to the ED and less differentiated referrals to the specialists, presenting on their own initiative or via the GP with no work up.

Tony Curry noted that these were well recognised issues but felt that there had been little mention of ECA in the update. He was also unsure as to the extent in which the views of senior clinicians were considered with regards the supply and demand and the associated challenges. The process within the ED could be better with triage to the common specialities of demand, such as gastro, using clinicians trained under those specialities. Clive Walsh replied that the Care Group seemed to be highly engaged with its clinicians. He acknowledged that he had not referred to ECA within his update but did advise that work was ongoing between the Director of Performance and the Unplanned Care Board and it was felt that the ED could be helped by decongesting the department where people were waiting who hadn’t even been seen.

Sue Liburd asked everyone to be specific when referring to site ie HUTH or NLaG.

Amanda Stanford referred to the GIM structure and advised that it was not where it needed to be. Clive Walsh agreed.

Dr Pathak also felt that this situation repeatedly arose year after year with a supposed plan to address it and then the plan not being realised. HUTH had an Urgent Treatment Centre (UTC) and Dr Pathak was unclear why this did not seem to be having an impact. He recognised that a lot of hospitals, including HUTH, had surgical Eds where a patient can be sent directly to the wards and have their treatment, and again wondered why there appeared to be no impact on flow.

Dr Pathak also questioned the discharge process of the patients from HUTH to the community. He noted that the figures had improved to some extent, but when comparing the figures across Yorkshire, HUTH were the worst performing. Clive Walsh responded to this and agreed that patients at Hull Royal Infirmary and Castle Hill Hospital who do not meet the criteria to reside is around 90 to 100. He acknowledged that social care was under a great deal of pressure of its own due to demand and funding and there had been little in the recent Budget about increased funding for social care. He also believed there was perhaps too much focus on patients that couldn't move on to social care and less on the patients that were in our control. He was keen to emphasise a focus on flow as a project, working alongside clinicians to improve this.

Stuart Hall asked if he was correct in thinking that Non-Executive directors can gain access to papers across all the Committees-in-Common. They were indeed able to attend any meeting but this would be constraining on time. He did have a concern with having a daily snapshot of the current position within ED, as to what would be done with that information.

Tony Curry raised question over the efficacy of the UTC, in terms of opening hours and loss of some of the physiotherapy services back out into the community. There was some frustration as to whether the UTC was operating as it was intended. Clive Walsh responded to say that Jonathan Lofthouse was having the same conversation with Executives.

Sue Liburd referred back to the audiology service concerns and asked Rob Chidlow when the paper was expected to be presented back to the Committee. Rob Chidlow replied that that there was currently no specific date, and indeed a deep dive may be applicable. Richard Dickinson added that the team were expecting a reporting framework to come through from the Head and Neck Care Group around audiology and some key performance metrics around that activity. There was some work also on the National Paediatric Audiology Review and oversight that was affecting a number of organisations, as well as the IT related system.

ACTION: To schedule Quality Governance sub-committee agenda item on the new infrastructure around the national piece.

ACTION: A deep dive into the audiology adult and paediatric service to be included on the February agenda.

HIGHLIGHT: The Committee acknowledges that a challenging winter was expected and noted were concerns around staff health and the need to

recognise staff wellbeing. This was to be referred to the Work, Education & Culture Committees-in-Common

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

The committee Chair reported that there were no matters referred.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

Rebecca Thompson took the report as read. She emphasised that it was a new-look report with the new strategic risks for this Committee, ie the quality risk and the research and innovation risk which both Amanda Stanford and Dr Kate Wood have contributed to. It was hoped there was now a clearer focus on the gaps and also the actions needed to address the gaps. The BAF has now been agreed to be presented quarterly, which would be more useful to the Committee. Rebecca Thompson also referred to the high level risk register, which contained all of the high level risks but the plan was to pull out those that were relevant to this Committee.

Tony Curry felt that some of the wording was unprecise, and Sue Liburd questioned whether he wanted the language to be reviewed with a greater clarity on the risks themselves, to which Tony Curry agreed. Rob Chidlow accepted that this was a fair point but believed the format was heading in the right direction.

Julie Beilby advised that she liked the new format but was concerned about the number of high level risks that had not been assessed regularly, as the register referred to some longstanding dates. She hoped that this would have moved on somewhat by the date of the next meeting.

David Sulch questioned whether the ophthalmology service needed a deep dive as he had noted there were 3 high risks that were overdue. He believed it was a service that was perhaps under the radar due it being an outpatient service. Rob Chidlow agreed that some assurance was needed for the long waiter patients.

Dr Pathak emphasised that issues had been highlighted to him during a previous visit to the service, particularly in relation to the telephone system as patients were having difficulty in getting through, which in turn added to the waiting issue.

Stuart Hall referred to the new high level risks on the risk register and that it was important to ensure there were mitigations against those risks with a timescale.

Sue Liburd asked all those present whether there was a consensus of positive feedback on the new format and indeed there was, as it was felt that it was easier to navigate.

3.2 **ACTION: Consider a deep dive into the ophthalmology services to be included in the February agenda.**

EQIA Report

Dr Kate Wood presented a verbal report advising that PA Consulting were currently supporting the Group in the SIP schemes and ensuring the EQIA is being performed appropriately. There were currently 21 EQIAs being put through the process, some of which would require executive oversight by Dr Kate Wood and Amanda Stanford. There were some additional schemes currently that do not require EQIA. A summary paper would be presented to the committee at the appropriate time. It had been noted that although a process was in place, there had been insufficient work done within the Care Groups to deal with EQIAs as a priority.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

4.1 CQC Improvement Plan

Rob Chidlow reminded that the paper was brought to the previous Committee meeting and a discussion as to what would be on the workplan going forward and the frequency. During the summer, the teams had been given the ability to go through everything as the Care Groups evolved and perform a thorough review which would go to Cabinet and subsequently back to this Committee and going forward report on a quarterly basis.

The paper provided to this meeting was an update to the previous paper. Rob Chidlow pointed out that the summer review had indeed moved some actions back into the red and amber category. There were issues at NLAG on the training of medical staff and at HUTH, similar issues were beginning to emerge on medical training, but some evidence hadn't been sustained, particularly within the Surgery core service. The picture at NLaG was improving, and at HUTH a smaller number of actions were going through the ratification process. There was contact in place with core services to stimulate the evidence base. Rob Chidlow felt that the training issue was an easy one to resolve with the right emphasis and also work being done on controlled documents. As a Group, there was a 90% compliance which was not sufficient, although at the time of the CQC inspection, HUTH surgery and medicine were only at 30 to 40% compliance, so there had been some good improvement. Family Services was also an outlier but again, some improvement had been noted.

Amanda Stanford felt it was important to retain focus and look at the core service rather than per Care Group. With regular emphasis, the services would hopefully use it to perform their own check and challenge and move into a comfortable routine.

David Sulch was pleased to read that maternity had made good progress with their mandatory training and wondered if there could be lessons learnt from this. Amanda Stanford replied that through the MIS Y6, the expectation was that every individual would be contacted, checked in onto the training and if were a non-attender to be contacted and challenged. She did acknowledge that this level of attention was not sustainable and advised that there was some national work ongoing around what was needed and not needed for statutory and mandatory training and how the culture was improved and embedded. Rob Chidlow believed that once the Care Groups had moved into a good rhythm of performance reviews and understood that they would be held to account for poor performance, the data would continue to improve.

David Sulch questioned whether the March/April timescales detailed on the red risks were realistic in view of it currently being the middle of winter and the Christmas period pending. Amanda Stanford considered it preferable to indicate a deadline in the hope that it would be reached, as alternatively, if deadlines were moved on, it could easily become a pattern.

Dr Pathak believe that historically, surgeons had been somewhat resistant to mandatory training and the recent restructure from NHSE had compounded the issue.

Tony Curry observed that there had been little movement at both HUTH and NLaG and questioned at what point does the Group take a stance with adherence to these deadlines as had been agreed with the CQC. Amanda Stanford accepted this was a fair challenge. She believed there was more of a handle at NLaG than at HUTH, and culturally, the moving of dates and the evidence base needed to be challenged. The ownership of the issues, which had been blurred on the North bank, was now clearer, along with the regulatory requirements now being clearer. The Group was currently on the second round of core service reviews with the teams and emphasis was now needed to move the ownership into the Care Groups' responsibility.

Sue Liburd observed that, in reference to NLaG, Dr Kate Wood had done some very good, focused work but Dr Kate Wood still felt that there was some complacency in culture, particularly on the North bank in terms of showing evidence and there needed to be a consistency of approach. She noted that people were still settling down into the new Group structure with different leadership teams.

Rob Chidlow referred to Tony Curry's point on movement and was pleased to say that he was reassured that on leaving the organisation, the mechanism was in place to promote improvements.

Julie Beilby was disappointed to note that out of the HUTH risks, a third were still red and whilst she acknowledged Dr Kate Wood's comments on work in progress, this was still a high number. Julie Beilby also believed that there needed to some consistency in the language used in the paper to avoid confusion.

Tony Curry acknowledged Dr Kate Wood's comments on the cultural shift and staff professional accountability, but also under the personal accountability. He strongly believed that if there was slow progress, then what was being done to address this

and questioned what line managers were doing. Sue Liburd recommended that this be referred to the Work, Education & Culture Committees-in-Common.

ACTION: Cultural issues to be referred to the Work, Education & Culture Committee

Assurance was agreed to be limited as the issues were understood but gaps were also recognised.

The Agenda was taken out of sequence at 10.15am to enable Yvonne McGrath to present the paper for Item 4.3 Maternity & Neonatal Assurance Report.

4.3 **Maternity & Neonatal Assurance Report**

Yvonne McGrath took the paper as read. She gave an update on BadgerNet and advised that there was further work to do. It had been received well at NLaG and lessons had been learnt. She advised that induction of labour was one of the main risks and were looking into doing a deep dive and building it into the Dashboard. The metrics could well be around the percentage of women delayed for longer than 24 hours and who would take priority.

Progress was being made on triage and the recruitment strategy going forward. The first meeting of the Maternity & Neonatal Intelligence Co-ordination meeting had taken place on 6 November 2024.

Sue Liburd asked for an update on the Maternity Support Workers (MSWs) and Yvonne McGrath replied that during the two weeks of strike action, risks had been managed in terms of staffing levels. Amanda Stanford added that it was hoped that an agreeable solution was soon to be reached and ultimately support be provided to the teams. Sue Liburd further added that Unison have again reached out and hoped that a resolution was soon reached. Yvonne McGrath advised that information had been received on what was being done elsewhere in supporting the MSWs.

Stuart Hall advised that a discussion had been held with regards the role of this Committee and how it interacts with the Board. Relating to admissions to the neonatal unit, standards appeared to be declining at NLaG and was unsure whether this was due to there being more admissions than expected or whether it was around issues with recording on DATIX. Yvonne McGrath replied that there were indeed more admissions, which were related to elective caesarean sections. There had also been issues with temperatures in theatres on all sites and remedial actions were in place to rectify this**.** She emphasised that there was work planned for next year on getting back to the basics of midwifery care.

Dr Pathak was pleased to see that the good work taken place on NICU had been recognised on the news and Amanda Stanford added that that included bereavement midwives also. The Group were on a journey to aspire to be outstanding.

Amanda Stanford believed that a deep dive into the induction of labour would need to be performed at some point and be brought to the Committee in the New Year.

David Sulch commended Yvonne McGrath on the work undertaken in producing a report of good quality and content.

Assurance was agreed as reasonable for both the North bank and the South bank.

The Agenda reverted back to Item 4.2 Infection, Prevention & Control Quarterly BAF at 10.30am.

4.2 **Infection, Prevention & Control Quarterly BAF**

Amanda Stanford took the paper as read. The IPC Board Assurance framework was not used on the South bank but had been used on the North bank, where challenges had been noted, but they were well recognised in terms of using the BAF. When observing the criteria, it was clear to see where there was compliance. The teams had been brought together to form one Infection, Prevention & Control team, with two operational IPC meetings on both sites with a steering group to consider the key strategic issues from an IPC perspective.

NLaG were 100% compliant, with challenges on the HUTH site noted in terms of Back- to-Basics. There were key priorities that the team were going to work on over the next twelve months ie. hand hygiene, PPE, antimicrobial prescribing. There were challenges on water safety on both sites.

Dr Pathak questioned how far the message around good practice, for example, bare below the elbow, had been passed and what impact had been seen to date. Also, it was well known about common bugs, but it had been noted that there had recently been a rise in microplasma chest infections and whether it was causing a concern, especially considering that there had been a shortage of antimicrobial medication. Amanda Stanford suggested a conversation with Debbie Wearmouth, Consultant Medical Microbiologist and Jo Goode, Chief Pharmacist on the microplasma chest infection rise as they were working alongside the IPC team on matters relating to antimicrobial prescribing, but it was recognised that there was a difference between HUTH and NLaG in terms of performance on this subject and that there was more work to be done on the South bank, indeed across the Group. This was linked to the switch from IV to oral prescriptions. Amanda Stanford again believed it was a cultural issue and that there was a need to empower managers to speak out when staff members were clearly flouting the requirements and were made aware of what was meant by a clinical area. It was envisaged that the Back-to-Basics piece would go some way into changing the current culture.

Assurance was agreed as limited.

4.4 **Children & Young People Assurance (to include update on medication errors)**

Debbie Bray presented the paper. With regards the deteriorating patient workstream, she advised that the Group was fully engaged and the bespoke sepsis screening tool was now in use across the paediatrics areas on both hospital sites. Some finalisation work was also ongoing with regards the new audit data tool that needed to be developed against the new sepsis tool. It would mark the huge progress made in being able to evidence that sepsis screening takes place.

Work was also ongoing in improving areas of compliance, particularly around documentation, which appeared to be an ongoing issue.

Debbie Bray advised that the Group is actively engaged with the regional network's work around Martha's Rule and indeed, the Yorkshire Critical Care Operational Delivery Network (ODN) were one of the pilot ODNs that were going to be taking forward some of that work and offering recommendations to organisations on the best use of resources.

From a medication safety perspective, it had been noted that there had been some good reporting, albeit the sharing of learning needed to be better. There also appeared to be a lack of neonatal electronic prescribing and across the Yorkshire & Humber Network, and indeed nationally, there was no benchmark to realise whether the Group was an outlier from a medication incident perspective. Going forward, the plan was to set such a benchmark at the very least within the Yorkshire and Humber Network but to aim for nationally.

Debbie Bray referred to the risks around EPMA and the guard rail facility, but these were making slow progress. Particularly notable was the need for an increase in the pharmacy workforce, specifically around neonatal prescribing.

Stuart Hall questioned how the Group was benchmarking itself against others and was keen to see the data once it was available. Also, regarding the medicine management update and the training in place in relation to specific common errors, Stuart was unsure whether the 78% indication of completeness was acceptable or not. Debbie Bray responded to say that it indeed did not meet the target and recognised that the education and training programme was one of the bigger pieces of work to be addressed. It was evident through the review that HUTH had a very robust education programme, and their medication management and administration packages were excellent and indeed recognised as such regionally. As a result, there was an active piece of work ongoing to roll that out across the NLaG sites to ensure absolute certainty on what the teams were expected to achieve from an education and training perspective**.**

David Sulch was encouraged that there was no evidence of any serious errors on medications and was unsure as to whether the Group was an outlier. He noted that there was the reliance on efficient reporting via Datix. On EPMA, it surely reduced the amount of staff time taken to prescribe, although he was unsure as to whether it reduced medication errors. David Sulch recommended that the Pharmacy issue be referred to the WEC Committees-in-Common.

ACTION: The issue around the need for an increase in the pharmacy workforce, specifically around neonatal prescribing, to be referred to the Work, Education & Culture Committee.

Suart Hall and Sue Liburd, in their roles as Maternity Safety Champions and Amanda Stanford agreed to ensure that this point was raised.

Amanda Stanford recognised that there was a question on how this would all be brought together, and to consider the voice of the child. The plan was to bring together the Child & Young Persons Board (CYP) to sit alongside the Planned and Unplanned Care Board, which would bring together stakeholders, internal to the organisation and also external stakeholders.

Dr Pathak questioned whether the electronic prescription system had improved the discharge rate of patients and whether there was any evidence on improved flow. Debbie Bray replied that from a discharge perspective across paediatrics and neonates, there were delays which were usually due to other pressures such as the electronic discharge. From a neonatal perspective, these were usually more planned, and the electronic discharge worked better.

Dr Kate Wood commended Debbie Bray on the paper. She asked when it was anticipated that the Group would see some substantive audit results. Debbie Bray accepted that some refinement was needed on how the data was collected and anticipated that over the next six months the data would be more meaningful. From a sepsis perspective, she was delighted with the new sepsis tool that had been developed and that the national team had recognised it and work had been commended. Dr Kate Wood emphasised that although the audit data was not available currently, case note reviews do take place.

Dr Kate Wood questioned why there seemed to be no run chart showing neonatal deaths. Amanda Stanford replied that it should be visible in the Maternity & Neonatal Assurance report. Rob Chidlow added that Yvonne McGrath had spoken around the data work and the indicators which were manually spreadsheet based and difficult to pull and there was a need to prioritise IPR indicators that the Board potentially see regularly. More support was needed from Business Intelligence (BI) which had already been flagged.

Richard Dickinson added that there was also a quarterly reporting of mortality through the Mortality Care Group which would feed through to the Committee. Dr Kate Wood agreed with his suggestion of including this in the mortality report. It was already contained within the maternity report but needed to be more visible. Amanda Stanford believed it would be a good idea to await the findings of the Letby Inquiry as there was sure to be a big set of recommendations that came out of that. Dr Kate Wood thought that for the time being, it was best not to have it included within the mortality report and Amanda Stanford reiterated that it was already contacted within the Maternity report.

David Sulch asked that the names be renacted from the complaints section.

Julie Beilby had concerns over the digital issues which Sue Liburd suggested she raised at the Board, as this was common across other committees-in-common. Stuart Hall echoed Julie Beilby's concerns.

HIGHLIGHT: EPMA issues to be escalated.

Assurance was agreed as limited due to issues around medication errors. The issues were understood but it was felt that there was still progress to be made.

4.5 **Mortality including Learning from Deaths (including FNOF Update)**

Austin Smithies presented a summary of the deep dive report and 10 recommendations for diagnostic code 226 ie Fractured Neck of Femur (FNOF), which was one of three diagnostic categories for the SHMI where there was a higher than expected value. It was felt that there had been some good quality improvement work done through the hip fracture governance meeting that had

started to take effect, however there was some caution noted in that there were still areas for improvement. Timeliness of the operative fixation of hip fractures was a major consideration that would have the biggest impact on mortality. There was a 20% increase relative risk of death within twelve months for those patients who waited more than forty-eight hours for surgery. This was a complex issue related to capacity and how cases are prioritised to align with that capacity. On a national scale, performance was poor and locally, even worse. Increased waiting times for surgery had equated to lower rates of return to independent living, with potential additional need for rehabilitation and an increase in incidents of hospital-acquired ulcers. These issues have started to be addressed at a monthly trauma efficiencies meeting, with support from the QI team. An intervention to identify the 'golden patient' was encouraged as good practice, as carried out in hip fracture units across the country. HUTH were reluctant to embrace this initiative. Excellent leadership was noted from the orthopaedic trauma theatres charge nurse as well as the orthopaedic and anaesthetic clinical lead. There had been early positive signs of a reduction in waiting time for surgery from 50 hours in September, 40 hours in October and 30 hours in the first three weeks of November. There was also evidence from the national data that the orthogeriatric service had reduced 30-day mortality of hip fracture patients by 20% nationally over the last decade. The Group were well under the recommended establishment of ortho geriatricians, as well as having around half the number of geriatricians than that recommended by the British Society of Geriatricians. The availability of a dedicated hip fracture ward also equated to reduced mortality. At Hull, patients were cared for on two wards where they received specialist care from an expert team, but the risk was moving them to Castle Hill Hospital where there was a lack of familiarity on the ward.

It was recognised that a review was needed to look for opportunities to improve coding to ensure the SHMI calculation was accurate, and that benefit would be gained from coders and clinicians working together.

Sue Liburd and David Sulch thanked Austin Smithies for his informative report. Dr Pathak noted good evidence-based data but recognised a pattern of temporary improvement followed by a decline. He asked whether there would be an improvement on flow from the ward to theatres and an improved use of anaesthetists. Austin Smithies accepted the question and responded that there was a plan to use a single theatre to improve on the efficiency of using a base of anaesthetists. The challenge was around the use of locums. It was also recognised that there was an obvious need for more ortho geriatricians.

David Sulch questioned whether the correct processes were in place to identify when the situation starts to deteriorate and regarding the rise in re-operation rates, what the contributing factors were. Austin Smithies responded to advise that it was recognised that there was a lag of some months on the national database, and this was being addressed, including as to whether blood alerts could be earlier. However, regarding the re-operation rates, investigations needed to take place.

ACTION: Austin Smithies to investigate further into improving processes of data collection

The Committee was divided as to limited or reasonable assurance, as at least one Non-Executive Director felt assurance was limited.

Dr Kate Wood presented the Mortality report and took the paper as read. She advised that positive improvements, in particular stroke and pneumonia, improvements had been noted, but for sepsis, there were still improvements to be made. David Sulch noted that at NLAG, reference was made to accrued mortality being a total number as opposed to a rate as per HUTH. Dr Kate Wood agreed to look into this further. David Sulch questioned whether the Group were being critical enough and Richard Dickinson replied that at the recent Mortality Improvement Group a conversation around this topic had taken place into how validation could be improved, noting the challenges of accessing systems and availability of case notes.

ACTION: Dr Kate Wood to investigate discrepancy in data

Sue Liburd questioned how sighted the Board were in terms of mortality to which Rob Chidlow replied that the latest guidance on Learning from Deaths was a mandatory Trust Board subject. Indeed, this Committee had reacted earlier in the year when it was felt that the SHMI was higher than expected. Stuart Hall felt at the very least, the recommended approach was to detail the latest changes in terms of the process and continue to perform the overview prior to highlighting to the Board.

ACTION: Dr Kate Wood to consider the recommendations with the Board

Assurance for HUTH was noted as limited and for NLaG reasonable.

4.6 **Integrated Performance Report (IPR): quality & safety metrics**

Dr Kate Wood presented the report. Relating to the Never Events, the process was currently being reviewed. The patients' safety alert with regards to bed rails was nearing completion and work ongoing with regards VTE. Rob Chidlow referred to the Friend and Family test data and that there had been a 15% decline. This had been benchmarked in that the Group were in the bottom eight for ED patient feedback. PALS were under particular pressures due to the volume of complaints from the ED. There was evidently a need to use the Friends & Family inpatient data better; there was a noticeable improvement at HUTH but the sample size was lower at NLaG and some BI or Information Services support was needed.

Amanda Stanford recognised that work was ongoing, in particular looking at the PALS service and checking that it was being used efficiently. Communication was a major issue and End of Life conversations/RESPECT documentation needed to improve. There was an End of Life quality priority which included a focus group meeting on a regular basis at the Queens Centre. Amanda Stanford also wanted to do some testing around incident reporting in a 12 hour wait. Stuart Hall felt that this had reinforced his concern that there was a lot of data being collected, and he recognised the good work that Amanda Stanford had spoken on, but it needed to be utilised well. Rob Chidlow acknowledged that it was a developing piece of work. There was a recognised mismatch between HUTH and NLaG data and data quality was extremely important.

Sue Liburd reflected that the item on IPR featuring later in the agenda was working well. Dr Kate Wood questioned why this item needed assurance and it was agreed to look at assurance as a piece of work in the New Year.

ACTION: The Committee to look at the process of assurance in the New Year

Assurance was agreed as limited.

4.7 **Individual Groups' Terms of Reference**

Amanda Stanford advised that Rob Chidlow would present the paper but that essentially, it was to provide some assurance around the structures. Rob advised that following the time out session in September, it was agreed that the workplan would be amended to build more focus on the challenging issues, noting that the Quality Governance Group was now known as the Patient Safety Learning Group (PSLG). The general feeling was that it was a good productive meeting, with good engagement and a structure was now building. Amanda recognised the good work that had been done by Richard Dickinson and the team and that a workplan and Chairs were now in place. It was felt that it would be the operational meeting to feed into this Committee. Also in place was the Patient Experience Group, which Mel Sharpe chaired which also had its own Terms of Reference, a Strategic Infection Committee and a Risk and Compliance Group, along with the Maternity and Neonatal Assurance Group and the Strategic Safeguarding Group, all of which would feed into this Committee.

Stuart Hall was pleased to see that these groups were executive-led and fed into this Committee but asked for clarification on how the executives were going to assure themselves within all these groups, to which Rob Chidlow replied that the structure was being looked at. Dr Kate Wood added that through the Care Group performance reviews starting in January 2025, information would be taken from such sub-groups.

Sue Liburd noted that this item was for information only.

5. ANNUAL REPORTS

There were none to discuss.

6. HIGHLIGHT REPORTS FROM SUB-GROUPS

6.1 **Patient Safety & Learning Group**

Stuart Hall believed the highlight reports were well structured papers.

David Sulch felt that as this Group was quite large and as a result, was a big meeting, that it may become difficult to lead, however, Dr Kate Wood responded that whilst she agreed with this statement, it was a big meeting because of the amount of Care Groups and it was still a good meeting, to which Rob Chidlow agreed.

Sue Liburd also liked the structure of the report in that they were easy to digest, and David Sulch agreed. He was approving and supportive of the framework and felt it was easy to digest. Sue Liburd hoped that they could act as a good example for other areas to emulate. Stuart Hall believed it was important to hold a meeting with David Sharif, Group Director of Assurance in this regard, and David Sulch thought it would be prudent for this Committee to feed back to the Board in a

similar way ie. Alert, Advise, Assure. The Committee in general were most approving and supportive of the framework of these highlight reports.

6.2 **Bi-Monthly Patient Experience Group**

As discussed above.

6.3 **Maternity & Neonatal Assurance Group**

As discussed above.

7**. ANY OTHER URGENT BUSINESS**

7.1 The following item was raised:

Workplan: Rob Chidlow informed the Committee that the workplan had been redrafted to reflect better the timing of some matters ie. a decision not to have a Committee meeting in January or August and the remapping of the sub-groups to ensure that the reports from these groups flow through to this Committee appropriately. However, the timeouts are scheduled in the first month after the end of the quarter and there may be a potential pressure in the Quarter 3 reporting, therefore this may not be a good suggestion, and it may be advisable to reschedule the January meeting and drop the December meeting instead. Sue Liburd wanted to gauge thoughts initially and David Sulch felt it prudent to leave as is currently, to see how matters progress until the middle of the next calendar year, after Quarter 1 25/26, but noted the concerns around potential delays in reporting.

Dr Kate Wood noted that Quality Priorities were not on the agenda. In view of the challenges coming into a group structure, it was proposed to continue with the current priorities. David Sulch felt this needed to be on the December agenda.

Dr Kate Wood and Sue Liburd thanked Rob Chidlow for all his hard work and support to the Committee, as it was noted that he was shortly to leave the organisation. Rob Chidlow in turn acknowledged the support he had received from the Quality Governance teams.

The Committee also thanked Stuart Hall for his invaluable contribution as he was shortly to leave his position as Non-Executive Director.

8. MATTERS TO BE REFERRED BY THE COMMITTEES

8. **Matters to be Referred to other Board Committees**

It was agreed that the following matters required referral to the Work, Education & Culture Committee:

Flu vaccination rates
Pharmacy neonatal post
Maternity Support Workers (MSW) pay deal

8.2 **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:

Winter pressures
ED oversight in relation to patient safety
Health and wellbeing of staff during winter
C&YP EPMA system
Potential deep dive into ophthalmology, audiology
CQC actions grip and control
Potential Induction of Labour deep dive next year
IPC BAF limited assurance
FNOF divided assurance between limited and reasonable
HUTH mortality data limited assurance
NLaG mortality data reasonable assurance

9. DATE AND TIME OF THE NEXT MEETING

9.1 **Date and Time of the next Quality & Safety CiC meeting:**

The next meeting to be held on Tuesday 17 December 2024 at 9.00am-12.30pm, in the Boardroom, Hull Royal Infirmary.

The committee Chair closed the meeting at 12.32pm.

Cumulative Record of Attendance at the Quality & Safety Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	Ma	Jun	Jul	Au	Sep	Oct	No	Dec	Jan	Feb	Mar
CORE MEMBERS													
Julie Beilby	Non-Executive Director							Y	Y				
Rob Chidlow	Interim Group Director of Quality Governance	Y	Y	N	Y	Y	Y	Y	Y				
Amanda Stanford	Group Chief Nurse	Y	Y	Y	Y	Y	Y	Y	Y				
David Sharif	Group Director of Assurance	Y	Y	Y	N	Y	Y	Y	N				
Sue Liburd	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y	Y				
David Sulch	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y	Y				
Dr Kate Wood	Group Chief Medical Officer	Y	N	Y	Y	D	Y	D	Y				
REQUIRED ATTENDEES													
Paul Bytheway	Interim Group Chief Delivery Officer			N	Y	Y		Y					

Tony Curry	Non-Executive Director	Y	N	Y	Y	Y	Y	Y	Y				
Richard Dickinson	Associate Director of Quality Governance	Y	Y	Y	Y	Y	Y	Y	Y				
Stuart Hall	Non-Executive Director	N	N	Y	N	Y		Y	Y				
Dr Ashok Pathak	Associate Non-Executive Director	Y	N	Y	N	Y	N	N	Y				
Yvonne McGrath	Group Director of Midwifery	N	N	N	Y	Y		Y	Y				
Michela Littlewood	Associate Director of Quality Governance	Y	Y	Y	Y	Y	Y	Y	N				
Alison Hurley	Deputy Director of Assurance	N	N	N	N	N		Y	N				
Sean Lyons	Trust Chairman	N	N	N	N	Y		N	N				
Linda Jackson	Vice Chair	N	N	N	Y	N	Y	N	N				
Rebecca Thompson	Deputy Director of Assurance	Y	Y	Y	Y	Y	Y	Y	Y				

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)025

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday, 13 February 2025
Director Lead	Helen Wright / Gill Ponder, Non-Executive Directors / Chairs of Performance, Education and Finance Committees-In-Common
Contact Officer / Author	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Performance, Estates and Finance Committees-in-Common meeting held on Wednesday 27th November and Wednesday 18th December 2024.
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	The minutes attached are for information.
Prior Approval Process	Performance, Estates and Finance Committees-in-Common on Wednesday 18th December 2024 and Tuesday 4th February 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:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 27 November 2024 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
Ivan McConnell	Group Chief Strategy and Partnerships Officer
Dr Kate Wood	Group Chief Medical Officer
Helen Wright	Non-Executive Director (HUTH)
Clive Walsh	Interim Group Chief Delivery Officer
Phillipa Russell	Deputy Director of Finance
Jane Hawkard	Non-Executive Director (HUTH)

In Attendance:

Simon Tighe	Group Deputy Director of Estates and Compliance & Information Services (item 4.5)
Rebecca Thompson	Deputy Director of Assurance (HUTH)
Lauren Rowbottom	Personal Assistant (Minutes)
Jenny Hinchliffe	Director of Nursing (South) (item 4.4)
Amanda Stanford	Group Chief Nurse (item 4.4)
Adam Creeggan	Group Director of Performance
David Sharif	Group Director of Assurance

Observers

Ian Reekie	Lead Governor (NLaG)
Karena Groom	Directorate Secretary

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 Mark Brearley, Interim Group

Finance Officer.

1.2 Staff Charter and Values

Gill Ponder 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 meeting held on 30 October 2024

The minutes of the meeting held on the 30 October 2024 were accepted as a true and accurate record.

1.5 Matters Arising

No items were raised.

1.6 Review of Effectiveness Outcome

David Sharif gave a verbal update and thanked respondents for participating in the survey: the response rate was not as anticipated and due to this each Committee will not receive an individual report. The results had been collated alongside the responses from other Committees-In-Common (CiC) and will be presented to the Board in December. Chairs of Committees will each receive a copy prior to submission to the Board.

Helen Wright wondered if it would be beneficial to revisit to attempt a higher response rate and gather valuable feedback. David Sharif stated the survey had been open longer than anticipated and colleagues had had a sufficient opportunity to complete it. Gill Ponder remarked that there had been a lot of changes to Committee members and attendees in recent months and that it might be better to wait until those currently attending had been present at a few meetings before repeating the exercise. David Sharif added that he would be happy to revisit this in 6 months' time.

Action: David Sharif to propose at the December Board to have a repeat of the Committee effectiveness review in 6 months' time.

1.7 Committees-in-Common Action Tracker

The following updates to the Action Tracker were noted:

Action Number	Subject	Action	Comments
3.1	BAF Report and Risk Register	David Sharif to arrange for the risk register to be updated to only show the short-term financial risk and the long-term financial risk be added to the BAF strategic risk register.	**Included in agenda items 3.1.and 3.2. Action can be closed.**
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. within the NLaG CQC report is updated to correctly reflect the timescales for production of the clinical strategy and the financial strategy.	**Agreed that the Finance papers going forward will include a section on progress with the development of the finance strategy.** **Carry forward to December when the progress update will be included in the finance report. The actual financial strategy is due to be completed in February.**
4.5	Estates and Facilities Update	Simon Tighe to update and re-present the north bank and south bank fire action plans.	**Included in agenda item 4.5, so can be closed.**
3.3.1	CQC Actions Report – Group	Adam Creegan to review the EOL CQC action and plan a meeting for those involved in this service to ensure this CQC action can be closed. Action owner changed to Ivan McConnell as the QI team are aware of action. Ivan to chase update on this action.	**Action not picked up. Carry forward to December.**
1.5	Committees-in-Common Action Tracker	Gill Ponder to refer issue to the Workforce, Education and Culture Committee regarding	**Referral completed to WEC. Closed.**

		the number of 25 occasions of violence and aggression between staff.	
4.1	Business Planning Timetable	Lauren Rowbottom to add the approval of the Business Plan to workplan.	**Business Plan had been added to the workplan for approval in February. Closed.**
4.2.1	Costing and Benchmarking	Ivan McConnell to bring a presentation on PA Consulting's work with the Group to the November CIC meeting.	**Ivan McConnell gave a detailed verbal update: Currently in week 6 of 6-week programme of work but have agreed to extend by an extra week free. Due diligence had been completed on the £85m challenge and identified actions and opportunities from reviews with the Care Groups.** **Identified multiple opportunities across theatres, outpatients and diagnostics.** **PMO function confirmed as insufficient and outlined a need for an engine room to underpin delivery of plans.** **<u>Ivan will share the detailed slidepack with members of the Committee.</u>**
4.4	Winter Plan	Lauren Rowbottom to add the Winter Plan on the agenda for the complete plan to come back to November's CiC. (Nick Cross, Jenny Hinchliffe and Amanda Stanford to attend)	**Verbal update from Clive at November's meeting.** **Winter plan going to the Board for approval in December before the next CiC, so agreed to close action.**

Action: Ivan McConnell to share the PA Consulting slide pack with members of the Committee.

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

Gill Ponder reported that no items had been referred for consideration at present to the PEF CiC.

3. RISK & ASSURANCE

3.1 Board Assurance Framework (BAF)

The report was taken as read and David Sharif provided an overview. The new BAF provided a more strategic approach and builds on risks shared with the Boards-in-Common. In future, the report would come to the CiC quarterly, alongside the Risk Register report.

He welcomed feedback from the report and highlighted that the key features of the new report had a clearer focus on actions and mitigations in place.

There were two risks which were aligned to this CiC and these were now linked more clearly to gaps in control and assurance. The BI investment and improving data quality action was pending a further conversation with Adam Creeggan.

Helen Wright voiced she wanted to see more around the mitigations and the journey to tolerable scores as she appreciated that it would not be possible to get to an 'Optimal' score quickly. She felt reassured to hear about the PMO support being put in place and the transformational changes taking place. She added that the work being carried out by PA Consulting would assist in mitigating some of the financial risk so consideration should be given to including that in the BAF.

Action: Lauren Rowbottom to amend the workplan for the BAF to come to the meeting quarterly in future. The next report will be February 2025.

3.2 Risk Register Report

David Sharif took the high-level risk report as read. This report was received at C&MP CiC and suggestions made in that meeting were helpful in improving the report further. These included tailoring the report to each CiC as the report itself was very detailed and covered more than just this CiC.

The next report will be in the same format, but will be a more condensed report focusing on items within the scope of this Committee.

David Sharif explained that the Finance in year risk was not on the risk register report as this was already an existing risk on the register, but was rated 12 so that would not appear as a high-level risk.

Helen Wright questioned if the risks had been effectively mitigated and added that it would be useful to see the pre and post mitigation scores in the report.

David Sharif stated that this report would be received quarterly at this CiC in future. The Committees requested that all high-level risks were included and not just those overdue for review. David Sharif mentioned that reporting was difficult with 2 different systems in use across the Group, but informed the CiC that a new system was due to be in place from April 2025.

Action: Lauren Rowbottom to amend the workplan for the risk register report to come to the meeting quarterly in future. Next report will be February 2025.

3.3 Review of Relevant External & Internal Audit Report(s) & Recommendation(s) as referred from the Audit, Risk & Governance Committee (ARG CiC)

There were no external or internal audit reports & recommendations to note.

3.4 Review of Relevant External Report(s), Recommendation(s) & Assurances(s) as appropriate

There were no external reports, recommendations or assurances to note.

COMMITTEE SPECIFIC BUSINESS ITEMS

4 Joint Business Items

4.1 Group Finance Report Month 7 and Update on progress with Financial Strategy

Phillipa Russell took the report as read. She highlighted that the year-to-date financial position was £15.2 million deficit in month 7 which was £1.5 million adverse to plan mainly due to a funding gap for pay award arrears. HUTH realised a £1.4 million gain relating to Elective Recovery Funding for last year and £2.0m of Balance Sheet flexibility, which were both non-recurrent so the underlying adverse variance was £4.6 million.

The Cost Improvement Plan (CIP) was ahead of plan at around £5.6 million overall. Due to the increased challenge in the second half of the year, Phillipa Russell explained that gaps would begin to emerge as the Group headed into the final months of the year. The forecast year end shortfall was £11.8 million, but if that was the outturn, it would still represent a £2 million improvement in the run rate. The PA Consulting work was aiming to improve on this position.

Capital expenditure was circa £20.6 million adverse to plan mainly due to CDC slippage, but mitigations had been agreed to ensure that the capital was spent and delayed schemes could be completed next year.

The Group's cash balance was significantly better at £78 million, due to receipt of deficit, pay award and Education Contract funding.

The current year end forecast outturn was a £20.7 million gap to plan, with a best-case scenario forecast of £13.5 million. Phillipa Russell advised that the Group were working with the local system and PA Consulting to ensure that everything possible had been done to close this gap before formally revising the year end forecast, in line with the required protocol. An updated forecast and recommendation would be brought to the CIC in December.

Action: Phillipa Russell to circulate details of the forecast revision protocol to members of the Committees-in-Common following this meeting.

Action: Phillipa Russell to bring the month 9 updated year end forecast and recommendation to December's meeting.

Helen Wright queried what the risk would be for cash at HUTH if they broke forecast at month 9. Phillipa Russell stated that cash support would be required by the end of January if HUTH cannot close a gap of £17 million. Jane Hawkard questioned if any other ICBs had declared that they could not meet the forecast and Phillipa Russell stated that nobody had declared regionally.

Jane Hawkard wondered why we would wait until month 9 to declare. Phillipa Russell explained that there were a number of steps that needed to be in place first, such as ensuring there is no further balance sheet flexibility, testing all forecast assumptions, looking at unpalatable options, increasing cost controls further and carrying out a peer review. She noted that all options had not yet been exhausted.

Helen Wright felt reassured that this was a known issue across the NHS and would not come as a surprise.

Gill Ponder asked for clarification on the stretched income target referred to on page 3 of the report and asked if that was the same target as the £8.1 million referred to on page 7 and Phillipa Russell replied that it was.

Gill Ponder felt unconvinced around grip and control and wondered if there was a lack of financial discipline due to overspending and under delivery of CIP, particularly at HUTH. Phillipa Russell did not disagree that there could be more grip and control, but the underlying position at HUTH was slightly more challenging due to the size of the site and added that NLAG's deficit was a higher percentage of turnover.

Gill Ponder questioned if 101% ERF forecast was realistic given the Group was in the winter period already and the holiday season was next month. Phillipa Russell explained that the forecast assumed a level of delivery following productivity and efficiency improvements. Clive Walsh agreed with Gill Ponder that services will be under more pressure, but the North Bank's Castle Hill site was largely protected from Winter pressures due to emergencies going to Hull Royal Infirmary.

Gill Ponder praised the reduced nurse agency spend and wondered if Medical Staffing planned to do the same. Dr Kate Wood stated that she chaired a monthly Medical Workforce sub-group alongside Simon Nearney where this was a main focus. Gill Ponder questioned if everything was being done that could be done to fill the 20% of vacant posts and Dr Kate Wood insisted that the Teams were doing everything they could on recruitment and retention, especially in a difficult to recruit to organisation.

4.1.1 Costing and Benchmarking Financial Strategy and Recovery Plans

This agenda item was covered within Ivan McConnell's earlier verbal update on PA Consulting's work within the action tracker updates.

4.2 Update on Business Planning - Operational Planning for 2025/26

Adam Creegan took the report as read. The steps taken since the last update were that all Care Groups had received their local guidance on expectations and all support and training tools have been put in place. Further work was underway with the Care Groups and the engagement would be concluded by the end of November.

On 18 December the Care Groups would review key themes and concerns following the engagement piece. National guidance was due on 23 December 2024 and planning would be adjusted accordingly.

Phillipa Russell advised that she would bring a further updated financial plan to the next CiC on 18 December 2024.

Jane Hawkard noted that the South Bank had a Planning and Transformation Group and wondered why the North did not have one. Adam Creeggan replied that there was one, but it did not work in the same way. He added that HUTH tended to use the Task and Finish Group process.

Jane Hawkard observed that it was important to learn lessons from previous experience and not be driven towards a plan that is unachievable for next year. Ivan McConnell anticipated that the work being done now would hopefully allow for a better position this time next year.

Clive Walsh added a potential risk of delays to the national guidance because the Secretary of State would be conducting a review of NHS priorities in the Spring.

Gill Ponder wondered if there was potential to do zero-base budgeting rather than basing budgets on previous budgets. Ivan McConnell acknowledged this but stated that it was a big piece of work to do that. Historic rollover budgets did not match current demand and capacity, but many changes were made to take account of this during the business and operational planning process, with underspends added to the CIP opportunity pipeline.

The Committees-In-Common agreed to limited assurance regarding achievement of the plan, but were reasonably assured that everything that could be done was being considered to reduce the gap. They highlighted for escalation to the Boards-in-Common that currently the Group was off plan, but appreciated a lot was being done to improve on the position. They also wanted to highlight that by month 9 the Group would more than likely have to declare a revised year end forecast and the remaining risks to the cash position, especially if there was under delivery on the CIP programme. However, PA Consulting were supporting the Group in improving the financial position and that work would also give a better platform for the start of 2025/26.

Jenny Hinchliffe and Amanda Stanford joined at 10.45am

4.3 Group Integrated Performance Report

Adam Creegan took the report as read.

Elective Care

Adam reported on the elective care performance, noting that the Group was the best performing in the best performing region for eliminating patients waiting over 65 weeks, with 13 at HUTH and 5 at NLAG. However, he highlighted the challenge of increasing numbers of 52-week waiting patients due to prioritising clearing 65-week waits, which would pose a threat to maintaining the 65-week performance if it was not addressed. The organisation had been set a goal of having no more than 8 patients waiting over 65 weeks by the end of December 2024 and he felt confident this was achievable. The organisation was now being recognised as one of the best at capped theatre utilisation, as previous issues with the Model Hospital reporting methodology had been corrected.

Adam Creeggan noted that the Group continued not to meet the RTT performance standard and explained that there had been a 7% growth in referrals, which had led to a proportionate increase in the Patient Tracking List (PTL). This was in the context of an expected reduction in demand in the current year's operational and financial plan. This would result in more patients waiting over 52 weeks than had previously been targeted next year.

Helen Wright noted the positives on improvements in performance.

Gill Ponder questioned why there were 40 cancelled operations due to no theatre time. Adam Creeggan stated this was due to several things such as patient complexity, poor planning, productivity and late starts. He explained that a process was in place called '642' that looks at the data on how long operations take and enables more challenge on overbooking and under booking lists.

Gill Ponder also questioned what was being done about the fact that both Trusts were 9.8% above the follow-up appointment activity plan. Adam Creeggan

responded that the outpatient transformation programme was being reviewed by PA Consulting, as this was an opportunity to increase capacity for first appointments for patients on the waiting list.

The Committees-In-Common agreed limited assurance for this item.

Diagnostics

Adam Creegan highlighted significant improvements in Group diagnostics performance, particularly in DEXA activity. Both Trusts were at 17.4% on DM01, which was an improvement for HUTH, but a slight deterioration for NLAG, due to equalising waiting times across the Group.

There was a 20% reduction in patients waiting for a diagnostic test and a 50% reduction in those waiting over 6 weeks. The organisation had made an improvement of 50 places on DEXA, going from being the worst in the country to the top 50% by using mutual aid across the Group. He noted an issue with audiology data quality at HUTH that is currently being investigated to understand the cause and scale of the problem, including if any patients had suffered any harm as a result. He would bring a report back to the CiC once investigations were complete.

Action: Adam Creeggan to bring a report back to the Committees once the investigations were complete into the recently discovered data quality issue at HUTH in audiology.

The Committees-In-Common agreed reasonable assurance for this item. They would highlight to the Board the data quality issue under investigation and the significant improvement in diagnostic performance.

Cancer

Adam Creeggan reported improvements in the enabling measures for Cancer 62 day performance, particularly the 28-day Faster Diagnosis Standard (FDS). The FDS position was expected to be around 80% for both Trusts from October and the number of decisions to treat by day 38 had also improved. Improvements in these enablers would lead to sustainable improvement in the 62-day standard.

Gill Ponder queried the data within the report that showed 62-day performance had improved by 5% but further into the report it stated that it had got worse by 9.7%. Adam Creeggan emphasised that this was an error due to tight deadlines with data and it was definitely an improvement of 5%.

Gill Ponder wondered if there had been resolutions to the head and neck pathway issues referred to in the report. Clive Walsh was unsure currently and would bring a further update on this to the next meeting.

Action: Clive Walsh to investigate the issues in the head and neck pathway, plans to resolve those issues and provide an update at the next CiC.

The Committees-In-Common agreed limited assurance for this item as the 62-day standard had not yet shown sustainable improvement. The CiC would highlight the improvements made in the enabling measures to the Board.

Urgent Care

Adam Creeggan discussed the challenges in urgent care, noting significant improvements in reducing the number of patients with no criteria to reside, but highlighted the impact of increased demand and GP collective action on performance. He highlighted the positive impact that Rossmore had on helping improve flow. Eight months previously HUTH was running at around 200+ No Criteria to Reside (NCTR) patients and the current data showed an improvement of 140 patients.

The team were working on improvements in ED delivery from the front of the pathway, three core objectives had been identified for improvement and from the metrics they were seeing positive improvements. Sustained improvement had been seen at NLAG where performance was 10% better, but HUTH's performance had deteriorated due to an anomalous 7% growth in demand. This had resulted in congestion in ED due to a shortage of assessment spaces and a deterioration in ambulance handover times. Handover processes and systems were being worked on to improve the handover time.

Jane Hawkard queried whether capacity was going to increase alongside the expected increase in activity over winter. Clive Walsh explained it would be more of an increase in Length of Stay (LoS) rather than an increase in demand and the Group has tried to plan around this.

Gill Ponder questioned if the number of ambulance handovers was the number of ambulances waiting or an aggregate number of people. Adam Creeggan explained it was an aggregate number of people waiting rather than ambulances, as there could be more than one patient on an ambulance.

Helen Wright commented that it was useful to see the trends and the data.

The Committees-In-Common agreed limited assurance for this item due to the lack of an overall sustained improvement in performance, but the CiC was reasonably assured by the improvements sustained at NLAG due to the level of grip and control over ED performance and risks. The CiC wished to highlight to the Board the increase in demand and the differences between the level of resources available to manage ED performance and risks at each site.

Simon Tighe joined the meeting at 11.15am

4.4 Winter Plan Deep Dive – Verbal Update

Clive Walsh gave a verbal update. He apologised for not having the winter plan for members to see before the meeting. The winter plan had been signed off by Cabinet and would be circulated after the meeting. Planning for next Winter would

be included in the business and operational planning exercise currently underway for 2025/26.

There was a Multi Agency Discharge Event (MADE) underway which commenced on Monday 25 November. This event would be used to improve pathways and relationships with external partners and help educate staff on what support for patients is available externally from the hospital.

There was a plan in place to improve flow on a small number of wards, supported by PA Consulting. Advice had been received from the ICB to embed the changes before widening the scope to include more wards.

The virtual wards on the South Bank had expanded capacity from 12 patients to 25 from December and the criteria for admission to a virtual ward had been broadened.

There were schemes in place to provide capacity and increase safety, as a 6% increase in demand had been assumed in the plan. These included £130k invested in Site Management on the North Bank to help manage ED performance and risks, £250k to increase community capacity and £650k on a number of internal schemes that could be mobilised and deliver results quickly, including paediatric service expansion and pharmacy in-reach. The winter plan included management, risk and escalation processes.

Jenny Hinchliffe gave an update on the current flow initiatives. At HUTH the congestion in the ED department was having a direct impact on flow, including pressure from the community and long ambulance waits. The teams were working closely with the QI team on improvement initiatives, focusing on patient safety, care and experience. Jenny Hinchliffe explained that she was working with clinicians on pathway 0 patients and work was taking place on board and ward rounds to ensure they identify discharges early and utilise the discharge lounge. There was a pilot over the next 2 weeks, targeting wards where the most support was needed but she noted that a lot relied on changing culture, job plans and other issues.

Other activities included longer term investment in virtual wards, the Home First initiative, working with system partners to assess patients in the community and a particular focus on the top 150 high intensity users of the ED service.

The discharge lounge on the North Bank only had. 12 chairs on Ward 1 and required beds to improve flow from ED. Work was ongoing to find a solution.

Amanda Stanford updated that the 13th floor (Rossmore) had never closed and this was classed as additional capacity. There was a further question around ward C20 at Castle Hill and how this ward was utilised. She also added that there was a piece of work to clarify temporary escalation spaces as the organisation needed to be clear about what they were, how they were managed and staffed as they were not purpose built for taking patients.

There were concerns around the Health and Wellbeing of staff through winter after a challenging summer and now with respiratory infections on the rise it was putting

more strain on staff. The Group was looking at additional support for all staff to keep them well as this had been proven to have a direct relationship to patient experience.

Clive Walsh observed that there was a good plan around flow and virtual wards, led by experienced clinicians. Although overall the Group was in an uncomfortable place with the delay to the winter plan, after some research it appeared to be same across other trusts. Cabinet had seen three iterations of the Winter Plan and they were now satisfied everything had been done that could be done. The Winter Plan would be managed by the Unplanned Care Board. Further assurance was provided by the ongoing work with PA Consulting, the ongoing MADE event, the requirement for investments to be supported by short business cases and ICB peer reviews. To summarise, to create additional capacity in ED, flow had to be improved to prevent ED being used as a ward.

Action: Clive Walsh to circulate the approved Winter Plan after the meeting.

The Committees-In-Common agreed reasonable assurance for this item. They highlighted that the Winter Plan had been agreed by Cabinet, but the verbal update had provided assurance on plans being put in place to manage flow, the MADE event and additional investment. They also felt it was very important to highlight the need for focus on staff Health and Wellbeing to the Board.

Jane Hawkard went on to praise the commitment to the plan.

Jenny Hinchliffe and Amanda Stanford left at 11.54am

4.5 Estates and Facilities – General Update to include Fire Action Plans

Simon Tighe took the report as read and stated the fire action plans were now in a format that was consistent across the Group. Overall, there were no high risks relating to fire and if any emerged, they would be linked to a high-risk action plan. The South bank fire Authorised Engineer had also been appointed on the North Bank, which would provide consistency.

Clear plans were in place to spend the remainder of the Capital plan and unallocated funds in the last 4 months of the year.

A paper was going to Cabinet in December regarding Car Parking charge increases. Following this, PEF would receive an update for review.

The Catering tender at Grimsby main entrance had received 4 expressions of interest and the decision on who had won the contract would be decided by December 2024. The family services coffee shop at Grimsby would be managed in house and would be open by January 2025.

Gill Ponder praised the report and structure. She turned attention to the number of actions in the fire action plan that have timescales over 2-3 years and questioned if these should be completed sooner. Simon Tighe replied that a detailed risk assessment process had been used to determine the priorities to focus on with the

resources available.

Gill Ponder queried whether the PSDS bids deadline had been met. Simon Tighe responded that it had been met and 3 bids had been submitted. There was a 2–3-month technical assessment period and a further update would be presented at the December meeting. He also advised the CiC that the scheme now required the Group to match any grants awarded.

There was a discussion around the TV and bed services for patients which were being reviewed.

Simon Tighe left the meeting at 12.00pm

The Committees-In-Common agreed reasonable assurance for this item. They highlighted the comprehensive fire actions plans that were in place, the harmonisation across the group with the appointment of the same Authorised Engineer and the submission of the PSDS bids.

4.6 Procurement Improvement Plan / KPI's

Phillipa Russell took the report as read. The Group had delivered savings of £5.9 million out of a £6.9 million target. There was a high level of confidence that the remainder of the savings for 2024/25 would be delivered and work had begun to review next year's target.

Jane Hawkard commented that she would like to see what the impact of procurement savings would be if the 15% vacancy rate was filled. Ivan McConnell stated that there were 221 expired contracts that needed to go through the PSR process.

Gill Ponder wondered when there would be a focus on contract management. Ivan McConnell voiced that the contract management team was small so they were not involved in all contracts, but this could be considered as part of the Procurement opportunity work with PA Consulting. Helen Wright added that in the Capital and Major Projects CiC the day before there was a discussion where the procurement team had not been involved in major projects historically. Going forward, she wanted reassurance that the procurement team were included.

The Committees-In-Common agreed they had reasonable assurance for this item. The CiC wanted to highlight the high level of confidence in delivering the planned savings for 2024/25, the 221 expired contracts, the level of vacancies and the spend to save opportunities that may be available.

4.7 Emerging Issues

No emerging issues were raised.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

The Committees-In-Common raised work plan amendments through the meeting.

5.2/ Consolidated North Bank Site Report /
5.3 Consolidated South Bank Site Report

Helen Wright wanted to know more about the operational improvements and effectiveness of these Committees, as it appeared from the reports there was a lot of work happening and she questioned if the team were just being busy or effective. Adam Creeggan explained that these meetings were being developed further following changes within the Executive team.

5.4 Planned Care Board Meeting Minutes

There were no minutes received.

5.5 Unplanned Care Board Meeting Minutes

There were no minutes received.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

Helen Wright reemphasised the focus on the Groups values and culture, ensuring that all staff live through these values. She had observed a number of positive things through the meeting that overall had a positive impact on culture, such as transformational change, PA Consulting activities and lots of work and initiatives around flow. She felt it was particularly important that there was a focus on staff health and wellbeing when enacting the winter plan.

Helen Wright expressed it felt positive to have transparent conversations around financial plans and what was needed to improve.

Jane Hawkard wanted to know more about what will be done to support staff's health and wellbeing. Clive Walsh reassured that a health and wellbeing plan would be launched around January/February time.

Adam Creeggan commented that some of the wordings around assurance could potentially give a negative emotion and be demotivating to staff, such as 'reasonable' and could a further assurance assessment be done to help improve this. Jane Hawkard suggested that the word reasonable could be changed to good.

Action: David Sharif to consider if there is a better way to word assurance ratings and bring a plan to the NED meeting.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

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

7.2 Matters for Escalation to the Trust Boards

Items for escalation to the Trust Board were captured within the summaries at the end of each section.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and time of the next PEF CiC meeting:

Wednesday, 18 December 2024 ~~Boardroom, Hull Royal Infirmary.~~

It was agreed that December's meeting would be shortened as data for performance reports would not be available in time for the meeting. The main focus of the meeting would be around Finance, planning, and estates and facilities with just a verbal update on key issues on performance, such as ED pressures. As the meeting was very close to Christmas, it was likely that some attendees would be on leave that week creating additional pressure on others, so a virtual meeting would be considered.

The meeting closed at 12.30pm.

Cumulative Record of Attendance at the PEF CiC 2024/2025

Name	Title	2024											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	
Helen Wright	Chair / Non-Executive Director (NED - HUTH)						Y	N	Y	Y	D	Y	
Lee Bond	Group Chief Financial Officer	Y	D	Y	Y		Y	Y	Y				
Mark Brearley	Interim Group Chief Financial Officer									Y	Y	D	
Jane Hawkard	NED (HUTH)	Y	Y	Y	Y		N	Y	Y	Y	N	Y	
Simon Parkes	NED (NLaG)	Y	Y	Y	Y		Y	Y	Y	Y	D	N	
Shaun Stacey	Group Chief Delivery Officer	Y	Y	Y	Y								
Paul Bytheway	Interim Group Chief Delivery Officer						Y	Y	Y	D	Y		
Clive Walsh	Interim Group Chief Delivery Officer											Y	
Dr Kate Wood	Group Chief Medical Officer	D	Y	D	Y		Y	Y	D	N	Y	Y	
REQUIRED ATTENDEES													
VACANT	Group Director of Estates	D	D	D	D		D	D	D	D	D	D	
Andy Haywood	Group Digital Information Officer	N	N	Y	N		N	N	N	N	N	N	
David Sharif	Group Director of Assurance or deputy	D	D	Y	Y		Y	Y	Y	Y	Y	Y	
Alison Drury	Deputy Director of Finance (HUTH)	Y	N	N	N								
Brian Shipley	Deputy Director of Finance (NLaG)	Y	Y	Y	N		Y	N	Y	N	N	N	
Stephen Evans	Operational Director of Finance (HUTH)	Y	Y	N	N		N	N					

Ian Reekie	Governor Observer (NLaG)	Y	Y	Y	Y		Y	Y	Y	D	D	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

PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Wednesday, 18th December 2024 at 09:00 to 12:30 hours on Microsoft Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Helen Wright	Non-Executive Director – Chair (HUTH)
Gill Ponder	Non-Executive Director (NLaG)
Ivan McConnell	Group Chief Strategy and Partnerships Officer
Dr Kate Wood	Group Chief Medical Officer
Clive Walsh	Interim Site CEO (North)
Jane Hawkard	Non-Executive Director (HUTH)
Emma Sayner	Group Chief Finance Officer
Simon Parkes	Non-Executive Director (NLaG)

In Attendance:

Craig Hodgson	Associate Director of Commercial Services (NLaG) (Item 4.4)
Rebecca Thompson	Deputy Director of Assurance (HUTH)
Lauren Rowbottom	Personal Assistant (Minutes)
David Sharif	Group Director of Assurance
Phillipa Russell	Deputy Director of Finance
Linda Jackson	Vice-Chair (NLaG)

Observers

Ian Reekie	Lead Governor (NLaG)
Karena Groom	Directorate Secretary
Tom Myers	Group Director of Estates

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 Adam Creeggan, Group Director of Performance and Sarah Tedford, Group Site CEO (South).

1.2 Staff Charter and Values

Helen Wright noted the Staff Charter and Group Values and reminded everyone to follow and live through 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 meeting held on 27 November 2024

The minutes of the meeting held on 27 November 2024 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.	**Agreed that the Finance papers going forward will include a section on progress with the development of the finance strategy.** **Carry forward for progress update to be included in the finance report. The actual financial strategy is due to be completed in February.**
3.3.1	CQC Actions Report – Group	Adam Creegan to review the EOL CQC action and plan a meeting for those involved in this service to ensure this CQC action can be closed.	**Ivan updated this was still work in progress due to sickness. Bringing back for 4th February.** Notified post meeting that data is being collated –

			confirming with CQC team that this action can be closed.
4.1	Business Planning Timetable	Lauren Rowbottom to add the Business Plan update to December's agenda and the Workplan.	**Business planning Update added to Decembers Agenda.** **Action can be closed.**
1.6	Review of Effectiveness Outcome	David Sharif to propose at the December Board to have a repeat of the Committee effectiveness review in 6 months' time.	**There is a paper going to the next NED meeting on 19 Dec on the assurance rating action.** **The Board meeting on 12 Dec will cover off the other action re effectiveness.** **Timescale to be moved to May 2025.**
1.7	Committees-in-Common Action Tracker	Ivan McConnell to share the PA consulting slide pack with members of the Committee.	**On the agenda for December's meeting. Can be closed.**
4.1	Group Finance Report Month 7 and Update on progress with Financial Strategy	Phillipa Russell to circulate details of the forecast revision protocol to members of the Committees-in-Common following this meeting.	**This was circulated to members of the Committee by Lauren Rowbottom. Action complete.**
6.1	AOB	David Sharif to consider if there is a better way to word assurance ratings and bring a plan to a NED meeting.	**To be discussed at NED meeting this week. Carry forward to February.**
4.3	Group Integrated Performance Report	Adam Creeggan to bring a report back to the Committees once the investigations were complete into the recently discovered data quality issue at HUTH in audiology.	**To leave on the action tracker, work in progress. Update in February's meeting.**
4.3	Group Integrated Performance Report	Clive Walsh to investigate the issues in the head and neck pathway, plans to resolve those issues and provide an update at the next CiC.	**Additional capacity from January 2025. Another Locum consultant starting in January. Want to see the result of this. To bring an update to the next meeting.**

2. MATTERS REFERRED

2.1 Matters referred by the Trust Board(s) or other Board Committees

Gill Ponder reported that there were debates around the BAF score of 25 for the finance risk around long-term sustainability at the December Board.

Action: David Sharif and Emma Sayner to facilitate a paper to help with the discussion around the finance BAF risk score at Februarys PEF.

3. RISK & ASSURANCE

3.1 Review of Relevant External & Internal Audit Report(s) & Recommendation(s) as referred from the Audit, Risk & Governance Committee (ARG CiC)

Emma Sayner gave a brief overview of the report which focused on CIP. This will be discussed in more detail at the next ARG CiC in January 2025.

Helen Wright noted that the contents of the report was covered within the PA Consulting report on this agenda and this transformation programme was required to improve the CIP process. PMO needs to be strengthened to support this work.

Emma Sayner agreed that there had been a huge amount of work done since the audit was undertaken and one of the biggest areas to work through was the PA Consulting proposals. She stated she was working with the Group Chief Nurse and Group Chief Medical Officer to ensure the Trust had a multi-disciplinary understanding of ambition in relation to cost improvements.

3.2 Review of Relevant External Report(s), Recommendation(s) & Assurances(s) as appropriate

There were no external reports, recommendations or assurances to note.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

<u>Joint Business Items</u>

4.1 Group Finance Report Month 8 including updated forecast and recommendation

Phillipa Russell gave a verbal update and shared a presentation on the screen. She reported a year-to-date deficit of £18 million, with a £2 million adverse variance to plan, primarily due to pay award pressures.

Philippa Russell noted that the year-to-date capital expenditure was £20.6 million, which was £16.5 million below plan. The organisation continued to manage cash reasonably well, potentially avoiding the need for cash support until the end of the

year.

Philippa Russell highlighted the elective recovery performance, with the group slightly below plan year-to-date HUTH was performing slightly better than NLaG.

She presented the forecast scenarios, with the best case being a £14 million deficit, the likely case a £20.7 million deficit and the worst case a £43.9 million deficit, emphasising the need for further actions to improve the financial position.

She then went on to outline the action plan to address the financial gap, which included balance sheet flexibility, elective capacity improvements, PA Consulting opportunities and additional income sources, with Emma Sayner providing context on system-wide income opportunities.

Gill Ponder queried if there were more opportunities in grip and control and the unpalatables. Philippa Russell updated there had been a discretionary spend panel now put into place that started within the last week, with a lot more work to follow in the new year.

Simon Parkes queried how much provision was left of the annual leave release. Philippa Russell explained the action plan assumed everything comes out but currently the policy on carrying forward any leave misaligns with the position of having no annual leave accrued and this posed a risk.

Dr Kate Wood suggested sharing the details of the run rate in the next report as next year cost savings would be identified such as license duplications getting aligned across the North and South bank.

Helen Wright thanked Philippa for the update. The Committee agreed to revisit this at the next meeting to determine whether the Group should be breaking protocol. Gap closing activities are still being undertaken.

4.1.2 Presentation on the PA Consulting work

Ivan McConnell gave an update on PA Consulting work. Currently the group have PA support up until 1 January 2025. A proposal for further support in Q4 had been submitted and this was awaiting approval.

Ivan McConnell highlighted significant opportunities identified by PA Consulting for 2025-26, including outpatient transformation, diagnostics and theatre productivity, with a focus on maximizing income generation and improving patient flow.

The need for a robust PMO (Project Management Office) to manage the transformation programme was emphasised, noting the current lack of complex programme directors and the importance of building internal capability. There was also a need for the PMO to run a Delivery Engine Room and this posed a financial risk. Further financial risks were also identified associated with the transformation programme, including the need to address non-recurrent savings and the potential impact of unpalatable decisions on workforce and service delivery.

Ivan McConnell outlined areas of opportunities. Theatres had 17 potential areas to be improved and of those, 4 had been prioritised. Outpatients identified 18 areas of improvement opportunities and 4 areas were being prioritised. Rossmore was currently running at 92% occupancy and No Criteria to Reside (NCTR) reductions had been identified.

Emma Sayner outlined the next steps, including securing regional approval for PA Consulting support, building internal PMO capability and ensuring the transformation programme is aligned with financial and operational goals.

Gill Ponder referenced in the report the 'golden patient' and wondered how those patients were identified. Dr Kate Wood explained the process of the 'golden patient' which identifies patients on a theatre list who don't require much preparation and are deemed to be more straightforward than complex patients. This process allows staff to prepare the more complex patients whilst still ensuring the theatre list runs to time.

Linda Jackson wondered what plan B was if the business case for PA Consulting support was not approved. Emma Sayner reassured her that the risk of it not being approved was very low.

The CiC wished to highlight to the Board the finance forecast and likely deficit of £20.7 million and a best case of £14 million and the need for further support for external assistance from PA Consulting. There is Limited Assurance that the plan will be achieved, but reasonable assurance that everything possible is being done to minimise the gap. They also commended work around Rossmore.

4.2 Update on Business Planning

Ivan McConnell updated that the second operational planning meeting was held on 18 December and was expecting planning guidance to be available early January 2025. First cut activity plans had been submitted and the second cut submissions would be on 17 January. There had been no concerns raised.

The Committees-In-Common agreed reasonable assurance.

4.3 Performance Update / Deep Dive: Diagnostics *(October Data)* including update on Audiology Data Quality

Clive Walsh gave a verbal update. He noted a transcription error within the report, NLAG performance should have been 73.4%.

Urgent Care (UEC)
Performance against the 4-hour standard was not improving and the Group would be moving to tier 1 for further support with UEC at the end of January 2025. Across the country a lot of trusts were not delivering at the rate of improvement required. Clive Walsh outlined a number of improvement opportunities to increase the speed of ambulance handover of patients and improvements within the emergency pathways. The team had worked with CHCP to have 1 of their staff members in

triage alongside a HUTH ED staff member, this had allowed an ED Consultant to help with the ambulance queues and minimise patient risk.

The South bank had seen an increase in congestion at the front doors of ED.

Gill Ponder wondered when we would see benefits of the winter plan. Clive Walsh updated that this was being phased, with additional pharmacy support starting next week.

Jane Hawkard felt it would be useful in future reports to see the information on the 3 key enablers that were being prioritised, including time to see first clinician.

Clive Walsh added that there was a business case to look at employing three additional consultants in ED now, which had been approved. A case for a further 3.7 Consultants was also being reviewed. The Executive team had asked for further information on the distribution of clinical care.

Action: Clive Walsh to create a trend diagram of the three key enabling metrics for urgent care and present it at the next meeting.

Action: Clive Walsh to provide an update on the recruitment of three additional Consultants for urgent care, including expected start dates and impact on performance.

Cancer
Clive Walsh highlighted improvements in the 28-day faster cancer diagnosis standard, with HUTH slightly under and NLaG slightly over the 77% target, but noted no significant improvement in the 62-day treatment standard yet, as it would take time for the pathway improvement actions to feed through into that performance measure.

Elective
Clive Walsh gave a brief update on the Elective performance across the group. He reported there would be around 40-45 patients who were going to be over 65 weeks by 22 December, but that figure was expected to be reduced by 31 December. There was a need to treat patients waiting the longest and to increase total activity levels to keep pace with demand and reduce the overall waiting list. He planned to have a look at previous data presented to determine why reasonable assurance was provided that the target would be met at the last CiC meeting.

Gill Ponder questioned why the 65-week waiters had increased compared to previous months of reductions. Clive Walsh explained that the Group always had patients on the verge of tipping over onto the 65-week wait mark and many of those patients were within ENT, Cardiology and Plastics where capacity constraints were greatest. The Head and Neck Care Group had been questioned to see if there was anything more that could be done to increase activity levels.

Action: Clive Walsh to conduct a review to understand why the assurance level for 65-week waiters was inaccurate at the last CiC meeting and present the lessons learned at the next meeting.

Clive Walsh expressed concern about not having an ERF process or enough money in the system to maintain maximum waits performance. Gill Ponder asked if this had been flagged as a risk and David Sharif stated that he would check this was logged on the risk register.

Action: David Sharif to check if the ERF funding process was logged on the risk register.

Deep Dive - Diagnostics *(October Data)* including update on Audiology Data Quality

Clive Walsh gave a detailed report on Diagnostic services, as part of the CiCs deep dive into that area. The overall position had improved with the Group comparing well to other providers and there were similar issues with diagnostics across the ICB. The standard to meet next year would be no more than 5% of patients waiting over 6 weeks, which is a challenge versus current performance levels. The Group was undertaking more diagnostic activity and bringing waiting times down, but the number of patients on the waiting list was still increasing due to increased demand.

Clive Walsh stated that he wished to bring a further detailed report to the March meeting on the data quality issues within Audiology, after any potential harm had been reviewed by the Quality and Safety Committees in Common at their February meeting.

Shifting some work to the Community Diagnostic Centres (CDC) would enable main hospital sites to increase overall activity levels. Clive Walsh felt confident that this would help get on top of the total volumes and the backlog.

Clive Walsh added that he was undertaking a lot of work within financial and operational planning, supported by PA Consulting, to address the mismatch between demand and capacity in endoscopy, which had been exacerbated by the work on the washers which had taken longer than expected. There was an opportunity to bring the Allam Building online in 2025 to help create extra capacity in Endoscopy. The Emergency Department had been using the endoscopy department to care for patients overnight due to pressures in ED.

The national bowel screening programme were looking at changing who gets referred for further investigations, with the screening age potentially dropping to 50 and a possible reduced sensitivity threshold for the test. This would present a risk of a 33% increase in demand for colonoscopies.

Ivan McConnell updated that the CDC would allow more opportunity for more tests each year and would allow the group to shift activity from acute sites. NHSE had advised that the provisional CDC business cases had been changed and tariffs reduced resulting in a £2m loss unless action is taken to offset that.

Gill Ponder wondered if the non-obstetric ultrasound decisions at HUTH and NLaG were compatible with that requirement. Ivan McConnell explained it was not incompatible and non-obstetric ultrasounds formed part of the CDC contract.

Gill Ponder highlighted the mutual aid in DEXA across the Group to equalise waiting times and asked why there was a reduction in diagnostic tests in October. Clive Walsh stated he would check this and feedback.

Action: Clive Walsh to confirm whether the reduction in the number of diagnostic tests performed in October for DEXA scans is due to mutual aid scans not being reflected in the graph.

The Committees-In-Common agreed limited assurance and highlighted concerns around sustainability. They wanted to escalate the pressures within ED, issues around flow and the time to see first clinician, as well as the ambulance handovers and entering tier 1 for support. Furthermore, they were concerned around the 65-week waiting patients, the size and shape of the waiting lists, lessons learnt from 65 week wait assurance at the last meeting, improvements in FDS performance that had not yet been reflected in improvements in the 62 day standard and the risk to future ERF funding and CDC income.

Craig Hodgson joined the meeting at 11.36am.

4.4 Estates and Facilities - General Update including PSDS Bid Values

Craig Hodgson provided an update on estates and facilities, including the Estates Return Information Collection (ERIC) data submission, staff parking charges, retail catering and the retail tender exercise.
He highlighted that the ERIC data in Model Hospital had not been published yet and this was expected by January 2025.

The PSDS bid break down had been embedded within the report and they were still waiting to hear the decision on these.

Craig Hodgson highlighted that staff parking charges were being reviewed. There was a proposal to increase and align to pay bands. The team were continuing to look at service options within the community and linking with system partners.

HUTH's retail performance review was on-going and recommendations had been made to Cabinet.

The estates team were reviewing patient entertainment bed services in conjunction with the digital team and they were also looking at harmonising the cleaning services across the Group.

The Total Facilities Management on the South bank contract had been signed by both parties and the retail tender exercise was concluding. The outcome would be presented to February's meeting.

Gill Ponder queried if the money would be available if the PSDS bids were successful. Craig Hodgson explained that the bids needed to be made and, if

successful, a decision can be made whether to progress, which would include alignment of the match funding required.

Jane Hawkard wanted further reassurance that the Capital meeting understood what was behind the critical infrastructure numbers. Craig Hodgson stated it all went through the risk register and a confirm and challenge process.

The Committees-In-Common agreed reasonable assurance and wanted to highlight plans to reduce the Backlog Maintenance and Critical Infrastructure Risks from allocated capital and Public Sector Decarbonisation Scheme (PSDS) funding. Whilst funding was nowhere near the level needed to eradicate those risks, significant improvements would be achieved in 2025/26 as a result of the PSDS work being carried out at Scunthorpe Hospital.

Craig Hodgson left the meeting at 11.59am

4.5 Contract Approvals

There were no contracts for approval.

4.6 Emerging Issues

No emerging issues were raised.

5. ITEMS FOR INFORMATION

5.1 Work Plan for PEF CiC

The Committees-In-Common had nothing to raise in relation to the work plan.

5.2/ Consolidated North Bank Site Report /
5.3 Consolidated South Bank Site Report

The Committees-In-Common had nothing to raise from the consolidated North and South Bank Site Reports.

5.4 Planned Care Board Meeting Draft Minutes

Helen Wright noted a previous issue regarding Executive attendance to the planned care board and wondered if attendance had improved. Clive Walsh responded that attendance had improved.

5.5 Unplanned Care Board Meeting Draft Minutes

The Committees-In-Common had nothing to raise from the Unplanned Care Board Minutes

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business (Including actions agreed that positively influence culture)

Helen Wright reflected on the positive impact of the meeting on culture, highlighting the recognition of colleagues' efforts, the transformational approach to change and the importance of honesty and transparency in assurance reporting.

7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON

7.1 Matters to be Referred to other Board Committees

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

7.2 Matters for Escalation to the Trust Boards 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 4 February 2025, 9am to 12.30pm in The Boardroom at Diana Princess of Wales Hospital.

The meeting closed at 12.04pm

Cumulative Record of Attendance at the PEF CiC 2024/2025

Name	Title	2024											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CORE MEMBERS													
Gill Ponder	Chair / Non-Executive Director (NED – NLaG)	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
Helen Wright	Chair / Non-Executive Director (NED - HUTH)						Y	N	Y	Y	D	Y	Y
Lee Bond	Group Chief Financial Officer	Y	D	Y	Y		Y	Y	Y				
Mark Brearley	Interim Group Chief Financial Officer									Y	Y	D	
Emma Sayner	Group Chief Financial Officer												Y
Jane Hawkard	NED (HUTH)	Y	Y	Y	Y		N	Y	Y	Y	N	Y	Y
Simon Parkes	NED (NLaG)	Y	Y	Y	Y		Y	Y	Y	Y	D	N	Y
Shaun Stacey	Group Chief Delivery Officer	Y	Y	Y	Y								
Paul Bytheway	Interim Group Chief Delivery Officer						Y	Y	Y	D	Y		
Clive Walsh	Interim Site Chief Executive North											Y	Y
Sarah Tedford	Interim Site Chief Executive South												
Dr Kate Wood	Group Chief Medical Officer	D	Y	D	Y		Y	Y	D	N	Y	Y	Y
REQUIRED ATTENDEES													
VACANT	Group Director of Estates	D	D	D	D		D	D	D	D	D	D	D
Andy Haywood	Group Digital Information Officer	N	N	Y	N		N	N	N	N	N	N	N
David Sharif	Group Director of Assurance or deputy	D	D	Y	Y		Y	Y	Y	Y	Y	Y	Y
Alison Drury	Deputy Director of Finance (HUTH)	Y	N	N	N								

Brian Shipley	Deputy Director of Finance (NLaG)	Y	Y	Y	N		Y	N	Y	N	N	N	N
Stephen Evans	Operational Director of Finance (HUTH)	Y	Y	N	N		N	N					
Ian Reekie	Governor Observer (NLaG)	Y	Y	Y	Y		Y	Y	Y	D	D	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)026

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday, 13 February 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	Lauren Rowbottom, Personal Assistant
Title of Report	Minutes from the Workforce, Education and Culture Committees-In-Common held on November 2024
Executive Summary	The minutes attached are the formal account of the meeting. The minutes include any action and resolutions made.
Background Information and/or Supporting Document(s) (if applicable)	The minutes attached are for information.
Prior Approval Process	Workforce, Education and Culture Committees-In-Common held on Wednesday 29th January 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 Thursday, 28th November at 13:30 to 17:00 in The Nightingale Room, Education Centre, Scunthorpe General Hospital

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (HUTH) Chair
David Sulch	Non-Executive Director (HUTH)
Dr Kate Wood	Group Chief Medical Officer
Amanda Stanford	Group Chief Nurse
Paul Bunyan	Group Director of Planning, Recruitment, Wellbeing, and Improvement (Item 4.2 and 4.6)
Julie Beilby	Non-Executive Director (NLaG) (Virtual)

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Lauren Rowbottom	Personal Assistant (HUTH) (Minute Taker)
Lucy Vere	Group Director of Learning and Organisational Development (Item 4.2, 4.6 and 4.7)
Helen Knowles	Director of People Services
Linda Jackson	Vice-Chair (NLaG)
Ashok Pathak	Associate Non-Executive Director (HUTH)

Observers:

Robert Pickersgill	Deputy Lead Governor

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committees in Common Chair welcomed those present to the meeting. Apologies were noted by Simon Nearney, Group Chief People Officer, Sue Liburd, Non-Executive Director (NLaG), and David Sharif, Group Director of Assurance.

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 24th October 2024**

The minutes of the meeting held on the 24th October 2024 were accepted as a true and accurate record subject to the below amendments;

- Linda Jackson to be added to the attendance list.
- Ashok Pathak's apologies to be noted.
- Julie Beilby job title to be updated to remove 'associate'.

1.5 **Matters Arising**

The committee chair invited committee members to raise any matters requiring discussion not captured on the agenda.

1.6 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

Action 4.9 - The medical workforce strategy was discussed, with plans to align it with the people strategy. This was expected to be finalised by April. Target date to be reset to April 2025.

1.7 **Emerging Issues**

Amanda explained the re-banding process for Healthcare Support Workers from Band 2 to Band 3, led by Joe Ledger and Caroline Corbett. The team had done extensive work on job profiles and found that many healthcare support workers were performing duties that warranted a Band 3 classification. The re-banding process faced challenges from unions. The management team was aiming to finalise the re-banding process by February, with an update expected in March 2025.

Action: Amanda Stanford to bring a formal update on the band 2/3 HCA support workers in March 2025.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

The following matters were referred to the CIC.

Amanda and Paul provided an update on flu vaccination rates, noting that uptake was low but slightly improving. HUTH was around 32% and NLaG was around 34% against a national average of 33%. Efforts were being made to address vaccine hesitancy and improve accessibility to vaccinations.

Paul discussed the Maternity Support Workers pay deal and currently there was no ability to increase the deal and talks were ongoing with the Unions. If a formal resolution could not be made then ACAS become involved. Amanda added that Jonathan Lofthouse was having on-going conversations with the Union to try and conclude this issue.

Amanda discussed gaps in pharmacy provision on the South Bank, particularly in relation to maternity services. They planned to reach out to Jo Good for more information and address the issue.

Amanda and Tony discussed the high level of staff assaults, particularly on the North Bank where there had been 25 incidents involving members of staff. Amanda committed to working with Simon Nearney to understand the data and develop a response plan. Ashok felt it would be interesting to find out what departments these instances happened in and what the ethnic background was of the members of staff. Amanda mentioned a training package on violence and aggression, which would be taken to the cabinet for scaling up. The goal was to understand the data on patient-on-staff and staff-on-staff violence and respond effectively.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**

Rebecca Thompson took the report as read. She highlighted that the BAF for the CIC had a new look and was linked to supporting staff. It was hoped the report clearly linked actions to the gaps in controls and assurance. Included in the report was the high-level risks and the mitigations in place. There was a future piece of work to highlight the risks relating directly to this CiC. The report would now be coming to this CiC quarterly.

Action: Lauren Rowbottom to update the workplan to reflect quarterly BAF reports.

Julie Beily complimented the new format of the report. She worried that there appeared to be a lot of high-level risks and questioned whether people used risk register as a route to get priorities raised. It was noted that a lot of people do use risk registers to further business cases. NLaG process has historically managed this aspect. HUTH is developing similar challenge.

3.2 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit report and recommendations to note.

3.3 **Review of relevant External Reports, Recommendations & Assurances as appropriate**

There were no external or internal report and recommendations and assurances to note.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Registered Nursing and Midwifery Staffing

4.1.1 Registered Nursing and Midwifery Staffing (HUTH)

Amanda Stanford took the report as read.

Amanda reported that HUTH had good recruitment and retention, with an over-arching recruitment strategy to reduce temporary staffing. Turnover was low across the organisation, and efforts were focused on supporting internationally educated nurses and career progression into senior leadership roles.

A paper had been taken to Board around how the group approached Safer Staffing as an organisation. Currently two different tools were used across the North and South. The work was being led by Jenny Hincliffe and plans was eventually both HUTH and NLaG would have a systematic approach.

Linda noticed that the care hours per day (CHPD) at HUTH was at 7.75% comparing to NLaG at 9.1% and questioned how the site who have over recruited had lower care hours. Amanda explained that CHPD was broken down by the number of staff on duty and NLaG naturally had a higher level of staffing compared to HUTH.

Ashok wondered if areas such as head and neck and critical care had recruitment difficulties. Amanda stated that head and neck was a specialist area that was always hard to recruit too, but critical care was usually easy so this was unusual. She stated there was a lot of work to do especially within HUTH such as learning from HR process and revisiting the approach to perception.

The Committees-In-Common agreed reasonable assurance for this item.

4.1.2 Registered Nursing and Midwifery Staffing (NLaG)

Amanda Stanford took the report as read. NLaG faced challenges with vacancies and turnover, particularly among Band 5 Nurses. The team was working to understand the reasons for higher turnover and improve retention through career

development and flexible working opportunities through the power of working in a Group. Efforts were being made to standardise staffing models across the organisation. The Safe Nursing Care Tool (SNCT) was being used to benchmark and address staffing gaps, with a focus on improving rostering efficiency.

Ashok praised the excellent recruitment process, improvements in retention and the decrease in agency work. Amanda added that financially the Group was spending a million less per month on agency work.

Linda Jackson voiced that the differences across the North and South required focus to help overlay safety, quality and patient care.

The Committees-In-Common agreed reasonable assurance for this item.

4.2 **Apprenticeship Levy Annual Report**

Lucy reported on the significant growth in apprenticeship starts and levy spend, highlighting the need to increase participation of younger people with 27% of HUTH apprentices under the age of 20 and 7% at NLaG. Plans included joining the Enable group for intelligent levy transfer and adapting to upcoming changes in the apprenticeship levy. She thanked her team across the North and South on the comprehensive report and for being so welcoming to the apprenticeship programmes.

The apprenticeship levy spend had increased, with HUTH committing £700,000 and NLaG £200,000. Efforts were being made to utilise expiring levy funds and support roles that benefit the community and the trust. Upcoming changes to the apprenticeship levy will reorient it towards lower band levels and new starters. The trust was preparing for these changes by increasing cohorts for Level 7 programs and exploring the flexibility of the new Growth and Skills Levy.

Lucy expressed she would bring a report back in March following the creation of an enabling group.

Action: Lucy Vere to bring an apprenticeship levy report update in March 2025.

Julie praised the report and queried how does engagement with academies in East and West Lindsey happen as they are outside ICB footprint. Lucy to follow up. Lucy explained that individuals attend schools to ensure they are adequately supporting individuals.

Ashok queried whether funding was pre-determined, or dependant on the number of apprenticeships the Group had. Lucy responded that funding was done from potential turnovers and was a set income on an annual basis.

The Committees-In-Common agreed significant assurance for this item.

4.3 Undergraduate Medical Education Annual Report

4.3.1/ Undergraduate Medical Education Annual Report (HUTH)
4.3.2 Undergraduate Medical Education Annual Report (NLaG)

Dr Kate Wood took the report as read. She apologised that the reports where not yet aligned.

Kate reported good feedback from students on both HUTH and NLaG, indicating a positive educational experience. However, challenges remained with Physician Associate (PA) roles and student placements due to the need for quality supervision and appropriate placement opportunities.

There were national challenges with PA roles, including a review called by Wes Streeting. This had caused uncertainty and difficulty in moving forward with PA programs, impacting on recruitment and retention.

Ashok noted the national issues from trade unions regarding physician associates and wondered if this would have an impact on the number of recruits. Kate said currently it was hard to tell currently and they were actively working on this.

The Committees-In-Common agreed reasonable assurance for both HUTH and NLaG.

4.4 Guardian of Safe Working Hours Quarterly Report HUTH & NLaG

4.4.1 Guardian of Safe Working Hours Quarterly Report (HUTH)

Helen Knowles took the report as read and gave a brief overview of some highlights. Admin support had transferred management to the people services as of September 2024 and this had provided an opportunity to understand the impact across the organisation and standardise reports. Helen thanked teams for working well together in producing this report.

In HUTH there had been 177 exception reports submitted in the last quarter. 10 fines were issues totaling over £16,000. 6 of those were issued to the Paediatrics Department and a business case had been put forward to review staffing levels and help redesign the rota.

In the last quarter over 94.1% of trainee drs posts were filled.

There were 5 exception reports escalated as an immediate safety concern, 4 of which related to minimum staffing levels and 1 was related to a drs concern. Reviews and support were in place following these reports.

Ashok noticed the improvements of plastic surgery and questioned what had happened to improve this area. Helen explained that the plastic surgery rota had been redesigned leading to service improvements.

David questioned whether it was a clinical or educational supervisor who signed of on an exceptional report. Kate explained that the process across the group was it could be either.

The Committees-In-Common agreed reasonable assurance for this item.

4.4.2 **Guardian of Safe Working Hours Quarterly Report (NLaG)**

Helen Knowles took the report as read and gave a brief overview of some highlights. The number of exception reports in NLaG had increased and they mostly related to excessive hours at a foundation level and safety concerns. There were no fines issued over this quarter.

In the last quarter over 89.9% of trainee drs posts were filled.

There were 107 exception reports, 5 of which were exceptional reports regarding immediate safety concerns. The main issues being around foundation drs unable to access supervision while caring for unwell patients and drs unable to take breaks during shifts. All of these issues were escalated and in-reach support was given.

The Committees-In-Common agreed reasonable assurance for this item.

4.5 **Deep Dive: Retention of NLaG Staff**

Paul presented a deep dive into staff retention noting that turnover levels were on target at 10% but were higher for lower banded roles such as Health Care Assistants (HCA) and administration and clerical roles. Data showed there was a higher proportion of HCA's leaving within the first year of employment.

Paul praised the new exit interview process.

14% of leavers at NLaG were under the age of 25. 80% of those were female and 20% were male. 76% of those leavers were white British.

40% of leavers at HUTH were under the age of 35. 70% were female and 20% was male. 71% of those leavers were white British.

Paul reported that following the deep dive and looking into the retention of staff the core actions moving forward were the development of the people strategy and a further deep dive into the 1st year leavers.

Linda noticed from the data that band 9 turnover percentage was high and suggested a deeper look into why this was happening at this level. Ashok queried whether senior management at this level receive an exit interview. Paul stated they do and receive a leavers survey.

Amanda wondered if there was any learning that could be taken away from Digestive Diseases as the data showed a decrease in leavers in the first year.

Paul explained that it was too early to say but a review of good practice within the Care Groups would be undertaken.

4.6 **WRES and WDES Action Plans**

Lucy Vere took the report as read and gave a brief overview of some highlights.

Lucy reported the key areas of focus were direct discrimination, ensuring the group had a reporting tool to report ableism. The disability staff network was in a good place as was the mental health and wellbeing resources for disabled staff. The group was also looking at harmonising the support for neurodivergent staff and there were plans to create a clear programme around inclusive recruitment.

Slight improvements had been seen in reasonable adjustments for staff, but this was still an area of focus to ensure all accessibilities were focused on.

Ashok observed from the report that disabled people were prone to bullying, and over time this had not shifted. Lucy explained that further development was needed in this area, particularly in ensuring disabled staff could speak up.

Tony questioned which areas where the priority areas that would make a difference. Lucy stated that inclusive recruitment, talent management and having clear actions and measures around those where two key areas that would help make a difference, although this still had a long way to go.

Julie Beily praised the report. She noticed that from the retention deep dive, and the WDES action report the two same themes appeared which was flexible working and career development.

4.7 **Group Leadership Programme**

Lucy Vere took the report as read and went over the levels of Leadership Programmes.

- Level 1 – Bitesize learning. This had been live since November and was bookable through ESR and HEY247.

- Level 2 – Great leader's courses which a new cohort would be starting in January 2025.

- Level 3 - System strategists' courses where being developed and these were expected to be available by September 2025.

- Level 4 – This included master classes and senior leadership development, which was going to be piloted in January 2025.

Lucy updated that her team had been working with the Care Groups and directorates to understand their needs and tailor them into the leadership programmes.

David praised the leadership programmes available to staff noting it offered a great range of training.

Amanda thanked Lucy for the report, she queried how we were ensuring the message of what the Group expects and what is important of a leader was consistent. Lucy explained that following the staff survey a series of briefings to managers and leaders would take place ensuring they were clear on expectations and this would also be built into training content.

5. ITEMS FOR INFORMATION / TO NOTE

5.1 The work plan was noted and there were no issues raised.

5.2 Appeal Panels

Tony Cury gave a brief overview of the paper prepared by Lindsay Harding which culminated in a recommendation that NEDs were no longer required to sit on appeal panels. The CIC were asked for their views.

Julie stated it would be important to ensure panels had a robust and balanced policy in place.

Linda made the point that taking NEDs out of the appeal panels would free up time to help with the larger cultural piece of work across the Group.

The Committees-In-Common unanimously supported the recommendation providing that robust policies were in place.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

Julie questioned if the co-pilot feature for AI notes was being used. Rebecca advised that once the testing phase had completed, her team would be early adopters.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

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

7.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

a) Band 2/3 Job Description issue was discussed. This is a national issue but there was no national steer on how to resolve. Discussions were ongoing.

b) Healthcare Support Workers – Back pay discussions were ongoing with the Unions.
c) Flu vaccination rates for both organisations were around the national average at 30%, but this was low in comparison to previous years.
d) NLAG Nurse agency spend across the Group had reduced dramatically. Vacancies and retention were also improving.
e) Retention deep dive – There was an improving position and exit interviews were in place. Higher turnover was still being reported for estates, healthcare assistants and admin.
f) Additional assurance was requested regarding violence and aggression towards staff and a report was requested examining the issues around where the incidents reported to WEC.
g) Apprenticeship Levy changes – a comprehensive report was received detailing the current apprenticeship work and the changes to the Levy. The CIC agreed significant assurance for the work being carried out.
h) Medical Education annual reports – HUTH had seen an increase in incivility reports and there were national issues impacting the Group regarding Physician Assistants. Reasonable assurance was agreed but further information was required.
i) WDES and WRES action plans were presented.
j) The CIC approved the proposal to remove NEDs from Appeal Panels.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Thursday 19th December, in the Boardroom, Alderson House, Hull Royal Infirmary

The Committee chair closed the meeting at 16.20 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y	Y		Y	D				
Amanda Stanford	Group Chief Nurse	D	D	Y	D	D		Y	Y				
Kate Wood	Group Chief Medical Officer	Y	N	Y	D	D		D	Y				
Tony Curry	Non-Executive Director (HUTH)	N	N	Y	Y	Y		Y	Y				
Kate Truscott	Non-Executive Director (NLaG)	Y	Y	Y	D	D							
Julie Beilby	Non-Executive Director (NLaG)							Y	Y				
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	Y	Y		Y	Y				

Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	Y	Y		Y	N				
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y	Y	Y		Y	D				

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Thursday, 28th November at 13:30 to 17:00 in The Nightingale Room, Education Centre, Scunthorpe General Hospital

For the purpose of transacting the business set out below:

Present:

Core Members:

Tony Curry	Non-Executive Director (HUTH) Chair
David Sulch	Non-Executive Director (HUTH)
Dr Kate Wood	Group Chief Medical Officer
Amanda Stanford	Group Chief Nurse
Paul Bunyan	Group Director of Planning, Recruitment, Wellbeing, and Improvement (Item 4.2 and 4.6)
Julie Beilby	Non-Executive Director (NLaG) (Virtual)

In Attendance:

Rebecca Thompson	Deputy Director of Assurance (HUTH)
Lauren Rowbottom	Personal Assistant (HUTH) (Minute Taker)
Lucy Vere	Group Director of Learning and Organisational Development (Item 4.2, 4.6 and 4.7)
Helen Knowles	Director of People Services
Linda Jackson	Vice-Chair (NLaG)
Ashok Pathak	Associate Non-Executive Director (HUTH)

Observers:

Robert Pickersgill	Deputy Lead Governor

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committees in Common Chair welcomed those present to the meeting. Apologies were noted by Simon Nearney, Group Chief People Officer, Sue Liburd, Non-Executive Director (NLaG), and David Sharif, Group Director of Assurance.

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 24th October 2024**

The minutes of the meeting held on the 24th October 2024 were accepted as a true and accurate record subject to the below amendments;

- Linda Jackson to be added to the attendance list.
- Ashok Pathak's apologies to be noted.
- Julie Beilby job title to be updated to remove 'associate'.

1.5 **Matters Arising**

The committee chair invited committee members to raise any matters requiring discussion not captured on the agenda.

1.6 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

Action 4.9 - The medical workforce strategy was discussed, with plans to align it with the people strategy. This was expected to be finalised by April. Target date to be reset to April 2025.

1.7 **Emerging Issues**

Amanda explained the re-banding process for Healthcare Support Workers from Band 2 to Band 3, led by Jo Ledger and Caroline Corbett. The team had done extensive work on job profiles and found that many healthcare support workers were performing duties that warranted a Band 3 classification. The re-banding process faced challenges from unions. The management team was aiming to finalise the re-banding process by February, with an update expected in March 2025.

Action: Amanda Stanford to bring a formal update on the band 2/3 HCA support workers in March 2025.

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

The following matters were referred to the CIC.

Amanda and Paul provided an update on flu vaccination rates, noting that uptake was low but slightly improving. HUTH was around 32% and NLaG was around 34% against a national average of 33%. Efforts were being made to address vaccine hesitancy and improve accessibility to vaccinations.

Paul discussed the Maternity Support Workers pay deal and currently there was no ability to increase the deal and talks were ongoing with the Unions. If a formal resolution could not be made then ACAS become involved. Amanda added that Jonathan Lofthouse was having on-going conversations with the Union to try and conclude this issue.

Amanda discussed gaps in pharmacy provision on the South Bank, particularly in relation to maternity services. They planned to reach out to Jo Good for more information and address the issue.

Amanda and Tony discussed the high level of staff assaults, particularly on the North Bank where there had been 25 incidents involving members of staff. Amanda committed to working with Simon Nearney to understand the data and develop a response plan. Ashok felt it would be interesting to find out what departments these instances happened in and what the ethnic background was of the members of staff. Amanda mentioned a training package on violence and aggression, which would be taken to the cabinet for scaling up. The goal was to understand the data on patient-on-staff and staff-on-staff violence and respond effectively.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**

Rebecca Thompson took the report as read. She highlighted that the BAF for the CIC had a new look and was linked to supporting staff. It was hoped the report clearly linked actions to the gaps in controls and assurance. Included in the report was the high-level risks and the mitigations in place. There was a future piece of work to highlight the risks relating directly to this CiC. The report would now be coming to this CiC quarterly.

Action: Lauren Rowbottom to update the workplan to reflect quarterly BAF reports.

Julie Beilby complimented the new format of the report. She worried that there appeared to be a lot of high-level risks and questioned whether people used risk register as a route to get priorities raised. It was noted that a lot of people do use risk registers to further business cases. NLaG process has historically managed this aspect. HUTH is developing similar challenge.

3.2 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit report and recommendations to note.

3.3 **Review of relevant External Reports, Recommendations & Assurances as appropriate**

There were no external or internal report and recommendations and assurances to note.

4 COMMITTEE SPECIFIC BUSINESS ITEMS

Joint Business Items

4.1 Registered Nursing and Midwifery Staffing

4.1.1 Registered Nursing and Midwifery Staffing (HUTH)

Amanda Stanford took the report as read.

Amanda reported that HUTH had good recruitment and retention, with an over-arching recruitment strategy to reduce temporary staffing. Turnover was low across the organisation, and efforts were focused on supporting internationally educated nurses and career progression into senior leadership roles.

A paper had been taken to Board around how the group approached Safer Staffing as an organisation. Currently two different tools were used across the North and South. The work was being led by Jenny Hinchliffe and plans was eventually both HUTH and NLaG would have a systematic approach.

Linda noticed that the care hours per day (CHPD) at HUTH was at 7.75% comparing to NLaG at 9.1% and questioned how the site who have over recruited had lower care hours. Amanda explained that CHPD was broken down by the number of staff on duty and NLaG naturally had a higher level of staffing compared to HUTH.

Ashok wondered if areas such as head and neck and critical care had recruitment difficulties. Amanda stated that head and neck was a specialist area that was always hard to recruit too, but critical care was usually easy so this was unusual. She stated there was a lot of work to do especially within HUTH such as learning from HR process and revisiting the approach to perception.

The Committees-In-Common agreed reasonable assurance for this item.

4.1.2 Registered Nursing and Midwifery Staffing (NLaG)

Amanda Stanford took the report as read. NLaG faced challenges with vacancies and turnover, particularly among Band 5 Nurses. The team was working to understand the reasons for higher turnover and improve retention through career

development and flexible working opportunities through the power of working in a Group. Efforts were being made to standardise staffing models across the organisation. The Safe Nursing Care Tool (SNCT) was being used to benchmark and address staffing gaps, with a focus on improving rostering efficiency.

Ashok praised the excellent recruitment process, improvements in retention and the decrease in agency work. Amanda added that financially the Group was spending a million less per month on agency work.

Linda Jackson voiced that the differences across the North and South required focus to help overlay safety, quality and patient care.

The Committees-In-Common agreed reasonable assurance for this item.

4.2 **Apprenticeship Levy Annual Report**

Lucy reported on the significant growth in apprenticeship starts and levy spend, highlighting the need to increase participation of younger people with 27% of HUTH apprentices under the age of 20 and 7% at NLaG. Plans included joining the Enable group for intelligent levy transfer and adapting to upcoming changes in the apprenticeship levy. She thanked her team across the North and South on the comprehensive report and for being so welcoming to the apprenticeship programmes.

The apprenticeship levy spend had increased, with HUTH committing £700,000 and NLaG £200,000. Efforts were being made to utilise expiring levy funds and support roles that benefit the community and the trust. Upcoming changes to the apprenticeship levy will reorient it towards lower band levels and new starters. The trust was preparing for these changes by increasing cohorts for Level 7 programs and exploring the flexibility of the new Growth and Skills Levy.

Lucy expressed she would bring a report back in March following the creation of an enabling group.

Action: Lucy Vere to bring an apprenticeship levy report update in March 2025.

Julie praised the report and queried how does engagement with academies in East and West Lindsey happen as they are outside ICB footprint. Lucy to follow up. Lucy explained that individuals attend schools to ensure they are adequately supporting individuals.

Ashok queried whether funding was pre-determined, or dependant on the number of apprenticeships the Group had. Lucy responded that funding was done from potential turnovers and was a set income on an annual basis.

The Committees-In-Common agreed significant assurance for this item.

4.3 Undergraduate Medical Education Annual Report

4.3.1/ Undergraduate Medical Education Annual Report (HUTH)
4.3.2 Undergraduate Medical Education Annual Report (NLaG)

Dr Kate Wood took the report as read. She apologised that the reports where not yet aligned.

Kate reported good feedback from students on both HUTH and NLaG, indicating a positive educational experience. However, challenges remained with Physician Associate (PA) roles and student placements due to the need for quality supervision and appropriate placement opportunities.

There were national challenges with PA roles, including a review called by Wes Streeting. This had caused uncertainty and difficulty in moving forward with PA programs, impacting on recruitment and retention.

Ashok noted the national issues from trade unions regarding physician associates and wondered if this would have an impact on the number of recruits. Kate said currently it was hard to tell currently and they were actively working on this.

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4.4 Guardian of Safe Working Hours Quarterly Report HUTH & NLaG

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Helen Knowles took the report as read and gave a brief overview of some highlights. Admin support had transferred management to the people services as of September 2024 and this had provided an opportunity to understand the impact across the organisation and standardise reports. Helen thanked teams for working well together in producing this report.

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5. ITEMS FOR INFORMATION / TO NOTE

5.1 The work plan was noted and there were no issues raised.

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Tony Cury gave a brief overview of the paper prepared by Lindsay Harding which culminated in a recommendation that NEDs were no longer required to sit on appeal panels. The CIC were asked for their views.

Julie stated it would be important to ensure panels had a robust and balanced policy in place.

Linda made the point that taking NEDs out of the appeal panels would free up time to help with the larger cultural piece of work across the Group.

The Committees-In-Common unanimously supported the recommendation providing that robust policies were in place.

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

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7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

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

7.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

a) Band 2/3 Job Description issue was discussed. This is a national issue but there was no national steer on how to resolve. Discussions were ongoing.
b) Healthcare Support Workers – Back pay discussions were ongoing with the Unions.
c) Flu vaccination rates for both organisations were around the national average at 30%, but this was low in comparison to previous years.
d) NLAG Nurse agency spend across the Group had reduced dramatically. Vacancies and retention were also improving.
e) Retention deep dive – There was an improving position and exit interviews were in place. Higher turnover was still being reported for estates, healthcare assistants and admin.
f) Additional assurance was requested regarding violence and aggression towards staff and a report was requested examining the issues around where the incidents reported to WEC.
g) Apprenticeship Levy changes – a comprehensive report was received detailing the current apprenticeship work and the changes to the Levy. The CIC agreed significant assurance for the work being carried out.
h) Medical Education annual reports – HUTH had seen an increase in incivility reports and there were national issues impacting the Group regarding Physician Assistants. Reasonable assurance was agreed but further information was required.
i) WDES and WRES action plans were presented.
j) The CIC approved the proposal to remove NEDs from Appeal Panels.

8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Thursday 19th December, in the Boardroom, Alderson House, Hull Royal Infirmary

The Committee chair closed the meeting at 16.20 hours.

Cumulative Record of Attendance at the Workforce, Education and Culture Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Simon Nearney	Group Chief People Officer	Y	Y	Y	Y	Y		Y	D				
Amanda Stanford	Group Chief Nurse	D	D	Y	D	D		Y	Y				
Kate Wood	Group Chief Medical Officer	Y	N	Y	D	D		D	Y				
Tony Curry	Non-Executive Director (HUTH)	N	N	Y	Y	Y		Y	Y				
Kate Truscott	Non-Executive Director (NLaG)	Y	Y	Y	D	D							

Julie Beilby	Non-Executive Director (NLaG)							Y	Y				
David Sulch	Non-Executive Director (HUTH)	Y	Y	Y	Y	Y		Y	Y				
Sue Liburd	Non-Executive Director (NLaG)	Y	Y	Y	Y	Y		Y	N				
REQUIRED ATTENDEES													
David Sharif	Group Director of Assurance	Y	D	Y	Y	Y		Y	D				

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)027

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 13 February 2025
Director Lead	Helen Wright, Committee Chair of Capital & Major Projects CIC Gill Ponder, Committee Chair of Capital & Major Projects
Contact Officer / Author	Helen Wright, Committee Chair of Capital & Major Projects CIC Gill Ponder, Committee Chair of Capital & Major Projects
Title of Report	Capital & Major Projects Committees-in-Common Minutes – November 2024
Executive Summary	The Capital & Major Projects Committees in Common Minutes from the meeting held on 26 November 2024
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Capital & Major Projects Committees-in-Common held on 30 January 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 ☐ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other – please detail below:

CAPITAL & MAJOR PROJECTS COMMITTEES-IN-COMMON MEETING

Minutes of the meeting held on Tuesday, 26 November 2024 at 9.00am to 12.00pm at Boardroom, Hull Royal Infirmary

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 (Chair)
Mark Brearley	Group Chief Financial Officer
Tony Curry	Non-Executive Director HUTH

In Attendance:

David Sharif	Group Director of Assurance
Rebecca Thompson	Deputy Director of Assurance
Jackie Railton	Head of Strategic Planning (Item 4.6)
Linsay Cunningham	Deputy Director of Strategy and Partnerships (Item 4.5)
Alex Best	Group Deputy Director of Capital Services
Andy Haywood	Group Chief Digital Officer
Jo Palmer	PA to the Committees in Common (Minute taker)

Observers:

Stuart Hall	Vice Chair, HUTH
Ian Reekie	Lead Governor NLAG

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Committee Chair welcomed those present to the meeting. Apologies for absence were noted from Ivan McConnell, Group Chief Strategy and Partnerships Officer.

1.2 Staff Charter and Values

Gill Ponder asked all in attendance to be mindful of the Staff Charter and Values 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 29 October 2024**

The minutes of the meeting held on the 29 October 2024 were accepted as a true and accurate record.

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 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

August 2024 8.1 – Castlehill Hospital Boardroom is now equipped with MS Teams and can therefore be used for a future meeting.

ACTION: to schedule a 2025 meeting at Castle Hill Boardroom.

October 2024 3.1 – Andy Haywood advised that investigations are complete and both North and South banks were on the same platform. Item to be closed.

October 2024 3.1 - David Sharif advised that the first meeting of the Risk and Compliance Group was to be held on 16 December 2024 when he would raise this issue.

Action carried forward to the next meeting.

October 2024 4.1 – Mark Brearley to send the 2025/26 draft Capital Programme update through to the Chairs within 24 hours. It would take into account items deferred from 2024/25 and those brought forward from 2025/26.

Received. **ACTION: to review and debate at a future meeting.**

October 2024 7.1 – Update on the SGH boiler house is on the agenda so item to be closed.

1.7 **Review of Effectiveness – Outcome**

David Sharif thanked those that had completed the review but reported that there had been a poor response rate. It had not been possible to report on individual Committees and in view of this and the poor response rate, no written update had been produced for the Committee (CiC). Instead, it would form part of a combined report for all the Committees to be submitted to the Board in December. Gill Ponder suggested that the outcome should be shared with the Chairs before the paper went to Board. David Sharif agreed to share the report with the Chairs after the meeting.

ACTION: David Sharif to share effectiveness outcome report with Committee Chairs.

1.8 **Review of Committee Terms of Reference & Work Plans**

David Sharif reported that other Committees had taken the opportunity to hold a timeout session in order to discuss their Terms of Reference (ToR) and workplans and good feedback on the benefits of such a session had been received. Helen Wright referred to the agenda set discussion where it was agreed to wait for twelve months before having a Capital & Major Projects timeout. Gill Ponder reiterated that due to the bi-monthly frequency of the meetings, it would be preferable to hold a virtual timeout rather than cancel a meeting. She noted that Quarter 4 required a comprehensive agenda, due to the financial year end and the new financial year beginning. David Sharif agreed and suggested an alternative option would be to add the timeout onto another CiC meeting but acknowledged it would be time consuming. David Sharif suggested timetabling a timeout at the beginning of the new financial year ie April instead of having a CiC meeting.

With regard to changes to the Terms of Reference, Gill Ponder asked that with reference to 4.6 HASR, the scope be updated, as it made reference to maternity which had been descoped. In relation to 5.2 'In attendance', reference was made to the Group Director of Transformation, which did not exist. Appendix A NLaG decisions being referred to the HUTH Board needed amending and, finally, the last point on the workplan relating to the risk report lead needed amending from Chief Medical Officer to Group Director of Assurance.

ACTION: Jo Palmer to arrange a timeout session to replace the April 2025 meeting.

ACTION: Jo Palmer to amend paragraphs 4.6, 5.2 and Appendix A in the ToR and also amend the workplan to reflect the changes agreed by the CiC and liaise with Sarah Meggitt to get the amendments to the TOR included in an agenda for approval by the Boards in Common

2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

The Committee Chair reported that no matters had been referred by the Trust Board(s) and / or other Committees-in-Common.

3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**

David Sharif presented the BAF, which had been revised in terms of content and approach. The reporting format had changed and he welcomed feedback but the information presented was as before. The BAF had gone through a rigorous refresh which had culminated in two risks relating to this CiC ie. the Digital agenda and strategic capital investment.

The risk description had been updated and the individual risks now incorporated a risk appetite, which had been agreed and discussed at one of the Board Development sessions. There was also a list of controls and gaps in controls, along with sources of assurance.

In relation to Digital, there were two actions which cover all the gaps, similarly in Estates, the Group was in a strategic phase. For the high-level risks, further work needed to be done on the timings for those risks presented to the CiC as well as those in the more detailed report, as it had caused a mismatch in the scores being presented. The second issue was around risks coming through which were initially moved to a holding status while they were being discussed within the Care Groups. While in the holding status, these risks were not included in the risk register. David Sharif acknowledged that there was more work to be done to ensure that a complete picture of the overall high-level risks was being presented.

Helen Wright commented that she liked the improved format as it was user friendly and easy to digest. In relation to the current score, risk appetite and the tolerable score, it was unclear on what the journey would be to get to the tolerable score as it was clear that reaching the optimal scores would be more of a longer-term aspiration. Whilst acknowledging the gaps in control and in order to reach the tolerable score, the mitigations needed, and timescales should also be included. The risk score pre and post mitigation was needed to show that the mitigating actions taken had reduced the likelihood or the severity of the risk. Gill Ponder agreed.

Tony Curry added that he was not convinced by the wording of the Digital and Estates risks as it was not clear or precise, which he felt should be at this level.

Stuart Hall referred to his attendance at the Top 100 meeting when he felt there was some disconnect in the work that the Care Groups were doing on risk and the Board's oversight of the risks. In relation to the overdue high-level risks and the launch of the Risk and Compliance group on 16 December 2024, he was unsure how this linked in with the Committees and whether the new group was expected to report into it. David Sharif responded that it would serve as a check and challenge to Care Groups on their individual risks and how they updated and managed those risks. It would work across the Care Groups and directorates and highlight the corporate wide risks, which would ultimately flow through to the Committees in Common. Gill Ponder asked if the group would feed into this CiC and David Sharif replied that although it was an executive group, it would feed through to this CiC via the Risk Register report and ultimately the BAF.

Gill Ponder referred to the Using Major Capital Effectively risk and stated that she felt that the content included was Estates biased, despite there being lots of other uses of capital such as Digital and equipment replacement. She noted that the Risk Register was full of equipment issues and resulting potential harm to patients. David Sharif replied that it was a strategic objective viewed from the top downwards, but Gill Ponder believed the scope needed to be broadened to include the Capital risk for Digital and Equipment Replacement.

Helen Wright agreed that there were a lot of risks related to equipment and suggested a deep dive to understand the strategy in relation to equipment and whether there was any potential for a leasing strategy as opposed to capital purchase. Mark Brearley replied that even with a leasing arrangement, resources

would still be tied up in assets and it was important to balance the overall programme between major schemes and replacement and maintenance capital. Helen Wright agreed and stated that there was still a need to consider whether the equipment was up to date and whether it was regularly replaced. Gill Ponder noted that the Quality & Safety CiC would be looking at any patient safety risks from insufficient capital to replace equipment that could no longer be maintained, but purely from a capital perspective, the use of major capital effectively sits with the Capital & Major Projects CiC as a strategic risk.

Gill Ponder also noted that the decision for the BAF to come to the CiC quarterly needed reflecting in the workplan. The frequency of the strategic risk reviews also needed to be reflected in the work plan and David Sharif believed this should also be quarterly, alongside the BAF.

ACTION: Jo Palmer to amend the workplan to show the new quarterly frequency of the BAF and the strategic risk review.

Gill Ponder referred to the high-level risk summary in that the risks presented were not focused on those aligned to this CiC. David Sharif advised that this was due to the limitations of the system but agreed to investigate the possibility of dividing the risks into separate reports for each CiC.

ACTION: David Sharif to investigate the possibility of dividing the high-level risk report into separate reports for each CiC and how to better reflect the impact of mitigating actions on reducing the likelihood or severity of risks and thus the risk scores

Gill Ponder referred to overdue Digital risk 3919 from March 2024 on the e-radiology results system. Andy Haywood advised that it did not currently sit with Digital but he would investigate and report back.

ACTION: Andy Haywood to investigate why risk 3919 was overdue for review and report back to the next meeting

Gill Ponder commented on there still being no reference to mitigations and Helen Wright agreed that there was still no emphasis on mitigating risks. David Sharif acknowledged that it was still work in progress.

Gill Ponder's final point was on the new risk 3385 Delay in UPS install for the main data centre at Scunthorpe General Hospital (SGH), but Andy Haywood confirmed that this was now complete and could be closed. It was unclear as to why it had been added as a new risk when completion of the work had been reported to the Performance, Estates & Finance CiC in October.

ACTION: Andy Haywood to confirm closure of risk 3385 and to liaise with David Sharif on the outcome

Helen Wright's final comment was on mitigations and when the CiC could expect to see reference to them. David Sharif replied that the new system would hopefully be a turning point for better visibility.

ACTION: David Sharif to liaise with the supplier regarding additional reporting capability on mitigations and to include equipment, Estates and Digital capital elements in future BAF and high-level risk reports

3.2 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit reports & recommendations to note.

3.3 **Review of Relevant External Reports & Recommendations**

There were no external reports or recommendations to note.

4. COMMITTEE SPECIFIC BUSINESS ITEMS

4.1 **Capital Plan Delivery – Expenditure against 2024/25 Plan**

- **Approval of amendments to the 2024/25 plan**

Mark Brearley took the paper as read. An update was circulated the day before the meeting regarding Capital Plan slippage 2024/25 and the draft 2025/26 plan. Additional funding had been received but he acknowledged that the Group was behind on spend and, to mitigate this, some schemes for 2025/26 had been brought forward. The Group had received a request from NHS England (NHSE) for additional capital to be spent in 2024/25 some of which was for the removal of additional Reinforced Autoclaved Aerated Concrete (RAAC).

Tony Curry queried the £0.9m spend for the ground floor of the Emergency Department, particularly when this had been done not too many years ago and wondered if there was a particular reason why more investment was needed. Mark Brearley responded that the area was in constant heavy use and the opinion from the Care Groups was that the Group needed to reuse the discharge lounge to improve flow.

Gill Ponder referred to the supplementary report from Phillipa Russell, Deputy Group Chief Finance Officer, regarding a slippage on spend of £16.5m, around £12m of which was related to the Community Diagnostic Centres (CDC). She noted that there was no list of schemes brought forward that would add up to the balance of £16.5m to ensure that the full capital allocation for the year would be spent. Mark Brearley replied that the £16.5m was the underspend to date, but he expected that at least £12m of that would be recovered in year. Regarding the update from Phillipa Russell, and the two tables referring to HUTH and NLaG, the schemes in red were the ones that were slipping and those in black were the ones due to be replacing them, up to the balance of the slippage that could not be recovered. Gill Ponder made the point that the reasons why the items in black did not add up to the full £16.5m year to date slippage were clear from Mark Brearley's explanation but not from the paper, therefore Mark Brearley advised he would ensure that the report was clearer in the future.

Helen Wright commented that when slippage had been noted at a previous meeting, Jonathan Lofthouse and Lee Bond had presented a list of Cabinet-approved projects that were being suggested to pull forward from 2025/26 and she questioned whether these were still in progress. Mark Brearley confirmed that

some of these had indeed been incorporated into the programme and some schemes had been added since. For example, the hybrid theatre had been on the list originally. The plan had been to spend around £1m in this financial year on equipment and next year to continue to spend on its implementation. Unfortunately, the CDCs had had delivery issues which had impacted on spend.

Alex Best added that there tended to be a period where once the go ahead had been received, plans had to be put into place to secure the funding. For example, Theatre 9 and the Public Sector Decarbonisation Scheme (PSDS), the latter of which had £3.4m allocated to it this year. A number of large schemes such as windows, roofing and PV on site were currently out pre-tender and Gill Ponder asked if they would be delivered by the end of financial year. Alex Best replied that they were being ordered to take advantage of prices and secure them in the order book. Where necessary, items would be vested if they had not actually been delivered by the end of the year.

Gill Ponder had a question about deferring EPR spend until 2025/26. She asked when there would be a decision on whether that had been agreed. Andy Haywood advised that he was awaiting written confirmation. Gill Ponder asked if there was a contingency plan if it was not agreed and Andy Haywood replied that there was, but he did not think it would be needed.

- **SGH Boiler House location escalation**

Gill Ponder referred to the boiler house issue and was unsure as to why the Capital Committee had escalated the issue to the CiC. Alex Best explained that there was a need to resite the boiler house due to the PSDS works at Scunthorpe and 4 options had been considered for new locations. There were significant practical reasons why 3 of the options had been discounted, which were explained in the paper. As a result, the decision had been made to proceed with locating it on the Estates workshop area. The area had been underfunded for many years and was in a poor state of repair. The appearance would be improved by the new building, but it was one storey higher. As a result, there would be a stakeholder communication programme undertaken with local residents, covering all aspects of the build including mitigating actions to minimise the impact on adjacent houses, such as not having any windows in the new building that would overlook their gardens and ways in which the building would be designed to be less obtrusive.

4.2 **Review & Approval of Business Cases within CiC's Delegated Limits**

There were none to discuss.

4.3 **Approval of Investment & Disinvestment Decisions & Business Cases within Delegated Limits and/or Endorsement for Trust Board Approval**

- **Contract Approvals – Allam Building CHH Internal Fit (Phase 2 remaining works)**

Gill Ponder noted that this paper had come to the CiC for approval but that it was part of a bigger scheme, therefore should still go to the Board for ultimate approval as the total scheme value exceeded the delegated authority of the CiC. Alex Best advised that permission was sought for an extension to the main contract for

Phase 1, with a view to completion by March 2025. The Group's cost consultants had reviewed the proposal and confirmed that the costs were in line with the original business case and represented value for money while maintaining the high standards required.

Helen Wright was aware that this scheme had been extensively discussed at previous meetings and at the Group Capital Committee meeting. There was awareness that the building was not fit for purpose, and she was looking for assurance that it was money well spent and that the building would become fit for purpose. Alex Best confirmed that there was a valid need for continuing the build and that there was a Legacy agreement with the Allam family that needed to be honoured in some way on the top floor. The building was designed with an endoscopy unit in mind therefore it was very difficult to repurpose it for anything else. There was a collaboration with the Infection Prevention Control team to see what other services could be included, but airflow was an issue.

Helen Wright asked for clarification on the saving on the doors and Alex Best responded that this was because they were ordered in advance before any inflationary increases. Stuart Hall felt that this was a project which must proceed regardless. The first-floor accommodation should proceed to be used for educational purposes, although there were no doubt other buildings were available on site that could be used. Regarding the ground floor, this was constructed with endoscopy in mind and would be too costly to repurpose. He wondered whether there was some concern over activity levels in that there may well be insufficient activity to justify it. Alex Best agreed that maximising activity was preferable to repurposing it. Mark Brearley added that he and Jonathan Lofthouse had been involved with discussions with the Care Group regarding their projected use of the building, but the Care Group did have concerns with some of their rooms being currently used by other services. Jonathan Lofthouse had asked that once the scheme was completed, a full internal audit was undertaken on lessons learned for the future.

Gill Ponder referred to the late request for this paper to be discussed and reminded all to be mindful that agenda set meetings were in place for a reason. Any contracts for approval for the future would need to be made apparent by the time of the agenda set. Alex Best apologised for the lateness on this occasion which was due to tender alignment.

Gill Ponder asked if the CiC was content to endorse the proposal and the CiC agreed that they were and that the paper could be submitted to the Board for financial approval.

ACTION: Having obtained the CiC's endorsement, Alex Best to submit the contract approval paper to the Board for financial approval

4.4 **Post Capital Project Evaluation**

Mark Brearley advised that this report was the first of its kind and had been based on the project evaluation reports for the Scunthorpe General Hospital MRI & IAAU schemes and the Diana Princess of Wales IAAU scheme. The evaluation templates from NHSE had been followed which aimed to consider the lessons learned and the business case benefits realised from these schemes.

Tony Curry noted the outcomes but felt that there were no facts and indeed a lack of detail. Mark Brearley emphasised that the NHSE template had been used but agreed that more data and evidence could be added to support the assessments in future.

Helen Wright agreed that there was lots of narrative but no supporting data or measures. She wanted to compliment the team in assessing how much projects were going to cost, however, there was a need to reflect contingency for inevitable building delays within timetables as such schemes very rarely get completed on the original planned dates. Alex Best fully agreed there needed to be more realism in the planning phase, with contingency built in for unexpected construction issues discovered once building had started.

Stuart Hall also wished to commend Alex Best on his update and believed they would evolve as time progressed, drawing on lessons learned. He did question the Procurement process for the building works being performed by Estates & Facilities, as opposed to Procurement. Alex Best responded that this seemed to have been a HUTH process previously, but going forward, there would be significant involvement with Procurement. Mark Brearley believed there needed to be a Procurement strategy using expertise from Estates & Facilities.

Gill Ponder raised concern over some details within the reports. She questioned an example of non-English speaking patients being unable to be scanned on mobile scanners and expressed concern about why that would be the case and whether there was a health inequality issue that needed to be addressed, given that the Group continued to use mobile scanners to increase capacity. The reports also referred to the delivery of benefits to claustrophobic and bariatric patients and the removal of potential inequalities due to age, mobility and race where the responses were very generic. She felt that this needed to be more specific. There was also reference to an assessment of the level of transformation for stakeholders but as we were still not meeting the standards for DMO1 or faster diagnosis, she questioned the possibility of an overly optimistic assessment. Gill Ponder's final observation was regarding spending as she thought that she recollected that the IAAU's had been delayed and were, therefore, over budget due to contractors being onsite for longer than originally planned. However, she also added that her recollection might be incorrect, so Alex Best agreed to check and feedback.

ACTION: Alex Best to check whether the IAAUs had been delayed and were consequently over budget with Finance and feedback

Helen Wright voiced that it was easier to do the evaluations in a timely manner and asked Mark Brearley to consider reviewing the schedule and submitting to the CiC soon as practically possible, to which he agreed.

Assurance for the Capital Delivery items was agreed as reasonable, as there was good progress and clear visibility and plans in place for further actions needed.

Highlight: Mitigation to the slippage on the 2024/25 Capital plan and development of 2025/26 plan, the endorsed Allam contract for Board approval and the Post Capital Project Evaluation which was a step forward, in view of the previous lack of benefit realisation reporting following the completion of major Capital projects.

The meeting paused for a 10-minute break at 10.30am.

4.5 **Humber Acute Services Review**

- **Update since the last meeting**

Linsay Cunningham advised that the final meeting of the local resolution process with North Lincolnshire Council was held on 18 November 2024 following the ICB's decision to progress with the recommendations from the Humber Acute Services Review (HASR). The Council had concerns relating to transport, access, health inequalities and sustainability of services at Scunthorpe General Hospital. The outcome of a number of meetings with the Council was a series of mitigations which would be taken to Cabinet and then presented at a full Council meeting on 5 December 2024, when the Council would make a decision on whether it was satisfied with the mitigations or whether it would refer the case to the Secretary of State. There had already been a referral by Lincolnshire County Council some months previously, where all evidence requested by the Department of Health had been provided. The operational teams were working through implementation plans, but an agreement was in place not to enact any of the recommendations until after the Council meeting.

- **Goole & District Hospital**

Linsay Cunningham briefly gave an update on discussions around the future use of Goole & District Hospital (GDH). Work had begun on a review of what was currently there and the potential options going forward. There appeared to be a great deal of vacant space and it was agreed that a tour of the site would prove helpful for the CiC to assist their understanding of future discussions. Detailed activity modelling was taking place, including analysis of where patients travelled from to use services there. The modelling was also reviewing where Goole residents accessed services.

A high-level options appraisal was underway with Care Groups, Place Directors, ICB colleagues and CHCP who ran the Urgent Treatment Centre (UTC) based there. Four broad options were emerging from this work which were to remain as is, maximise usage, close or find an alternative use. However, there were many sub-options within each of those categories. Alternative use such as residential care or supportive housing could be considered, but there was a need to engage with a wider range of stakeholders including staff, Governors and the local community because there was a strong desire to keep local services for local people, particularly the UTC and Outpatient services. The ICB were currently in the process of completing a review of UTC provision in the area. Inpatient activity was low and there might be a need to look at consolidating that elsewhere. It was hoped that a robust business case would be available to present to Cabinet at the end of January. Gill Ponder welcomed the possibility of this being available to present to the Committee at the January meeting, ready to submit to the Board in February but appreciated the tight timescales due to the Christmas holiday period. David Sharif advised there was a meeting of the Governors at GDH on 22 January 2025.

There was a suggestion by Helen Wright of holding the next meeting at Goole Hospital should the facilities be sufficient, to be followed by a tour around the site. Gill Ponder pointed out that the room would need to have MS Teams facilities.

ACTION: Jo Palmer to investigate room availability and suitability for the CiC meeting on 30 January 2025.

4.6 **Community Diagnostic Centre Programme**

- **Update since the last meeting**

Jackie Railton acknowledged the build delays.

A potential risk due to slippages in schemes across the ICB meant that there was a revenue income risk of £2.2m to the ICB which could potentially pose a proportionate financial risk across acute providers. There needed to be action taken as a Group to mitigate build delays by carrying out activity elsewhere to reduce backlogs and recover planned income.

Gill Ponder thanked Jackie Railton for her update.

Helen Wright reflected that the CiC were aware of the delays but queried when the opportunities for pulling back income would become known. Jackie Railton referenced the two CT and two MRI mobile vans across the whole of the Humber and North Yorkshire ICB and how it had become evident that national assumptions of the volume of activity that could be delivered from a mobile van were much higher than what was possible, due to time lost when moving the vans between locations. A mitigating action was looking at the schedule to reduce movement and maximise activity. Phlebotomy was another area where extra sessions were being planned to mitigate loss of income.

Mark Brearley added that through the work with PA Consulting, work was being done to explore new opportunities and pressure was being put on all providers to manage their costs and activities to mitigate the income risks from slippage in CDC builds.

Gill Ponder noted that actions were being taken but asked when it would translate into a plan that stated what the potential income loss was and how much each mitigating action would recover. Jackie Railton responded that a submission had been made to the ICB and the NHSE in October 2024 for H2 2024/25 and what they hoped to achieve by the end of March. Regarding the slippage at the hubs, she believed there was an opportunity to provide services at other venues before the go live date, but there was a need to cover off recruitment issues and undertake pilot work at some GPs to pull work through, as was evident with the Hull hub. In addition, looking at some of the specialties, there were opportunities to move some of the services from the hospital site to the CDC.

Assurance was agreed as reasonable in view of the risks being well managed. Helen Wright was reassured that despite some delays to the schemes, it was apparent that the Group were targeting income delivery and aiming to hit the income plans for H2.

HIGHLIGHT: The impending decision from the meeting with North Lincolnshire Council on 5 December 2024 about HASR and steps in place to mitigate the activity and income impact of build delays with the CDCs

4.7 **Digital Plan Delivery – Bi-monthly updates on changes since last meeting**

Andy Haywood took the paper as read. In terms of the Digital strategy and actions to be taken against some of the major risks and ensuring that the strategy is effective, he informed the CIC that the Digital team had engaged with around six hundred members of staff, including attendees at a nursing conference the day before the meeting, looking into how staff felt the Digital service had impacted on their work and what improvements could be made. The team had spoken with the Board during a development session in terms of creating some broader goals. An outline of the strategy was due to go to Cabinet in December. Further work needed to be undertaken around funding models, business cases and capital requirements.

With regards to EPR, there were no major updates as the Group were still waiting for a meeting with NHSE with regards to the affordability gap and, at the very minimum, there was a need for a decision on whether they would allow the cases to proceed with the gap.

Andy Haywood referred to action point 6.1 June 2024 on the action tracker in relation to a confirm and challenge workshop on business case benefits between the OBC and FBC. He suggested waiting for the steer from NHSE before having the check and challenge workshop and that was agreed.

Andy Haywood further advised that the closing stages had been reached for a tender for expert programme support on infrastructure, clinical and operational readiness.

Scan for Safety was now part of the Digital team's portfolio and an internal audit was soon to be undertaken on the system's suitability for stock control and valuation. Mark Brearley added that the concept of Scan for Safety in terms of its ability to scan devices and implants was well known and well used as a quality initiative. The internal audit report was around the applicability of the system as a stock control and valuation system feeding into the Group's financial systems, which had been delayed somewhat.

Andy Haywood advised that there was to be an event later in the week involving many staff in order to involve them with some of the new innovative tools that NHSE have allowed the Group to pilot for free until 31 March 2025. For assurance purposes, the data protection impact assessments and privacy notices had been done nationally and there would be no patient data being used. The challenge set for those involved was that any ideas would have to be worth investing in. It was recognised that it was an opportunity, albeit at short notice, to address the challenges encountered in the strategy engagement around being more comfortable with digital innovation and getting more staff involvement. The event was supported by Microsoft partners.

Helen Wright welcomed the commitment to looking at the ten-year plan as to what the cost would be to run, develop and maintain the digital estate. She asked whether Andy Haywood knew what the timeframe on visibility would be and he

replied that there was a draft plan on the strategy, but it would depend on the level of ambition as an organisation.

Gill Ponder commented that she had found the report helpful and commended the clear update and summary. She informed the CiC that she had looked at one of the videos on patient led booking and believed it would be of massive benefit to patients in managing their appointments and felt that it would go some way towards eradicating inefficiencies. Andy Haywood agreed that it had potential to make big improvements if staff were willing to engage and begin to innovate with it, along with its ability to interact with the NHS App. Initially, the scope had been kept deliberately tight and, over time, it could replace Patient Knows Best without any functionality being lost.

Assurance was agreed as significant.

ACTION: Andy Haywood to feed back to the CiC regarding action 6.1 on the action tracker

Action: Andy Haywood to update the CiC and subsequently the Board on EPR once feedback had been received from NHSE.

HIGHLIGHT: Engagement in development of the strategy, no further update on EPR and the CiC acknowledged the longer-term vision now apparent including on the level of spend that would be needed to realise the Group's digital ambitions.

5. HIGHLIGHT REPORTS FROM SUB-GROUPS

5.1 Group Capital Committee Minutes

Gill Ponder noted that items had been escalated to the CiC by the Group Capital Committee, but it was unclear why they had been escalated, as there were no asks of the CiC. She questioned the process for escalations and asked whether there was a need for David Sharif and his team to look at the issue from a governance perspective. David Sharif agreed that he and Alex Best ought to look at the process. Alex Best believed that items from a development perspective needed to be escalated to the Group Capital Committee at the very least, to which Gill Ponder agreed, along with a need for a process of escalating to this CiC if relevant. Helen Wright added that the escalation needed to be specific as to what was being asked. David Sharif felt that this could be articulated in the risk register if appropriate. Mark Brearley voiced that there needed to be some clarity for the CiC on what should be escalated from the Group Capital Committee. He believed that the latter were escalating matters purely for the CiC to be aware of, rather than there being a need for escalation. He suggested to David Sharif that this was something to be clarified for the various subcommittees. Helen Wright agreed that it would be good practice to highlight issues purely for the CiC's awareness. David Sharif believed it was good practice that patient safety issues were being raised and included in the risk register, resulting in awareness by the CiC.

ACTION: David Sharif and Alex Best to look at the escalation process from the Group Capital Committee to the CiC

6. ANY OTHER URGENT BUSINESS

6.1 Any Other Urgent Business

Helen Wright referenced previous conversations at agenda set meetings and communications around her commitment at the Trust Boards in Common to ask the CiCs to reflect on what had been debated and what actions had been taken which were felt to have a positive impact on culture. Gill Ponder noted that despite it being purely an assurance CiC, from this meeting she felt that the GDH debate would have a large impact on culture. Helen Wright asked that when structuring agendas, consideration was given to promoting values and having consideration for colleagues, patients and culture. David Sharif added that it was an important point to consider in an open, transparent and honest way. Gill Ponder further highlighted the work that was being done by the Digital team in involving staff in the development of the future strategy. The final comment came from Andy Haywood in that he believed Alex Best and Mark Brearley's paper on the post project evaluation of the MRI and IAAU projects was an excellent example of learning lessons, particularly as neither were employed by the Group from the outset.

7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 Matters to be Referred to other Board Committees

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

7.2 Matters for Escalation to the Trust Boards including any proposed changes to the BAFs

As previously detailed:

- Mitigation to the slippage on the 2024/25 Capital plan and development of 2025/26 plan, the endorsed Allam contract for Board approval and the Post Capital Project Evaluation, which was a step forward, in view of the previous lack of benefit realisation reporting following the completion of major Capital projects.

- The impending decision from the meeting with North Lincolnshire Council on 5 December 2024 about HASR and steps in place to mitigate the activity and income impact of build delays with the CDCs

- Engagement in development of the strategy, no further update on EPR and the CiC acknowledged the longer-term vision now apparent including on the level of spend that would be needed to realise the Group's digital ambitions.

8. DATE AND TIME OF THE NEXT MEETING

8.1 Date and Time of the next Capital & Major Projects CiC meeting:

The next meeting will be held on Thursday 30 January 2025 in the Boardroom, DPoW at 9.00am-12.00pm.

The Committee Chair closed the meeting at 11.36am.

Cumulative Record of Attendance at the Capital & Major Projects Committees-in-Common 2024/2025

Name	Title	2024 / 2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CORE MEMBERS													
Mark Brearley	Group Chief Financial Officer							Y	Y				
Gill Ponder	Non-Executive Director	Y		Y		Y		Y	Y				
David Sharif	Group Director of Assurance	Y		Y		Y		Y	Y				
Helen Wright	Non-Executive Director			Y		Y		N	Y				

Name	Title	2024/2025											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
REQUIRED ATTENDEES													
Julie Beilby	Non-Executive Director	Y		Y		N		N	N				
Alex Best	Interim Group Deputy Director of Capital Services	Y		Y		N		N	Y				
Paul Bytheway	Interim Group Chief Delivery Officer	N		Y		Y		Y					
Tony Curry	Non-Executive Director	Y		Y		Y		Y	Y				
Andy Haywood	Group Chief Digital Officer	N		Y		N		D	Y				
Craig Hodgson	Associate Director of Commercial Services	N		N		N		N	N				
Linda Jackson	Vice Chair	N		N		N		N	N				
Jonathan Lofthouse	Group Chief Executive	N		Y		Y		Y	N				
Sean Lyons	Trust Chairman	N		N		N		Y	N				
Ivan McConnell	Group Chief Strategy and Partnership Officer	Y		Y		Y		Y	D				
Simon Parkes	Non-Executive Director	Y		Y		Y		D	N				
Alastair Pickering	Chief Medical Information Officer	Y		N		Y		N	N				
Ian Reekie	Chair of Governors	Y		Y		Y		Y	Y				
Philippa Russell	Deputy Group Chief Finance Officer	N		N		N		N	N				
Rebecca Thompson	Deputy Director of Assurance	N		Y		Y		Y	Y				
Simon Tighe	Deputy Director of Estates & Facilities	N		N		N		N	N				
OPTIONAL ATTENDEES													
Stuart Hall	Non-Executive Director	Y		Y		Y		N	Y				
Linda Jackson	Non-Executive Director	N		N		N		N	N				
Simon Tighe	Deputy Director of Estate & Facilities	N		N		N		N	N				
Craig Hodgson	Associate Director of Commercial Services	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)028

Name of Meeting	Trust Boards-in-Common - Public
Date of the Meeting	13 February 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 – October 2024 - Public**
Executive Summary	Public minutes of the Audit, Risk and Governance Committees-in-Common (ARG CiC) meeting held on 1 October 2024, approved at the ARG CiC meeting on 23 January 2025.
Background Information and/or Supporting Document(s) (if applicable)	ARG CiC agenda papers – 1 October 2024
Prior Approval Process	ARG CiC meeting – 23 January 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 Tuesday 1 October 2024 at 9am to 12.30pm
Boardroom, Hull Royal Infirmary and via MS Teams

For the purpose of transacting the business set out below:

Present:
Core members:

Simon Parkes	Chair of ARG CiC (NLAG) / Non-Executive Director
Jane Hawkard	Chair of ARG CiC (HUTH) / Non-Executive Director
Gill Ponder	Non-Executive Director (NLAG)
Tony Curry	Non-Executive Director (HUTH)
Helen Wright	Non-Executive Director (HUTH)

In Attendance:

Mark Brearley	Interim Group Chief Financial Officer
David Sharif	Group Director of Assurance
Philippa Russell	Deputy Group Chief Financial Officer (Observing)
Sally Stevenson	Assistant DoF – Compliance & Counter Fraud - Group
Nicki Foley	Local Counter Fraud Specialist – Group
Brian Clerkin	Managing Director (SumerNI) – External Audit NLAG (from item 8)
Danielle Hodson	Internal Audit Manager (Audit Yorkshire) – NLAG
Asam Hussain	Head of Internal Audit (RSM) – HUTH
Robert Knowles	Client Manager (RSM) – HUTH (to item 14)
Paul Bytheway	Interim Group chief Delivery Officer (item 14.1)
Matt Overton	Group Operations Director (EPRR) (item 14.1)
Edd James	Director of Procurement (item 14.3)
Andy Haywood	Group Chief Digital Officer (items 18.1 to 18.3)
Sue Meakin	Group Data Protection Officer (items 18.1 to 18.3)
Ian Reekie	NLAG Governor Observer (from item 8)
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.

Part One – HUTH Business Items – All NED members plus HUTH only attendees in attendance

1. Welcome and Apologies for Absence

Jane Hawkard, HUTH Audit, Risk and Governance Committees-in-Common (ARG CiC) Chair welcomed those present, and introductions were made. Apologies for absence were received from, Rebecca Thompson, Deputy Director

of Assurance, James Collins (Forvis Mazars), Louise Stables (Forvis Mazars), Helen Higgs (Audit Yorkshire) and Chris Boyne (Audit Yorkshire).

It was noted that there were some difficulties being experienced in accessing Team Engine by a number of members.

2. Declarations of Interest

Jane Hawkard asked for any declarations of interest and none were made.

3. External Audit (Forvis Mazars)

3.1 HUTH External Audit Recommendations Action Plan Update

Mark Brearley advised that four items had been identified and the papers indicated progress made, noting some actions were complete and others on-going. Helen Wright referred to the previous meeting minutes, hoping for accurate valuations using the Scan for Safety system, and asked if it was proving to be delivering on that expectation. Mark Brearley confirmed that there was still quite a bit of work to be done with this, adding that he had spoken with the Procurement team and would welcome Internal Audit's view of the progress so far.

Tony Curry advised that Scan for Safety was in his portfolio and advised that it has not been rolled out Trust-wide (HUTH only, not in use at NLAG). The biggest constraining factor is that there is no central product catalogue of stock, resulting in no central accurate record of stock and therefore a process which is trying to mitigate that with a lot of work to be able to create it. Tony Curry advised that it was therefore still a long way off Trust wide at HUTH and a big question mark for NLAG.

Jane Hawkard commented that the pending audit would hopefully provide some more assurance. Mark Brearley stated that the focus of the work needed to be more financial accounting focused rather than just quality and safety focused, adding that his view was that the Trust needed to get to a position that it could be relied upon at the end of the year, and that would need some fairly rapid work which he would be pushing on that. Tony Curry added that it seemed the ICB have plans with Edd James to have an ICB-wide inventory management system which is centrally funded with York being the guinea pig for it, but he was not sure where that was at relative to where HUTH was at with rollout, etc. in a bid to have a robust inventory system.

3.2 Annual Review of External Auditor Performance / Additional Fees

Jane Hawkard queried who answered the performance questions shown in the paper and it was confirmed that it was the senior Finance team. Jane Hawkard also queried whether there would be a further cost if there was more work to do on value for money (VFM) in relation to CIPs. Sally Stevenson replied that James Collins was not anticipating any further fees as they were built into the new contract price, but the caveat to that was if there was a significant risk identified that required additional work then there may be additional charges.

Tony Curry queried who authorised the additional fees and it was confirmed that it had been Lee Bond, former Group Chief Financial Officer in discussion with Jane Hawkard at the time.

Brian Clerkin joined the meeting.

4. HUTH Private Agenda Items

There were no private items.

5. Any Other Urgent HUTH Business

There were no urgent items of business raised.

6. Matters for Escalation to the HUTH Trust Board (Public/Private)

There were no matters to escalate to the Board.

7. Matters To Highlight to other Trust Board CIC

There were no matters to highlight to other Trust Board CiC.

Part Two – Joint Business Items – NLAG attendees to join the meeting as necessary

8. Welcome and Apologies for absence for NLAG attendees joining the meeting

Apologies were as advised above. Simon Parkes advised that Ian Reekie would be joining the meeting at around 9.30am.

9. Declarations of Interest for NLAG attendees

Simon Parkes asked for any declarations of interest and none were made.

10. Minutes of the Previous ARG CiC Meeting on 25 July 2024

10.1 Public Minutes

The minutes were approved as a true and accurate record of the meeting.

10.2 Private Minutes

The minutes were approved as a true and accurate record of the meeting.

The meeting was paused to see if the issues with accessing papers on Team Engine could be resolved. The meeting resumed a few minutes later with members content to continue.

Ian Reekie joined the meeting.

11. Matters Arising and Review of ARG CiC Action Tracker

Jane Hawkard referred to item 12 referring to revisiting the HFMA checklist in the Autumn; Sally Stevenson replied that it was due to be looked at as a Group Finance function starting this week. Jane Hawkard noted that the next ARG CiC meeting was not until the end of January 2025 and asked how they could get assurance on this before then and it was agreed that an interim report would be circulated before the next meeting. Simon Parkes suggested that any comments on the interim report be fed back through him as Chair and he would consolidate them and pass them on for a response.

Action: Philippa Russell / Sally Stevenson

David Sharif referred to item 17.3 - Annual Review of Risk Management Strategy, which was still in draft and being worked on and also referred to the CAP risks.

Item 17.5 – Annual Claims Report and inclusion of peer data for benchmarking purposes. Relates to the production of the 2024/25 report. Rob Chidlow had confirmed that this was on track to be reported in future reports. Given Rob Chidlow was leaving the group it was agreed to leave the action on the action tracker.

Item 34.1 - Internal audit contracts – NLAG and HUTH; Sally Stevenson confirmed that the draft specification for the Group Internal Audit service would be circulated for comments in the next week or so.

12. Internal Audit – Group (Audit Yorkshire and RSM)

12.1 Group Internal Audit Progress Report 24/25 YTD

Asam Hussain advised that good progress was being made with regards the delivery of the Group Internal Audit plan. There was one final report on the agenda (Smart Cards and Access Management) but there are a further two reports in draft relating to the Group CIP and Waste Reduction audit and also the Lorenzo System specific to NLAG. There are a further three reviews in progress; Annual Leave, Junior Doctor Rostering and an additional review around Inventory Management, which was requested by management due to issues around physical verification of stock at month and year end. One audit was slightly delayed (Integrated Performance Reporting (IPR)) review, which had been postponed to quarter 4 due to work in train to improve the quality of the IPR. Simon Parkes asked for clarification regarding the postponed audit, as to whether the ARG CiC needed to approve this**.** This was confirmed. Simon Parkes stated that there was a lot of pressure on management currently and it was very easy to overload quarter 4 with audits that got pushed back and this needed to be kept a close eye on to avoid issues at year end, accepting that there was a need to be realistic with action deadlines to manage workloads appropriately**.**

Matt Overton joined the meeting.

Jane Hawkard referred to the Smart Card Access internal audit report, noting the indicated timescales for completion of the nine recommendations contained in it and whether these could be achieved. There had been previous issues where dates had not been met on other Digital related audits. Jane Hawkard noted that outstanding internal audit recommendations go to the Group Cabinet Risk and Assurance Committee and asked if their concerns about deadlines being missed could be taken back to that meeting. Mark Brearley advised he would take the issue back to Cabinet.

Action: Mark Brearley

Helen Wright noted that the majority of the recommendations on the report were medium priority and asked who was responsible for agreeing the level of priority. Robert Knowles replied that consultations took place with operational staff to discuss and agree these at the end of an audit, receiving challenge from auditees as appropriate.

12.2 Group IA Recommendations Status Report

Asam Hussain stated that there was a noticeable improvement in the NLAG overdue recommendations and confirmed that Group actions were all on track. Jane Hawkard queried the process for changing the implementation date and how the original and new dates were tracked. Sally Stevenson advised that this was all on an electronic tracker system, along with an explanation as to why the dates had changed. Sally Stevenson confirmed that to facilitate an implementation date change, there was a discussion between internal audit and management. Simon Parkes felt that ordinarily it should be the ARG CiC that formally approves a revised implementation date, with agreement implied if there were no specific concerns raised by the ARG CiC, having seen and accepted the original reports and deadlines. Mark Brearley agreed this was good practice and asked Sally Stevenson to work with the internal auditors to ensure any such changes do formally come through the ARG CiC for agreement.

Action: Sally Stevenson / RSM / Audit Yorkshire

Simon Parkes referred to all overdue recommendations, specifically those for NLAG which were at medium or low risk with updates, but essentially still overdue. Simon Parkes stated he would escalate this to the respective members of the Executive team.

Action: Simon Parkes

There were some overdue actions relating to HUTH dating back to 2021/22 and 2022/23. Simon Parkes asked whether these were still relevant. Assam Hussain advised that they had been reviewed previously and agreed as still relevant but they would revisit these again to determine whether still valid or superseded.

Action: Asam Hussain

Paul Bytheway joined the meeting.

13. Counter Fraud – Group

13.1 Group LCFS Progress Report

Nicki Foley took the paper as read but highlighted a couple of points for the ARG CiC. Mandatory e-learning at HUTH was introduced at the end of August 2024 to all 11,000 staff which was considered a positive move in improving awareness of NHS fraud. There had also been two new fraud referrals since the last ARG CiC meeting.

Jane Hawkard queried a case from August 2022 which was still ongoing due to prioritising other cases and asked what the process was for closing down cases. Nicki Foley replied that a decision to close down a case, if appropriate to do so, would be made in discussion with Mark Brearley and Sally Stevenson. Nicki Foley outlined the August 2022 case and why others had been prioritised over it.

Helen Wright asked if additional controls were put in place with a view to preventing duplicate payments in the future. Nicki Foley advised that these related to the National Fraud Initiative (NFI) exercise and explained that there is feedback to East Lancashire Financial Services (ELFS), the Trust's financial services provider, where these are identified. It was noted that there had been a change of system where a limited number of payments had been made on the old and new systems, resulting in duplicate payments. Helen Wright felt reassured with the explanation of the reason behind the duplication.

Simon Parkes was pleased to see that mandatory fraud awareness training had been launched at HUTH, noting it had a good take up at NLAG and was hopeful this would continue particularly to try and avoid the issue of staff working elsewhere whilst off sick.

14. Management Reports for Assurance

14.1 EPRR Core Standards Compliance Action Plans Update - Group

Paul Bytheway advised that they were unable to provide assurance to the ARG CiC at this point. Work had been done on the old core standards but formal validation had not yet been performed, although he added that all actions required to be taken were complete. Paul Bytheway reminded the ARG CiC that the process for Emergency Preparedness, Resilience and Response (EPRR) compliance in this region was changed last year which resulted in a dramatic drop in all compliance rates, and the reported 40% at NLAG was the highest in the region. The report also explained the 2024/25 process that is being undertaken.

Simon Parkes commented there was a lot of detail in the report and that some assurance could be taken from it, and asked for any questions. Gill Ponder understood that from discussions last year, the goalposts had moved and as such compliance scores had reduced dramatically despite supplying a substantial amount of evidence. Gill Ponder added that for 2024/25, her understanding was that the process was underway for preparing a submission but there was no requirement to re-submit the evidence submitted last year and evidence was only required to be submitted this time where there was non-compliance. Matt Overton confirmed this was correct, evidence was only required this year for non-compliance or partial compliance.

Gill Ponder commented that in her view the organisation was not good embedding improvements and when there is a need to look at something else the other things deteriorate again. Gill Ponder therefore posed the question to Matt Overton as to whether he was confident that the Trusts would still be compliant in all the areas that the Trusts had had to previously submit evidence for but were not required to do so for this year. Matt Overton replied that he could provide assurance that the annual self-assessment was performed against every core standard including those fully compliant previously, they just did not upload the evidence in support of fully compliant standards. An imminent ICB-led meeting would be peer reviewing each other's evidence for all 62 standards. Gill Ponder and Jane Hawkard were content that assurance had been provided.

Jane Hawkard referred to page 20 regarding the mass countermeasures and vaccination policy at NLAG not being suitable at HUTH, and queried what was being done instead as it did not say. Matt Overton replied that the counter measures covered a couple of elements, firstly that of community services. There was full compliance on the south bank last year and this year, but as HUTH do not manage community services, the overall service cannot be truly replicated across the two. There was work ongoing with the HUTH Emergency Department at Hull Royal Infirmary team to address HUTH compliance.

Simon Parkes summarised that the ARG CiC were not assured last time but there was reasonable assurance this time due to substantial progress being made on last year's standards, although not quite full assurance yet**.** Simon Parkes qualified this by acknowledging that the latest self-assessment was ongoing and things may have

changed, but there was 91% compliance at NLAG and slightly lower at HUTH, so well on the way to full compliance. It was confirmed that the results of the self-assessment and the ICB peer review exercise would be submitted to the December 2024 Trust Boards-in-Common meeting.

Following discussion, it was agreed that this would be highlighted to the Trust Boards-in-Common.

Paul Bytheway and Matt Overton left the meeting.

14.2 Board Assurance Framework and Risk Register – Group

The paper was taken as read and Simon Parkes invited questions from the Committee. Helen Wright reiterated discussions at other Committees-in-Common with regards to the overall scoring and current risk rating, and not being comfortable that so many risks were at red, adding there was a need for more activity and evidence around the mitigation to get scores closer to their target scores. Helen Wright stated that this remained outstanding in her view and there should be no complacency around the number of red risks. Tony Curry agreed with this, adding that there needed to be progress before going into quarter 4.

Gill Ponder noted there were thirteen overdue high risks for review, but it was unclear which high risks were overdue from Appendix 2 of the report. David Sharif agreed with the action focus around the Board Assurance Framework (BAF) going forward. In response to the overdue risks, David Sharif stated that there were fewer red overdue risk than previously (23), so a reduction but not at the pace everyone would like. David Sharif added that the report could be amended to make it clearer, although explained that the online Group report had a very clear visibility.

Simon Parkes raised the question of capacity to keep the risks up to date and therefore the capacity to put in train proper mitigation and action plans to drive the level of risk down. He went on to say that some of the risks may crystalise and therefore questioned to what extent the organisations could sensibly monitor over 600 risks and how seriously it was being taken, suggesting that it may be better to prioritise and monitor fewer and ask for more progress particularly where they are linked to the Trusts priorities. Simon Parkes suggested that this was maybe a topic for a Board Development session.

Edd James joined the meeting.

Gill Ponder suggested that divisional risks were being confused with strategic risks and that they were very much from the perspective of the department in question. Gill Ponder also commented that there was an organisational narrative of massive understaffing but didn't believe that metrics supported this narrative anymore as staffing is increasing and almost all nursing vacancies are filled. Gill Ponder supported that managers should have local risk registers, but a tiered approach was needed, ensuring that only strategic risks were fed into the CiC's which aligned with Trust strategic objective and core priorities. Helen Wright agreed with this view and advised that this had been discussed at the Performance, Estates and Finance CiC, in that they had asked for the Finance risk to be separated into the longer term finance risk versus the in-year tactical risk. This misalignment was the same across other risks.
Jane Hawkard commented the ARG CiC needed to ensure processes were in place to ensure the risks were fed into the BAF risks, but was struggling to see this. There

are 104 high level risks but Jane Hawkard queried the review process and asked where this was being done, noting the Risk Manager vacancy, and what steps were being taken. David Sharif confirmed that there was a refreshed Risk Management strategy coming, with a new BAF, a new Risk Manager and that Amanda Stanford was arranging a group to specifically manage risks across the care groups. Jane Hawkard considered that more emphasis was needed on the high level risks, to allow managers not to become swamped and to focus more clearly.

Gill Ponder commented that managers sometimes added items to the risk registers as an abdication of responsibility, forgetting that they actually need to take accountability for the risk and are responsible for mitigating that risk and stating what has been done to mitigate the risk.

Mark Brearley stated he had reviewed the high-level Estates and Facilities risks with the senior Estates staff the day before and there needed to be an organisational cultural balance. If the likelihood of something happening is almost certain he wants to understand what the action is and what the residual risk is. The ARG CiC discussed that there should be an original risk score, a target risk score and a mitigated risk score. It also considered that issues sometimes got conflated with risks.

Simon Parkes summarised that the ARG CiC role was to look at framework for the effectiveness of risk management and risk reporting, and that at present only limited assurance could be given to the Board, because the process of reporting made it very difficult to see the trajectory, and it was difficult for the ARG CiC to see which risks end up on at the high level risk register, which have not and why. Additionally, having an unmitigated and mitigated risk score should be a focus moving forward. Following discussion, it was agreed to highlight this issue to the Boards-in-Common.

14.3 Procurement Update (including Waiving of Standing Orders, Procurement KPIs and expired contracts recovery action plan) – Group

Simon Parkes advised that the paper would be taken as read and invited questions. Helen Wright thanked Edd James for the comprehensive report, and queried whether it was accurate that the HUTH quotation waivers actually related to single supplier or whether there had been no time to investigate a dual sourcing strategy. Edd James responded that this related in the main to maintenance contracts for equipment purchases, where it was necessary to continue with the maintenance from the supplier to keep the warranty active. However, what should be happening is that maintenance contracts are purchased at the same time as the equipment to avoid the need for single source waivers and Edd James confirmed there is a plan to get on top of this issue.

Gill Ponder was pleased to see there was a plan in place for expired contracts and looked forward to seeing progress on this against the plan. Simon Parkes noted that the number of expired contracts had reduced by a third in three months which was a substantial reduction, however Edd James confirmed it was due to data cleansing (e.g. checking if something needed renewing and establishing it did not so archiving the contract).

Tony Curry was pleased to see an increased focus on contract management but queried how far inventory management overlapped into Edd James role and future plans. Edd James advised that inventory management sat with him and confirmed a plan was in place to get on top of it. The first piece of work underway was to

improve catalogues held as they drive the inventory management system, this has involved cleansing 550,000 lines of catalogue data. In addition to this, conversations were taking place with stakeholders around the number of types of the same item they were using with a view to reducing the number, and work was also underway on improving storerooms by reducing stock held on site and ensuring users were confident that supplies could be obtained when needed rather than sitting on high stock levels. Tony Curry thanked Edd James for the update and asked for a more comprehensive update on the situation of stock management / cost reduction generally. Edd James confirmed he could provide a fuller update at the next meeting and Simon Parkes suggested he incorporate this into his next report to the ARG CiC.

Action: Edd James

Jane Hawkard reverted to the expired contracts, and queried for those that may be extended whether it would be on existing terms depending on value for money, how they would know. Edd James replied that conversations were taking place with existing suppliers and a process was underway of contacting all suppliers to advise of the new procurement collaborative across the three Trust and that there was an expectation that prices would be aligned across the three organisations and that buying power should be reflected in the prices, which should bring about financial benefits.

Mark Brearley commented that there was significant potential to add to the CIP plans in the area of clinical supplies / consumables and he had spoken to Edd James about this and noted that good progress was being made. Mark Brearley wanted to be absolutely sure about the Scan for Safety project from an efficiency perspective as well as quality and safety.

Simon Parkes noted the level of improvement and welcomed the recovery plan for reducing the number of expired contracts, which the ARG CiC had requested, and the important work taking place on data cleansing to understand the true position. Simon Parkes stated that the ARG CiC had reasonable assurance on this subject, which was on a pathway to substantial assurance.

Tony Curry asked Edd James if the Group was in a robust position on inventory management. Edd James stated that it was not the case yet, as there was still a lot of work to do, however plans were in place and underway.

Following discussion, it was agreed to highlight substantial improvement in this area to the Trust Boards-in-Common.

14.4 Review of Losses and Compensations – Group

Simon Parkes advised this was a routine report for information only, with questions by exception. Jane Hawkard referred to HUTH overseas visitors and the statement that debts had started to be written off, and queried how much more was there to be written off. Jane Hawkard also queried whether it related to emergency or planned treatments. Philippa Russell advised that these questions would be clarified and reported back to the ARG CiC.

Gill Ponder asked for clarification on the process for charging overseas patients within the Group and whether staff involved in the process had a process for notifying patients in advance that they did not qualify for free treatment and would

need to pay in advance. Mark Brearley agreed to take this as an action and feed back to the ARG CiC on the questions raised relating to overseas visitors.

Action: Mark Brearley

Gill Ponder felt that in light of current waiting lists, planned procedures should not be agreed for overseas patients who have not paid in advance as it was causing capacity issues as well as financial losses.

Gill Ponder also raised a question around why there had been such a big increase in HUTH salary overpayments (from one in 2021/22 to 41 in 2023/24, and at 19 for 2024/25 year to date) as referred to in Appendix A, and queried if this was due to a process change. Mark Brearley agree to establish the reason for this and report back to the Committee.

Action: Mark Brearley

Gill Ponder also raised a query around pharmacy waste and the fact that NLAG were reporting such waste and HUTH was showing zero, querying the reason for this difference. Mark Brearley advised that the difference could be related to inconsistent reporting and would investigate this further.

Action: Mark Brearley

Simon Parkes considered that limited assurance was received, due to the uncertainty on reasons for the issues raised. This would be highlighted to the Trust Boards-in-Common.

14.5 Review of Standards of Business Conduct Declarations – Group

Jane Hawkard highlighted sponsorship and whether there was a policy for this, as the amounts declared seemed high and there was uncertainty as to whether a threshold existed. David Sharif advised there was a policy in place and would check.

Action: David Sharif

Gill Ponder queried declarations of interest and whether the percentage figures related to those who had made declarations as opposed to those who could / should have made declarations. David Sharif confirmed that it related to percentage of that type out of a total across the Group. Gill Ponder stated that the table was not helpful as it was confusing. David Sharif confirmed there were two systems in place across the Group and agreed that there was a need to show the percentage of total number of staff who should submit declarations even if it was a nil return. Simon Parkes commented that the Group knows about those who have made declarations but there appeared to be significant gaps in declarations, which could be attributed to nil declarations, adding that the process needed to be clear and effective. The issue of private practice by consultants was also discussed, as well as declarations by decision making staff. The ARG CiC requested that this data be produced and reported no later than the end of the current financial year. David Sharif advised that they were working to try and harmonise the process across the Group, recognising also that the Trusts wanted to engender an open and transparent culture.

Action: David Sharif

The ARG CiC confirmed only limited assurance at this stage due to not knowing the full picture around compliance with making annual declarations. It was agreed to highlight this to the Trust Boards-in-Common.

14.6 Document Control Report - Group

Gill Ponder noted there were eleven documents overdue for review dating back to 2018/19, including apparent substantial policies and processes that should have been reviewed. Mark Brearley commented that the document might be extant but simply that the review date had not been updated. This was to be looked at and document authors to be contacted for updates.

Action: David Sharif

Jane Hawkard noted that within the Family Services Care Group, there were 49 overdue documents, despite working on a maternity plan all year and potential scrutiny by the CQC. David Sharif replied that this was on Amanda Stanford and Dr Kate Wood's radar. Helen Wright asked who was accountable for the policies as it may not be the author. David Sharif confirmed that each policy was assigned to a care group, and he had suggested that the report be taken to the site performance review meetings. Jane Hawkard added that policies should be consolidated where possible.

It was felt that assurance was limited at present, but that work was underway to address issues and harmonise processes Group wide. It was agreed to highlight this to the Trust Boards-in-Common.

The meeting paused for a 10 minute break. Robert Knowles left the meeting.

Andy Haywood joined the meeting.

15. Policies for Review/Approval

There were no policies for review / approval.

16. ARG CIC Governance Items

16.1 Schedule of ARG CIC Meetings 2025

The schedule of ARG CiC meeting dates for 2025 was provided for information.

17. Highlight Reports and Action Logs from Board Sub-Committees-in-Common

17.1 Performance, Estates & Finance CiC
17.2 Capital & Major Projects CiC
17.2 Quality & Safety CiC
17.3 Workforce, Education & Culture CiC

The above highlight reports and action logs were received for information. There were no issues raised.

18. Private Agenda Items

Refer to the private minutes for items 18.1 to 18.3.

Andy Haywood and Sue Meakin left the meeting.

19. Any Other Urgent Joint Business

There were no urgent items of joint business raised.

20. Matters for Escalation to the Trust Boards-in-Common (Public/Private)

The following joint items of business were agreed to be highlighted to the public Trust Boards-in-Common:

- EPRR Core Standards Compliance Action Plans Update – Group
- Board Assurance Framework and Risk Register – Group
- Procurement Update including expired contracts recovery action plan
- Review of Losses and Compensations – Group
- Review of Standards of Business Conduct Policy Declarations – Group
- Document Control Report – Group
- Group Internal Audit Reporting and Recommendations

The ARG CiC also highlighted some digital and cyber security updates to the private Trust Boards-in-Common.

21. Matters to Highlight to other Trust Board CiC

The frequency of mandatory IG training to be highlighted to the Workforce, Education & Culture Committees-in-Common.

22. Review of the Meeting (prior to HUTH attendees leaving)

Simon Parkes asked if there was any particular feedback on the meeting to let Sally Stevenson know.

Part Three - NLAG Business Items – HUTH attendees leave the meeting. All NED members remain

23. Minutes of the Previous NLAG ARG Committee Meeting on 6 August 2024

The minutes were approved as a true and accurate record of the meeting.

24. External Audit (Sumer NI)

24.1 Routine Progress Update

Brian Clerkin confirmed that the annual planning report would be brought back to the ARG CiC in January 2025, and also reminded the Committee that the normal national annual accounts submission deadlines resumed for NLAG this year (2024/25) after the extensions of the past two years.

24.2 Annual Review of External Auditor Performance/Additional Fees

No comments or questions were raised.

25. NLAG Private Agenda Items

There were no private agenda items to discuss.

26. Any Other Urgent NLAG Business

There were no urgent items of NLAG business raised.

27. Matters for Escalation to the NLAG Trust Board (Public/Private)

There were no matters to escalate to the NLAG Trust Board.

28. Matters to Highlight to other Trust Board CiC

There were no matters to highlight to other Trust Board CiC.

29. ARC CiC Workplan

The workplan was provided for information.

30. Date of the Next Meeting

Thursday 23 January 2025
9am to 12.30pm
Boardroom, HRI and via MS Teams

The meeting ended at 12.31pm.

Schedule of Attendance at Audit, Risk and Governance Committees-in-Common Meetings

Member / Attendee	Jan24	Apr24	Jun24 HUTH A/C's	Jul24	Aug24 NLAG A/C's	Oct24	Jan25	Total
Core Members:								
Simon Parkes – NED / NLAG ARG CiC Chair	Y	Y	N/A	Y	Y	Y		5/5
Jane Hawkard – NED / HUTH ARG CiC Chair	Y	Y	N*[1]	Y	N/A	Y		4/5
Gill Ponder – NED - NLAG	Y	Y	N/A	N	N	Y		3/5
Kate Truscott – NED - NLAG	Y	Y	N/A	N	N			2/4
Mike Robson – NED - HUTH	Y	Y						2/2
Tony Curry – NED - HUTH	Y	Y	Y		N/A	Y		4/5
Helen Wright – NED - HUTH			Y	N	N/A	Y		2/3
Sue Liburd – NED - NLAG				Y*[2]				1/1
Linda Jackson – Trust Vice Chair / NED - NLAG				Y*[2]	Y*[2]			2/2
Regular Attendees:								
Lee Bond – Group Chief Financial Officer	Y	Y	Y	Y	Y			5/5
Mark Brearley – Interim Group Chief Financial Officer						Y		1/1
Wendy Booth – Interim Governance Advisor (NLAG)	Y							1/1
David Sharif – Group Director of Assurance		Y	Y	Y	N	Y		4/5
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	Y	Y	Y	Y	Y	Y		6/6
Nicki Foley – Local Counter Fraud Specialist - Group	Y	Y	N/A	Y	N/A	Y		4/4
Rebecca Thompson – Deputy Director of Assurance	Y	Y	Y	Y	Y	N		5/6
Sue Meakin – Data Protection Officer and IG Lead	Y	Y	N/A	Y	N/A	Y		4/4
External Audit – NLAG (Sumer NI formerly ASM)	Y	Y	N/A	Y	Y	Y		5/5
External Audit - HUTH (Forvis Mazars formerly Mazars)	Y	Y	Y	Y	N/A	N		4/5
Internal Audit - NLAG (Audit Yorkshire)	Y	Y	N/A	Y	Y	Y		5/5
Internal Audit – HUTH (RSM)	Y	Y	Y	Y	N/A	Y		5/5
NLAG Governor (Observer)	Y	Y	N/A	Y	N/A	Y		5/5
Ad-hoc Attendees:								

Abolfazi Abdi – Deputy Chief Operating Officer	Y	-	-	-	-	-		1
Fran Moverley – Head of Freedom to Speak Up - HUTH	Y	-	-	-	-	-		1
Tony Deal – Group Chief Technology Officer	Y	Y	-	-	-	-		2
Steve Mattern- Group Director of IT Performance & Operations	Y	-	-	Y	-	-		2
Stuart Hall – HUTH Vice Chair (Observer)	Y	-	-	-	-	-		1
Nicola Parker – Asst. DoF – Planning & Control	-	Y	Y	-	Y	-		3
Rachel Kemp – Deputy Director, D2A Transformation	-	Y	-	-	-	-	-	1
Helen Knowles – Director of People Services	-	Y	-	-	-	-	-	1
Andy Haywood – Group Chief Digital Officer	-	Y	-	-	-	Y		2
Rob Chidlow – Group Interim Director of Quality Governance	-	-	-	Y	-	-		1
Paul Bytheway – Group Interim Chief Delivery Officer	-	-	-	Y	-	Y		2
Matt Overton – Group Operations Director - EPRR	-	-	-	Y	-	Y		2
Edd James – Director of Procurement	-	-	-	Y	-	Y		2
Sean Lyons – Group Chair	-	-	Y	-	Y	-	-	2
Jonathan Lofthouse – Group Chief Executive	-	-	Y	-	Y	-	-	2
Alison Hurley – Deputy Director of Assurance - NLAG	-	-	-	-	Y	-	-	1

Notes:

*1 – Tony Curry chaired the meeting in the absence of Jane Hawkard

*2 – In attendance to ensure quoracy

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)029

Name of Meeting	**Trust Boards-in-Common**
Date of the Meeting	13 February 2025
Director Lead	Simon Parkes and Jane Hawkard – NEDs / Chairs of Audit, Risk and Governance Committees-in-Common.
Contact Officer / Author	Sally Stevenson, Assistant Director of Finance – Compliance and Counter Fraud
Title of Report	**Results of Audit, Risk and Governance Committees-in-Common Annual Self-Assessment Exercise 2025**
Executive Summary	The annual self-assessment exercise has been conducted by the Audit, Risk and Governance Committees-in-Common (ARG CiC). The annual self-assessment documents from February 2024 for the two former Audit Committees (NLAG and HUTH) were reviewed initially by the Assistant Director of Finance – Compliance and Counter Fraud and updated accordingly to produce one combined ARG CiC self-assessment covering the first year of the new CiC approach. The latest self-assessment has also been undertaken using the updated 2024 HFMA NHS Audit Committee Handbook checklist, which includes eight new questions – these are shown in red type for ease of reference on the attached. The updated draft self-assessment document for 2025 was circulated to the following for review and comment as appropriate, with comments/suggestions duly incorporated as necessary: • Simon Parkes – NED / ARG CiC Chair (NLAG) • Jane Hawkard – NED / ARG CiC Chair (HUTH) • Tony Curry – NED / ARG CiC Member (HUTH) • Helen Wright – NED / ARG CiC Member (HUTH) • Gill Ponder – NED / ARG CiC Member (NLAG) • Julie Beilby – NED / ARG CiC Member (NLAG) • Emma Sayner – Group Chief Financial Officer (from Dec24) • David Sharif – Group Director of Assurance • Brian Clerkin / Jason McCallion – Sumer (NLAG External Audit) • James Collins / Louise Stables – Forvis Mazars (HUTH External Audit) • Chris Boyne / Danielle Hodgson – Audit Yorkshire (NLAG Internal Audit) • Asam Hussain – RSM (HUTH Internal Audit) **The Trust Boards-in-Common are asked to note the results of the latest self-assessment exercise performed by the Audit, Risk and Governance Committees-in-Common in January 2025.**

Background Information and/or Supporting Document(s) (if applicable)	Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2024) – self-assessment checklist template.
Prior Approval Process	Audit, Risk and Governance Committees-in-Common – 23 January 2025
Financial Implication(s) (if applicable)	-
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Audit, Risk and Governance Committees-in-Common

Self-Assessment Review of Committee Processes - HFMA NHS Audit Committee Handbook (2024) - 23 January 2025

Area/ Question	Yes	No	Comments/Action
1. Composition, establishment and duties			
1.1 Does the audit committee have written terms of reference and have they been approved by the governing body?	√		New Membership and Terms of Reference (ToR) produced for the introduction of Committees-in-Common (CiC) in January 2024, signed off by the Trust Boards-in-Common in December 2023. Minor revisions made to the Audit, Risk and Governance Committees-in-Common (ARG CiC) ToR during 2024 (to reflect new HFMA NHS Audit Committee Handbook (2024) and general CiC ToR changes) and approved by the Trust Boards-in-Common in August 2024.
1.2 Are the terms of reference reviewed annually?	√		Part of the ARG CiC's annual work plan, and also adjusted as necessary in the intervening period. See above details also.
1.3 Has the committee formally considered how it integrates with other committees that are reviewing risk?	√		The ARG CiC's ToR specifically refers to how it integrates with other Board sub-committees. This is achieved by reviewing their work, specifically in terms of the management of risks, through the routine receipt of action logs and highlight reports at each meeting of the ARG CiC, and identifying any issues that the ARG CiC feel further assurance is required on. Additionally, there is formal ARG CiC member representation on each of the Board sub-committees. Each CiC also has a standing agenda item to refer matters to Board / CiC's enabling each CiC to formally record their risk referral across the Group's governance.
1.4 Are committee members independent of the management team?	√		The ARG CiC membership comprises three Non-Executive Directors from each Trust, six in total.
1.5 Does at least one committee member have a financial background?	√		Yes, more than one.
1.6 Are all executive officers that you would expect to attend present at meetings?	√		Yes, Group Chief Financial Officer and Group Director of Assurance are in attendance at each meeting. Other executive officers attend as required. Attendance schedule produced annually. ToR include Group CEO and Chairman invited to attend as required / requested by the ARG CiC and attend at least once a year for the annual accounts and reports review meeting.

Area/ Question	Yes	No	Comments/Action
1.7 Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?	√		Minutes and highlight reports submitted to the Trust Boards-in-Common. The Chairs of ARG CiC present a highlight report at Trust Boards-in-Common (as do all other sub-committee Chairs). Highlight reports also submitted to the NLAG Council of Governors for oversight and scrutiny.
1.8 Does the committee prepare an annual report on its work and performance for the governing body?	√		Annual report submitted to the Trust Boards-in-Common and Council of Governors (NLAG only) for information.
1.9 Has the committee established a plan of matters to be dealt with across the year?	√		New ARG CiC workplan developed for the introduction of Committees-in-Common in January 2024, signed off by the Board in December 2023. Adjustments made in line with revisions to ToR. Subject to annual review and adjustment as necessary in the intervening period.
1.10 Are committee papers distributed in sufficient time for members to give them due consideration?	√		In line with ARG CiC ToR – five clear working days prior to each meeting (effective from June 2024 – previously seven calendar days before).
1.11 Has the committee been quorate for each meeting this year?	√		Six scheduled ARG CiC meetings during 2024 (Jan / Apr / Jun (HUTH accounts only) / Jul / Aug (NLAG accounts only) / Oct) and all were quorate.
1.12 Is there a succession plan in place for the chair of the audit committee?	√		Normal recruitment process for Non-Executive Directors and part of appraisal process with Group Chair. With the benefit of the CiC approach, the ARG CiC has two Chairs present at each meeting. There are also two nominated vice chairs in place. The Group has good responses to all NED vacancies. Having two members of the ARG Committee at each Trust with financial backgrounds gives assurance regarding succession planning.
1.13 Are there clear arrangements in place in terms of how the committee works within the integrated care system?		√	The Group Chief Executive brings routine updates to the Boards-in-common on ICS developments and risks. Being considered as part of the updated Risk Management Strategy, as per updates provided to ARG CiC by the Group Director of Assurance at July and October 2024 meetings). Updated Risk management strategy awaited and expected by March 2025. The ARG CiC have asked how ICS risks will be considered.

Area/ Question	Yes	No	Comments/Action
2. Internal control and risk management			
2.1 Has the committee reviewed the effectiveness of the organisation's risk management framework?	√		July 2024 ARG CiC meeting.
2.2 Has the committee reviewed the effectiveness of the organisation's assurance framework?	√		Through Internal Audit annual review at each Trust. The ARG CiC received the Annual Review of the Adequacy and Effectiveness of the System for Devising and Monitoring the Board Assurance Framework (BAF) at its July 2024 meeting. The ARG CiC also receives a routine report on the Group BAF and Risk Register at each meeting (excluding the accounts only meeting) since October 2024.
2.3 Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?	√		Through minutes from other Board sub-committees.
2.4 Has the committee reviewed the accuracy of the draft annual governance statement?	√		The ARG CiC endorses the Annual Governance Statement (AGS) for each Trust before they are presented to the Trust Boards-in-Common each year. ARG CiC minutes will evidence this.
2.5 Has the committee reviewed key data against the data quality dimensions?	√		The Committee receives reports from Internal Audit on the outcome of reviews of targeted KPI's as part of the IA annual plan. The Committee also receives updates in quality dimensions through receipt of the minutes from the Quality and Safety CiC and Workforce, Education and Culture CiC.
3. Annual report and accounts and disclosure statements			
3.1 Does the committee receive and review a draft of the organisation's annual report and accounts?	√		Annual Report and Accounts. The ARG CiC received the draft accounts for both Trusts for review prior to submission to the External Auditor and NHSE, and ARG CiC minutes will evidence this. The ARG CiC also received the audited accounts and annual reports for review. The HUTH audited accounts and annual report were approved by the ARG CiC in June 2024 under formal delegated authority from the HUTH Trust Board. The NLAG audited accounts and annual report were endorsed by the ARG CiC at its August 2024 meeting and recommended for approval at the NLAG Trust Board in August 2024 (final year of extended submission deadline to NHSE). Trust Boards-in-Common and ARG CiC minutes will evidence this.

Area/ Question	Yes	No	Comments/Action
Does the committee specifically review: • changes in accounting policies • changes in accounting practice due to changes in accounting standards • changes in estimation techniques • significant judgements made in preparing the accounts • the going concern assessment • significant adjustments resulting from the audit • explanations for any significant variances?	√		Facilitated as necessary through reports from Finance / External Auditor for each Trust and discussion at ARG CiC meetings. All items mentioned are reviewed by the Committee as part of the review of the annual accounts process, which are minuted.
3.3 Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?	√		Part of the Annual Accounts meeting discussions at the ARG CiC meetings (June 2024 for HUTH and August 2024 for NLAG) prior to submission to NHSE.
3.4 Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?	√		Robust discussions involving annual accounts. The Audit Completion Report for each Trust includes explanations for any areas of non-adjustment as appropriate.
4. Internal audit			
4.1 Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?	√		Formal Internal Audit (IA) Charter and IA Working Protocol with each Internal Audit Provider (currently Audit Yorkshire at NLAG and RSM UK at HUTH). Charter included as an appendix to the annual internal audit plan presented to the ARG CiC in April each year. Both charters were attached to the Group IA plan received at the April 2024 ARG CiC meeting.
4.2 Does the committee review and approve the internal audit plan, and any changes to the plan?	√		Annual IA plans are approved at the beginning of each financial year. Any changes to the IA plan are documented and approved through IA progress reports to each ARG CiC meeting as necessary.
4.3 Is the committee confident that the audit plan is derived from a clear risk assessment process?	√		2024/25 Group IA plan derived from Group Cabinet discussions on current risks (identified from reviewing Trust risk registers) and consideration of audits performed in 2023/24 and those proposed for 2024/25 and agreement of priority areas for review. Draft plan compiled for further discussion by Executive team and then submission of a final draft to the April 2024 ARG CiC for review and approval.

Area/ Question	Yes	No	Comments/Action
			Additionally, the ARG CiC may from time to time suggest items of concern for consideration of inclusion in the annual IA plan.
4.4 Does the committee receive periodic progress reports from the head of internal audit?	√		At each meeting – Group IA Progress Report produced since July 2024.
4.5 Does the committee effectively monitor the implementation of management actions arising from internal audit reports?	√		At each meeting – for NLAG, HUTH and Group recommendations.
4.6 Does the head of internal audit have a right of access to the committee and its chair at any time?	√		Specifically referred to in ARG CiC ToR.
4.7 Does the committee hold periodic private discussions with the internal auditors?	√		Once a year or at any other meeting if requested in advance by the auditors. Most recently undertaken in October 2024.
4.8 Does the committee assess the performance of internal audit?	√		KPI's (target / actual) included in IA progress reports and Annual Reports. No specific details on client survey feedback (number of responses, etc.) in IA Annual Report. No formal internal review mechanism for consideration by the ARG CiC (similar to the one for External Audit) – to be undertaken going forward.
4.9 Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?	√		Issues regarding this could be raised at the annual private meeting (most recently in October 2024) between the auditors and the ARG CiC members, or by calling an ad-hoc private meeting at any time or during ARG CiC meetings if such an issue arose. IA also meet with the HUTH ARG CiC Chair prior to each meeting and this provides a further opportunity to raise any issues should it be required.
4.10 Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*?	√		Audit Yorkshire's work is undertaken in accordance with their detailed Internal Audit Quality Assurance Manual which ensures a consistent approach and compliance with all relevant regulatory standards. In addition, there is an annual Internal Quality Assessment and an External Quality Assessment undertaken every five years to objectively assess compliance with Public Sector Internal Audit Standards. Audit Yorkshire undertook an Internal Quality Assessment in 2024 prior to an External Quality Assessment by CIPFA in September 2024 which confirmed full compliance with the Public Sector Internal Audit Standards.

Area/ Question	Yes	No	Comments/Action
			RSM's UK work is undertaken in accordance with their detailed Internal Audit Quality Assurance Manual to ensure continuous improvement, and compliance with all relevant regulatory standards. In addition, the Standards require internal audit providers to have an external review every five years to objectively assess the quality of their service. The RSM UK Risk Assurance service line commissioned an external independent review of their services in 2021, to provide assurance that their approach continued to meet the required Standards, with the following outcome: *'RSM IA 'generally conforms' (highest rating that can be achieved) to the requirements of the IIA Standards…and there were no instances of non-conformance with any of the Professional Standards'.*
4.11 Does the committee receive and review the head of internal audit's annual opinion?	√		ARG CiC minutes will evidence this for each Trust.
5. External audit			
5.1 Are appropriate external audit procurement arrangements in place?	√		Yes, evaluation panel established as necessary. NLAG procurement process involves Council of Governors representatives and COG approval.
5.2 Do the external auditors present their audit plan to the committee for agreement and approval?	√		ARG CiC minutes will evidence this for each Trust.
5.3 Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?	√		ARG CiC minutes will evidence this for each Trust. The Audit Completion Report from each External Auditor covers the requirements of ISA 260.
5.4 Does the committee review the external auditor's value for money conclusion?	√		ARG CiC minutes will evidence this for each Trust.
5.5 Does the external audit representative have a right of access to the committee and its chair at any time?	√		Specifically referred to in ARG CiC ToR.
5.6 Does the committee hold periodic private discussions with the external auditors?	√		Once a year or at any other meeting if requested in advance by the auditors. Most recently undertaken in October 2024.
5.7 Does the committee assess the performance of external audit?	√		Formalised approach with a paper to the ARG CiC providing a formal annual evaluation of External Audit performance for each Trust. Last undertaken in

Area/ Question	Yes	No	Comments/Action
			October 2024. Issues in the intervening period would be addressed as necessary.
5.8 Does the committee require assurance from external audit about its policies for ensuring independence?	√		Formal confirmation in audit planning/fee documentation from each Trust's External Auditor.
5.9 Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?	√		Policy for Engagement of External Auditors on Non-Audit Work in place for each Trust and subject to annual review. Minor revisions approved in January 2024 to reflect changes to job titles and committee names. Next scheduled review at January 2025 meeting. Details of non-audit work included in the annual ISA260 report from each Trust's External Auditor. Value of non-audit work also identified separately in the annual accounts for each Trust.
6. Clinical audit [Note: this section is only relevant for providers]			
6.1 If the committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?	√		The Quality & Safety Committees-in-Common (Q&S CiC) are responsible for monitoring delivery of clinical audit activity. Q&S CiC minutes received by ARG CiC.
7. Counter fraud			
7.1 Does the committee review and approve the counter fraud work plans, and any changes to the plans?	√		Group counter fraud work plan agreed by the Local Counter Fraud Specialist (LCFS) with Group Chief Financial Officer and received by the ARG CiC for review in April 2024.
7.2 Is the committee satisfied that the work plan is derived an appropriate risk assessment and that coverage is adequate?	√		Group counter fraud work plan informed by register of fraud risks, internal audit, Cabinet Office's National Fraud Initiative (NFI), NHS Counter Fraud Authority (NHS CFA) intelligence reports, etc. Work plan areas based on national provider standards established by the NHS CFA / Cabinet Office.
7.3 Does the audit committee receive periodic reports about counter fraud activity?	√		Standing agenda item for written Group counter fraud progress reports from the LCFS at each ARG CiC meeting. Group LCFS in attendance at each meeting.
7.4 Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?	√		ARG CiC minutes will evidence this where appropriate.
7.5 Do those working on counter fraud activity have a right of direct access to the committee and its chair?	√		Contained within ARG CiC ToR in relation to the LCFS. The LCFS also meets with the ARGC Chairs annually.

Area/ Question	Yes	No	Comments/Action
7.6 Does the committee receive and review an annual report on counter fraud activity?	√		Yes, ARG CiC minutes will evidence this.
7.8 Does the committee receive and discuss reports arising from quality inspections by NHSCFA?	√		ARG CiC minutes will evidence this where appropriate.

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)030

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**13 February 2025**
Director Lead	Ivan McConnell, Group Chief Strategy & Partnerships Officer
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 & 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 Meetings in January 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)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Integrated Performance Report

MONTH 9: December 2024 Performance

November 2024 for Cancer data
Produced January 2025

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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	**December 2024** **0** **1** **86** **2,857**	**December 2024** **0** **0** **8** **563**	• Care Groups focused on the clearance of first outpatient waits over 40 weeks to sustain delivery of 65 weeks • The number of 52 week breaches at HUTH has remained broadly static. Slight reduction in 52 week waits at NLaG (-33). The underlying linear growth in the waiting list and the associated volume of >52 week waits is placing significant pressure on the delivery of zero >65 week waits by 31st March • One breach of the >78week standard at HUTH resulted from a historic pathway recording error that was identified and corrected in month.
Diagnostic 6w Performance	**December 2024** **16.69%**	**December 2024** **20.5%**	• HUTH performance showed a small in-month reduction of 1.3% due to reduced capacity over the festive period but remains ahead of planned trajectory. NLaG deteriorated by 1.5% reduction in December and is behind trajectory: ○ Key modalities showing improvement at HUTH are DEXA at 16% compared with 27.2% in November, Urodynamics at 54% from 64.5% in November and Cystoscopy at 21.5% from 34.2% in November. Improvements were also seen in Neurophysiology from 8.9% now at 1.5% and Flexible Sigmoidoscopy down from 37.0% to 28.9%. ○ NLaG decline in performance was being driven by Urodynamics at 19.2% which increased from 7.1% in November, MRI at 25.4% compared to 10.6% and DEXA with a further decrease at 35.8% (largely mutual aid transfers from HUTH)
Cancer 62-day Performance (all sources)	**November 2024** **52.9%**	**November 2024** **71.5%**	• Both Trusts in Tier 1 for Cancer delivery; working with NE&Y Regional Office on recovery assurance • 62-day performance at NLaG improved by 20% in December. Performance at HUTH impacted by radiotherapy (treatment), oncology capacity (treatment planning), and prostatectomy surgical (treatment option OPAs & treatments) capacity, compounded by late Inter Provider Transfers (IPTs) • >63 day backlog test and challenge meetings in place and resulting in improvement at NLaG (below trajectory & improving). HUTH remains static (IPTs very late in pathway, urology surgical capacity & LGI diagnostic delays).
ED: 4 hour standard (Type 1 & 3) 78% by March 2025	**December 2024** **54.1%** **Trust compliance** **64.9% (plan 76.7%)** **Acute Footprint compliance (incl. Bransholme & ERCH)**	**December 2024** **67.5%** **Trust compliance** **71.0% (plan 77.3%)** **Acute Footprint compliance (incl. Goole UTC)**	• A&E 4 Hour standard (all types) at HUTH was 54.1% in December (plan 62.7%). Type 1 performance of 35.7% was below the 24/25 operating plan target of 39.7%. Type 3 performance (HRI UTC) was 92.9% in December against the 97.0% target. Attendances at UTC remain significantly below planned levels. • NLaG combined all types performance was 67.5% in December against a target of 74.0%. Type 1 performance was 44.5% (plan 57.8%) and Type 3 performance was 99.3% (plan 99.0%)

2. Pathway Summary – Benchmark Report – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

HUTH

Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 52 Week Breach	Nov 24	0	2,861			14
RTT 65 Week Breach	Nov 24	-	27			49
RTT 78 Week Breach	Nov 24	0	0			100
RTT 95th Percentile Admitted Waiting Time	Nov 24	18.0	59.5			61
RTT 95th Percentile Non-Admitted Waiting Time	Nov 24	18.0	54.6			44
RTT Admitted Treatment Within 18 Weeks	Nov 24	90.0%	57.7%			62
RTT Average (Median) Admitted Waiting Time	Nov 24	9.0	12.3			67
RTT Average (Median) Non-Admitted Waiting Time	Nov 24	5.0	8.4			66
RTT Average Wait for Incomplete	Nov 24	7.00	14.6			38
RTT Incomplete 18 Week Standard	Nov 24	92.00%	56.8%			32
RTT Incomplete 92nd Percentile	Nov 24	-	43.9			28
RTT Incomplete Pathways With a DTA	Nov 24	25.0%	15.6%			46
RTT Non-Admitted Treatment Within 18 Weeks	Nov 24	95.0%	66.3%			56
RTT Total Clock Starts	Nov 24	-	19,373			90
RTT Total Clock Stops	Nov 24	-	19,546			93
RTT Total Incompletes	Nov 24	-	79,506			17

NLAG

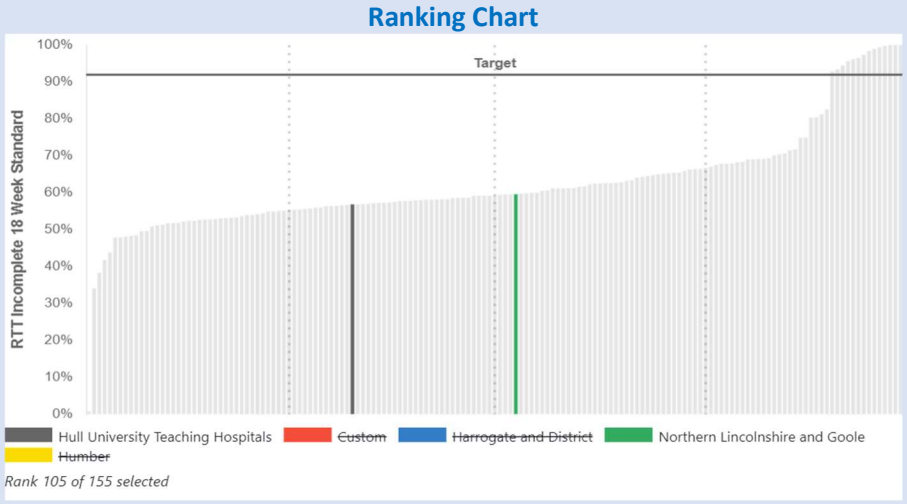
Indicator	Period	Target		SPC	Last 12 Months	Centile
RTT 52 Week Breach	Nov 24	0	595			60
RTT 65 Week Breach	Nov 24	-	4			72
RTT 78 Week Breach	Nov 24	0	0			100
RTT 95th Percentile Admitted Waiting Time	Nov 24	18.0	57.1			76
RTT 95th Percentile Non-Admitted Waiting Time	Nov 24	18.0	49.9			63
RTT Admitted Treatment Within 18 Weeks	Nov 24	90.0%	54.3%			44
RTT Average (Median) Admitted Waiting Time	Nov 24	9.0	15.1			42
RTT Average (Median) Non-Admitted Waiting Time	Nov 24	5.0	12.2			28
RTT Average Wait for Incomplete	Nov 24	7.00	13.9			52
RTT Incomplete 18 Week Standard	Nov 24	92.00%	59.6%			52
RTT Incomplete 92nd Percentile	Nov 24	-	40.1			58
RTT Incomplete Pathways With a DTA	Nov 24	25.0%	13.5%			59
RTT Non-Admitted Treatment Within 18 Weeks	Nov 24	95.0%	60.0%			29
RTT Total Clock Starts	Nov 24	-	9,892			54
RTT Total Clock Stops	Nov 24	-	9,689			60
RTT Total Incompletes	Nov 24	-	43,454			44

2. Pathway Benchmarking & Trend – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

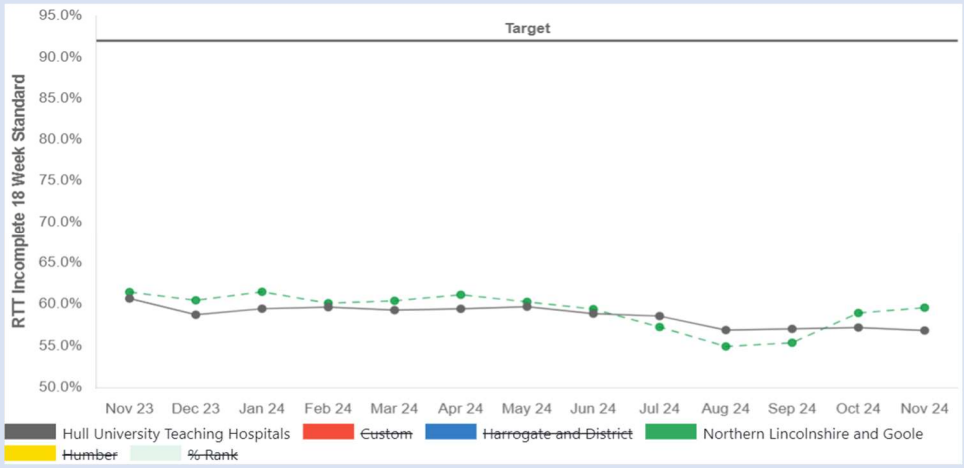
RTT – Incomplete Standard

Ranking Chart



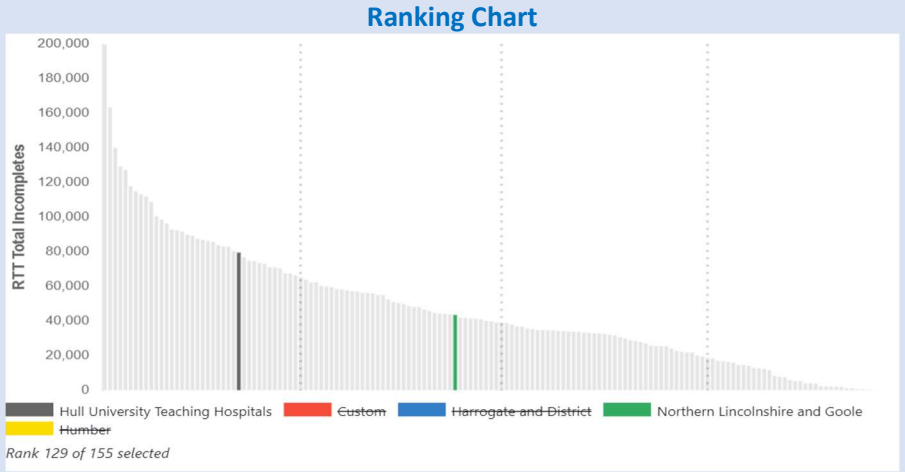
Rank 105 of 155 selected

Trend Chart



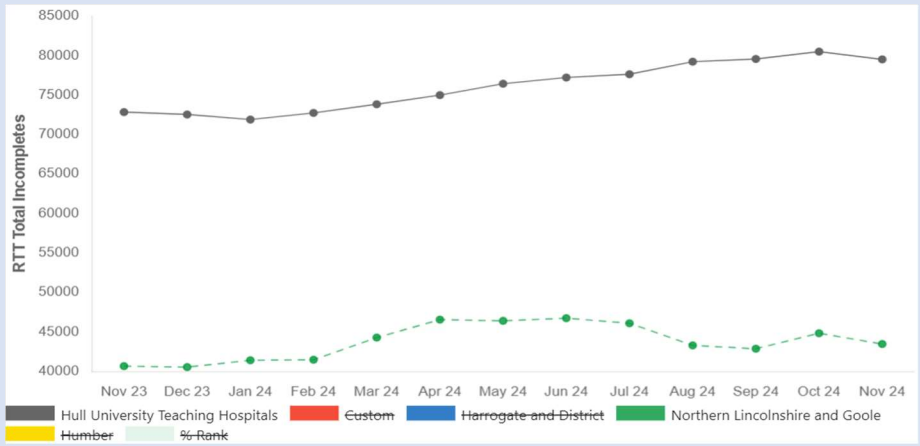
RTT – Total Waiting List Volume

Ranking Chart



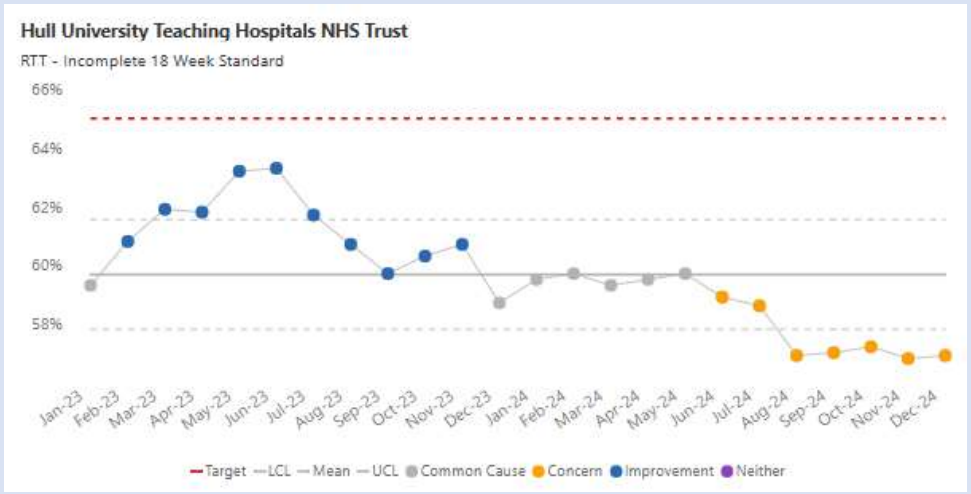
Rank 129 of 155 selected

Trend Chart



3. Referral to Treatment - HUTH

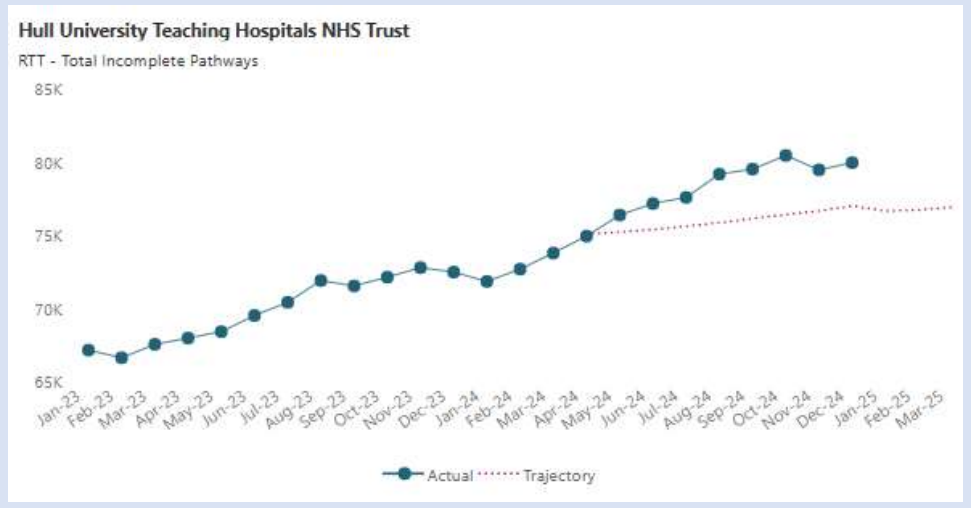
Compliance



Key Themes

- December 18 week RTT performance of 56.9% is broadly unchanged previous months.
- Waiting list volume continues to increase despite above plan pathway completion levels and now stands at 79,996. This predominately reflects an increase in referrals (all sources) of 4.7% YTD. Actions agreed with the wider HYN System to reduce GP referral demand specifically have not been deployed due, in part, to GP collective action.
- 57% of patients on the PTL are awaiting a first outpatient appointment. Largest volumes in ENT, Ophthalmology, Dermatology, Cardiology and Neurology
- 3.7% of patients are waiting over 52 weeks compared to 2.7% at the start of the financial year.
- Average wait for incomplete pathway is 14 weeks but remains broadly stable i.e. not increased despite the increase in PTL size.

Critical Enablers



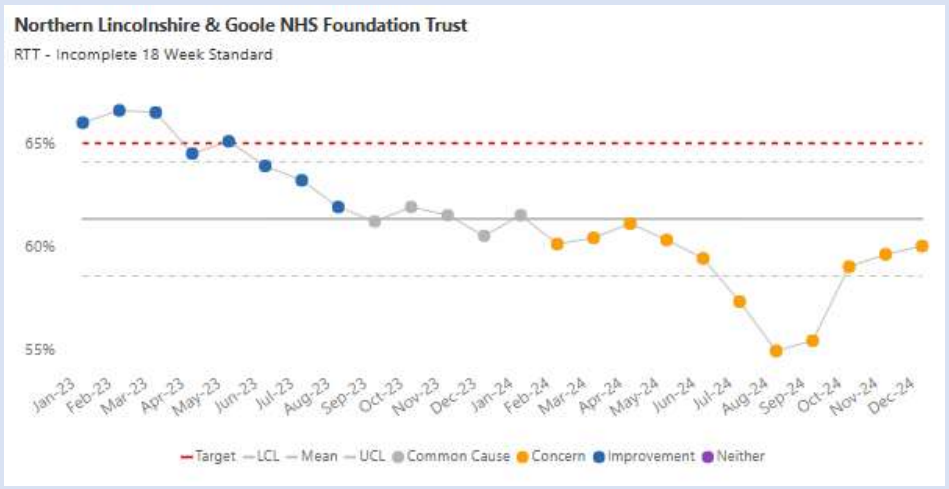
Actions

Critical actions being progressed through RTT Delivery Group:

- Increase first outpatient activity to restore 19/20 baseline. Where 19/20 baseline is being achieved Care Groups have identified additional activity schemes over and above the 24/25 operational plan to achieve additional Elective Recovery Funds income
- Care Groups reviews to decrease waits for first outpatient activity >40 weeks via reallocation of follow up outpatient activity without a procedure.
- Remedial admin action plans deployed to resolve pathway outcome recording delays to reduce total waiting list volume.
- Proposal under development 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.
- System engagement on Elective Strategy and pathway redesign.

4. Referral to Treatment - NLAG

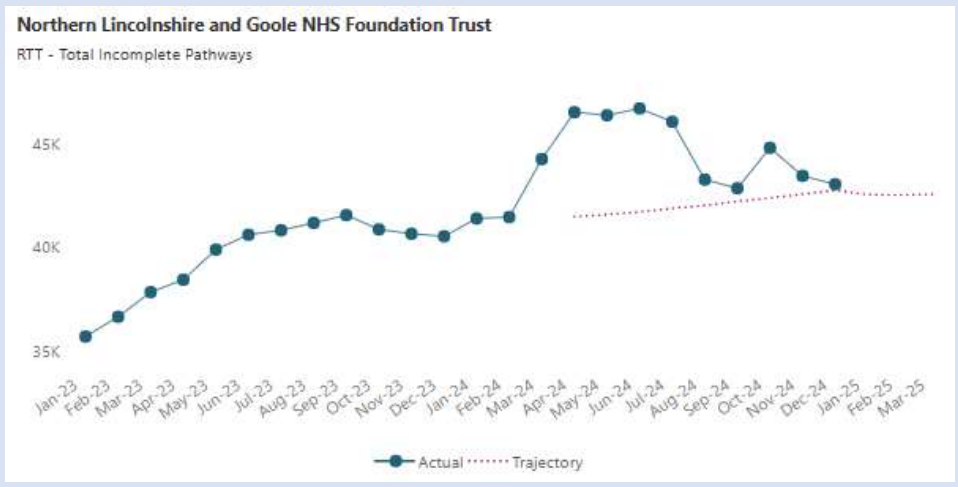
Compliance



Key Themes

- December performance of 60% shows an improvement of 1% on the previous month. This is a mathematical benefit relating to the correction of ASI inclusion in the waiting list total at NLAG from 7 October 2024.
- This reflects a cohort of 3,000 pathways awaiting triage that should have been included into the waiting list total volume when reported via national submissions. This reporting error in legacy NLAG controls did not impact on the clinical management of patients, only the correct reporting of waiting list volumes.
- Adjusting for the error in ASI inclusion the RTT waiting list volume has reduced to 43,053 in-month and is 290 over trajectory (noting that the trajectory baseline did not include the 3000 ASI patients).

Critical Enabler



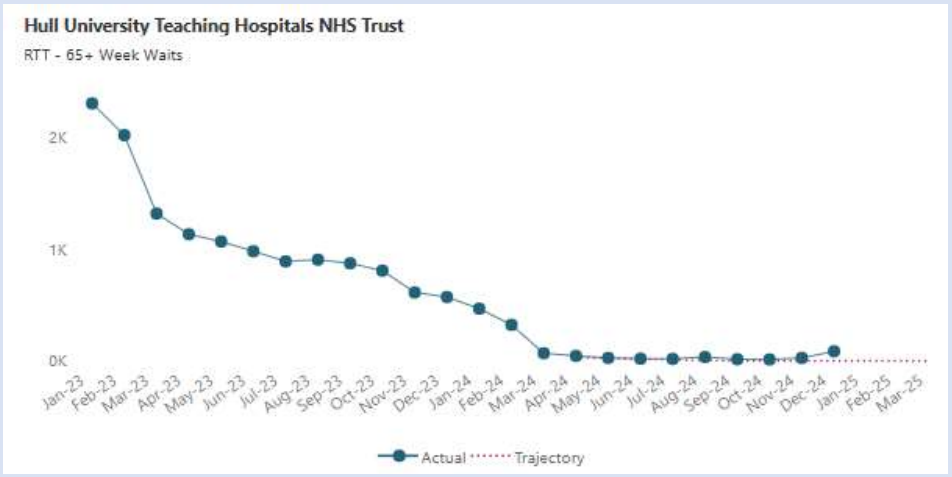
Actions

Critical actions being progressed through RTT Delivery Group:

- Increase first outpatient activity and decreased waits for first outpatient activity >13 weeks.
- Decrease follow up outpatient activity without a procedure.
- Care Groups have deployed additional activity over and above the 24/25 operational plan underpinned by Elective Recovery Funds
- Proposal under development 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.

5. Referral to Treatment – 65w Waits - HUTH

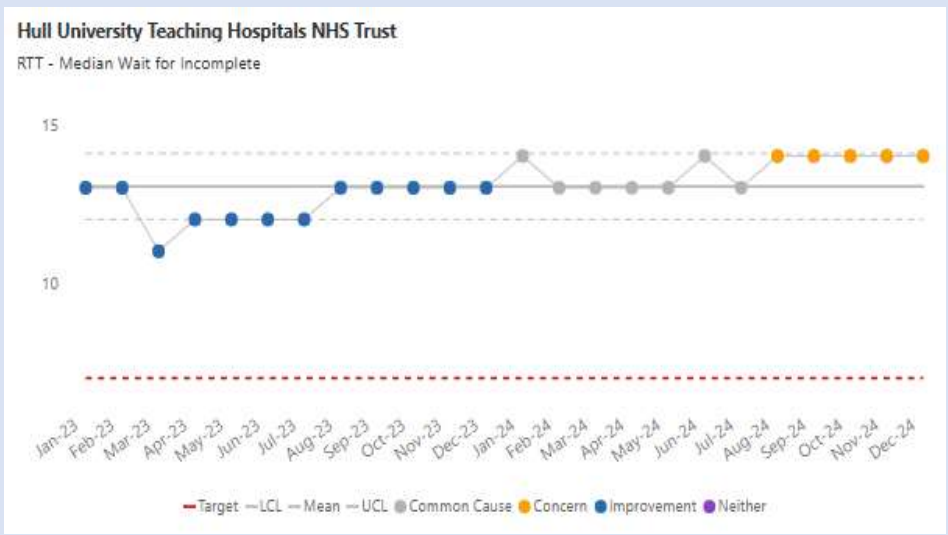
Compliance



Key Themes

- 86 patients exceeded 65 weeks at the end of December which was a significant increase on previous months. There was 1 x 78w breach reported. ENT is a critical risk, making up c80% of potential FYE breaches. Constrained capacity in this specialty is a national issue.
- Risks and mitigating actions relating to December delivery: -
  - ENT – additional weekend audiology and outpatient capacity is being delivered through Modality and HEYAS (insourcing providers).
  - 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.

Critical Enabler



Actions

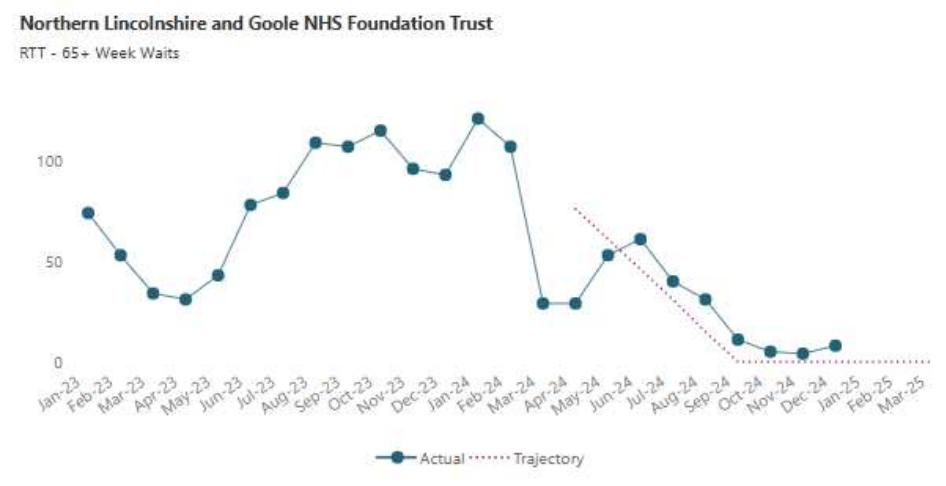
1. Control total of 8 x 65w waits for HHP at the end of December 2024 – not delivered
2. Reduce >52w waits by end of March 2025

Critical actions being delivered through the RTT Delivery Group

- Reduce first outpatient waits to <40 weeks, with the main challenge in ENT. Additional insourced activity in place alongside mutual aid via Y&S.
- Clinical decisions post-diagnostic tests with consultants in Cardiology to be addressed by triumvirate
- Continued focus at speciality level of patients dated and/or risks now focussed to eliminate the number of >65-week waits
- Delivery of 24/25 operating plan activity extension plans.
- Additional weekend waiting list initiatives to create capacity in Plastic surgery, Breast Surgery and ENT.
- Continued growth in 52 week backlog presents an ongoing risk.

6. Referral to Treatment – 65w Waits - NLAG

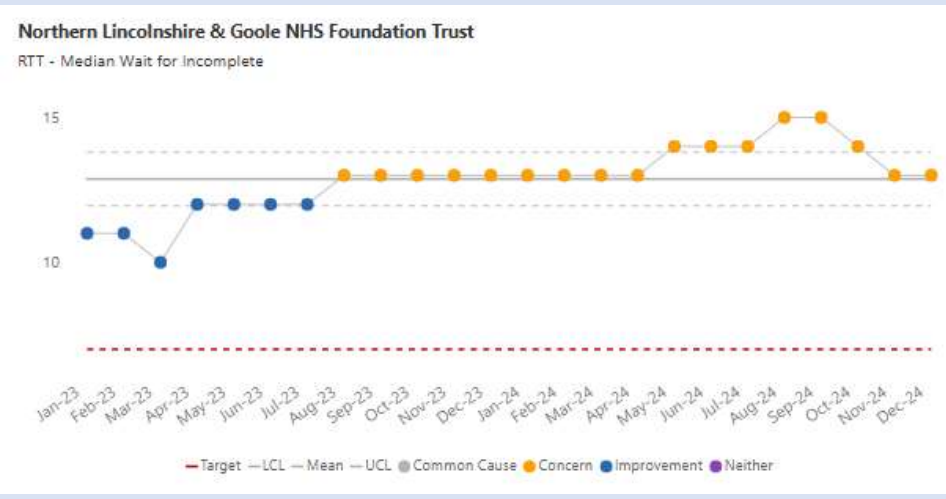
Compliance



Key Themes

- 8 breaches at the end of December, mainly due to patient choice
- Improvement in the last 3 months on median waiting time for incomplete pathways.

Critical Enabler



Actions

- New control total of 8 x 65w waits for HHP at the end of December 2024 – not delivered
- Reduce >52w waits by end of March 2025

Critical actions being delivered through the RTT Delivery Group

- Reduce first outpatient waits to <40 weeks, with the main challenge in Paediatrics (ADHD). Additional insourced activity in place.
- Delivery of 24/25 operating plan activity extension plans.
- Community Dental capacity and 65w breach risks – mitigated with weekend theatre lists but need sustainable solution
- Earlier planning of offering admission dates to reduce unreasonable offers and then patient choice breaches, alongside revised Group Access Policy.

7. Referral to Treatment – Data Quality - HUTH

Compliance

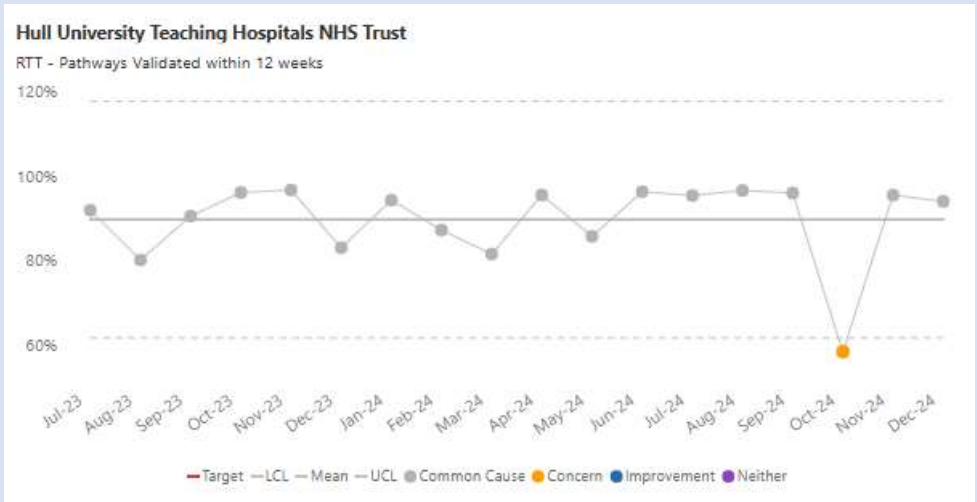
Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

The Trust has robust oversight arrangements in place to support timely validation, these are monitored by RTT BI data quality reports in conjunction with the LUNA system, with established escalation processes in place. LUNA is currently reporting that the Trust has a 99.42% confidence level for RTT PTL data quality.

Source Group Artificial Intelligence report commissioned to deliver a one-off insight into the data quality opportunity on the RTT PTL. Proof of concept sample validation of 500 pathways at each Trust completed w/c 11th November 2024 for 2 weeks. Outcome is that of the 417 pathways reviewed, 124 were removed, mainly in the 0-6w range due to incorrect clock restarts.

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
- Proposal under development 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.

8. Referral to Treatment – Data Quality - NLAG

Compliance

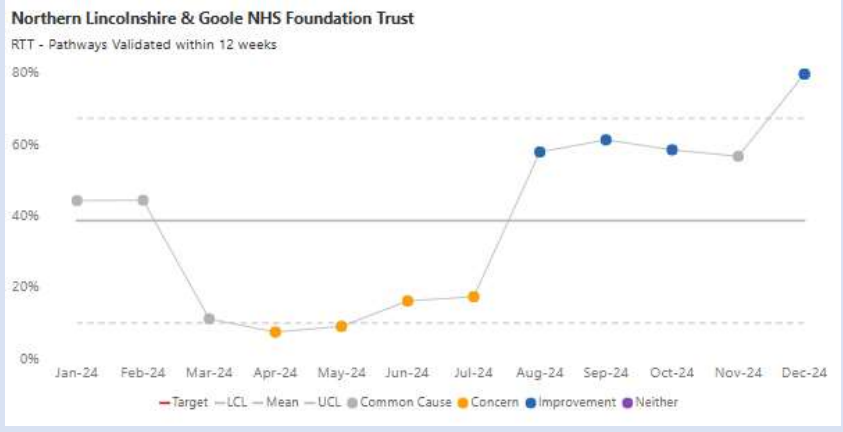
Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

- LUNA data quality is showing a reduction in the confidence rate to 99.17% 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 79.4%

Source Group Artificial Intelligence report commissioned to deliver a one-off insight into the data quality opportunity on the RTT PTL. Proof of concept sample validation of 500 pathways at each Trust completed w/c 11th November 2024 for 2 weeks. Outcome is that of the 498 pathways reviewed, 189 were removed, mainly in the 0-40w (39% removal rate).

Critical Enablers

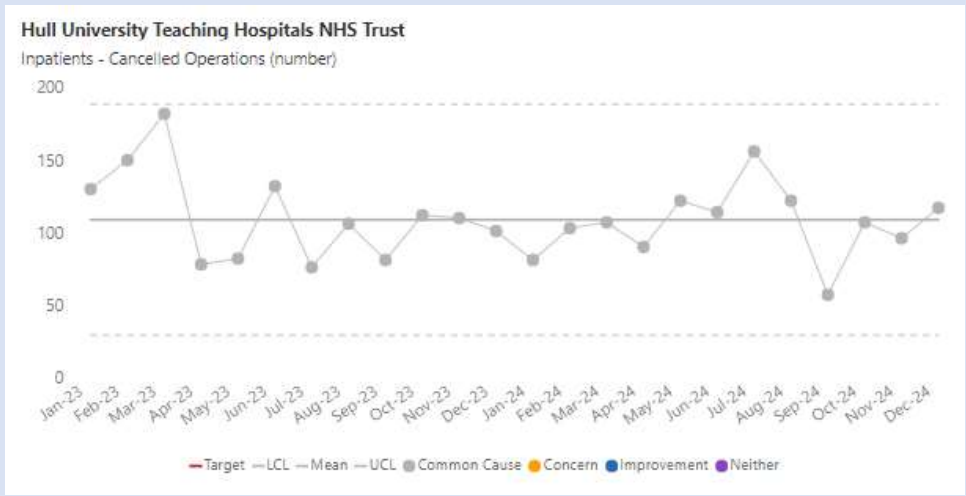


Actions

- Patient Services to reduce the number of unvalidated pathways and other key DQ reports including un-outcomed clinic and admission attendances to proactivity improve incomplete pathway management.
- Focus on improving up-to-date validation / tracking comments to
- Proposal under development 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.

9. Cancelled Operations - HUTH

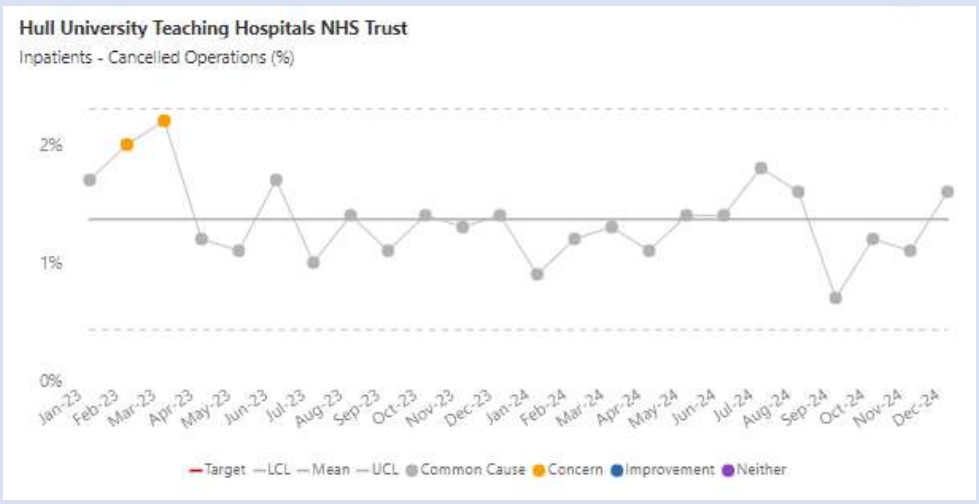
Compliance



Key Themes

- In December there were 117 cancelled operations on the day for non-clinical reasons which is a significant improvement on previous months and represents 1.6% of admissions.
- The largest reasons were –
  - No Beds (General and ICU) – 33
  - Emergency case – 19
  - No Surgeon – 18
  - Theatre list overrun - 17
- The main specialties for cancellations on the day are –
  - Interventional Radiology – 15 (Emergency cases)
  - Oral Surgery – 13 (No Consultant)
  - Neurosurgery – 12 (No Beds)
  - Urology – 12 (No Beds)
  - Vascular Surgery – 10 (No Beds)

Critical Enabler

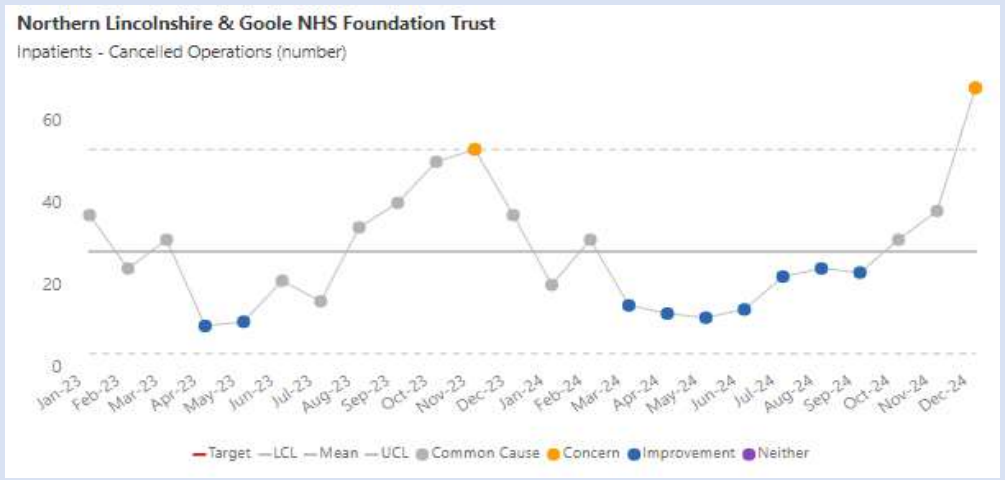


Actions

- Group level cancelled operations Standard Operating Procedure (SOP) developed and deployed with the Operations Director for Theatres responsible for approving all on the day cancellations
- Robust cancelled operations performance monitoring systems deployed at Group level including 28 day re-bookings reviewed weekly by Site Managing Director
- Review of cancellations trends and themes escalated to the speciality / pre-assessment teams.
- Focus in operational meetings regarding beds required for elective procedures to take place with review of 7/5/2 day pre-op to commence in Orthopaedics and ENT.
- 85% Capped utilisation report and actions going out to all Care Groups from 17th June.
- Progress GIRFT actions for High Volume Low Complexity activity.

10. Cancelled Operations - NLAG

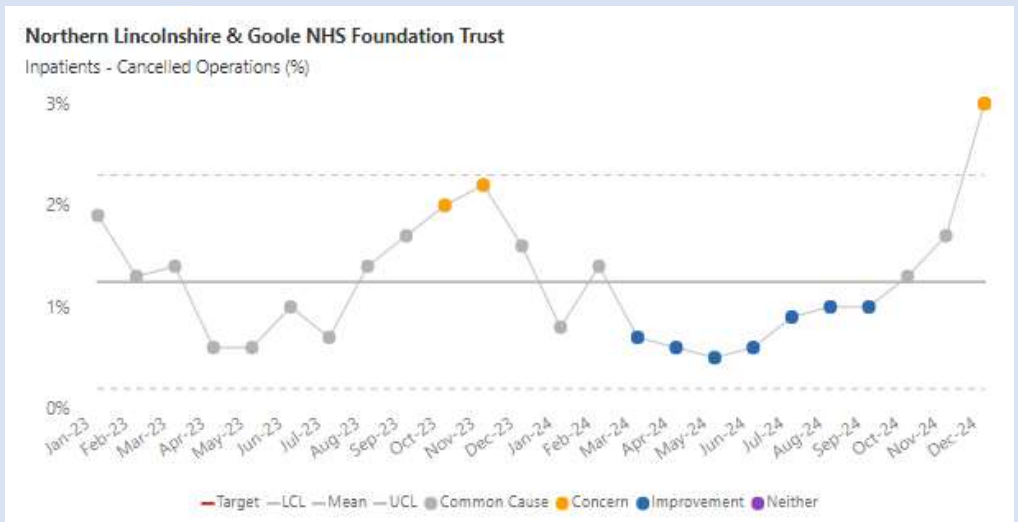
Compliance



Key Themes

- In December there were 69 cancelled operations on the day for non-clinical reasons which is a deterioration on previous months and represents 3.0% of admissions.
- The largest reasons were –
  - Anaesthetist unavailable – 21
  - List overrun – 8
  - Emergency cases – 7
  - Surgeon unavailable - 7
  - No equipment – 6
  - No theatre staff - 6
- The main specialties for cancellations on the day are –
  - Trauma & Orthopaedics – 17 (No anaesthetist)
  - General Surgery – 15 (No anaesthetist)
  - Ophthalmology – 11 (No theatre staff)

Critical Enabler

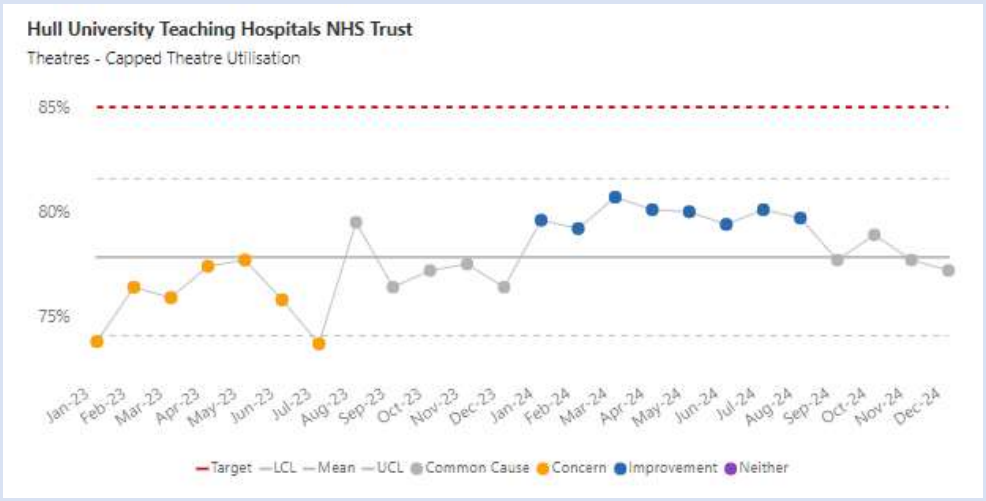


Actions

- Enhanced BIU support to report national data set and eliminate DQ issues.
- Additional daily scrutiny and feed back to specialities regarding capped utilisation and the additional minor patient to be added to all lists not delivering 85% utilisation.
- HUB commenced at GDH 10th June 2024, to support LoS and GIRFT standards improvement.
- Working with NHSE/GIRFT on improvement recommendations
- Reviewing all opportunities to sweat current assets.
- Cancelled operations Standard Operating Procedure (SOP) has been reissued at Group level with the Operations Director for Theatres responsible for approving on the day cancellations
- Standing down or lifting sessions SOP completed and deployed.

11. Capped Theatre Utilisation - HUTH

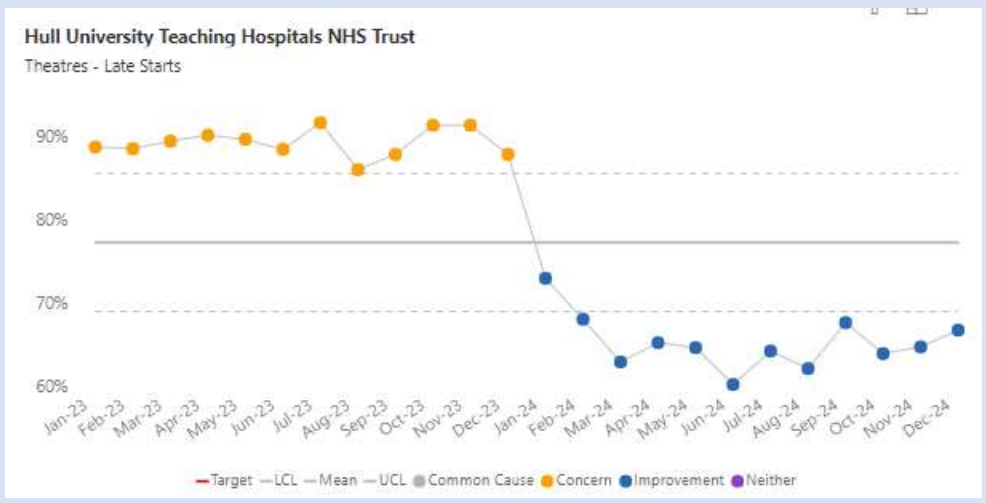
Compliance



Key Themes

- Improvement in capped theatre utilisation with latest Model Hospital data showing performance at 80.9% placing the Trust in the interquartile range (i.e. neither upper or lower quartiles) nationally.
- HUTH specifically commended on delivery of capped utilisation improvement by Professor Tim Briggs, Chair of GIRFT and NHSE National Director for Clinical Improvement & Elective Recovery.
- Internal reporting at 77.2% for capped theatre utilisation for December.
- Day Case capped theatre utilisation has deteriorated to 70.9% - improving this element of delivery is the critical enabler to improve to the aggregate activity standard of 85% given the associated patient volumes.
- Decrease in late starts to 66.8% (methodology 0 minutes = late start)

Critical Enabler

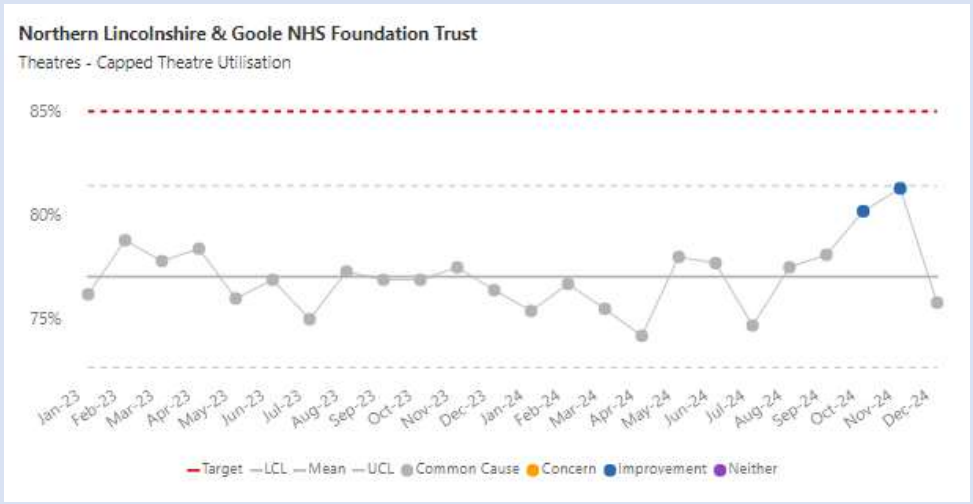


Actions

- Theatre Data Quality dashboard in place which is managed daily by the Theatres, Anaesthetics and Critical Care Group
- Theatres Insights Model being implemented and training roll out commenced at both Trusts.
- Improve recording of day case touch points in ORMIS
- Implementation in June of 1 extra patient per day case list for any list at <85% capped utilisation

12. Capped Theatre Utilisation - NLAG

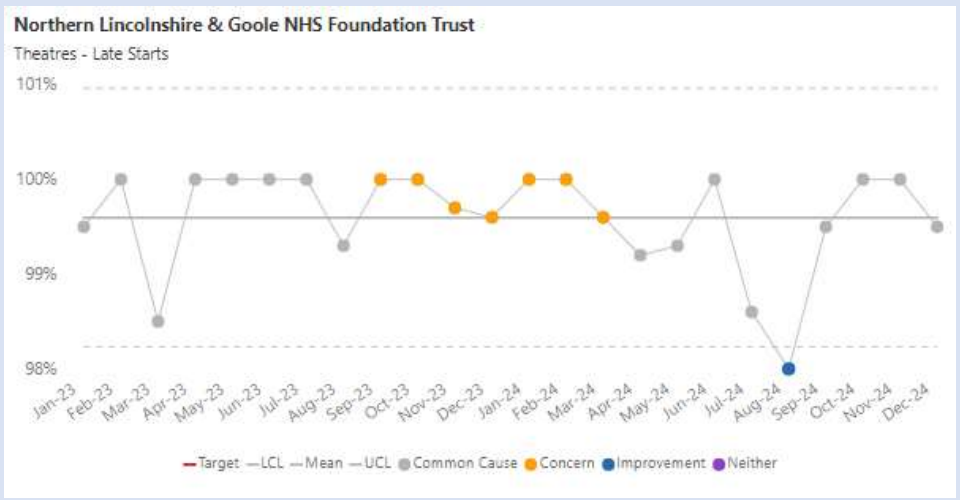
Compliance



Key Themes

- In the lower quartile nationally at 74.8% on Model Hospital, however, internal reporting shows improvement at 75.8%. this reflects a known mathematic function of the Model Hospital methodology and requires the Trust to improve recording delineation of day case and elective theatre sessions.
- Theatre late starts issue at NLAG with 99% of sessions starting late in October 2024 on the zero-minute measure, however, reduced on those starting over 10 minutes.

Critical Enabler



Actions

- CAP working group established with Theatre and Analytical leads to apply learning from HUTH analysts on improvement work undertaken on data quality issues with the fortnightly submissions to Model Health and the methodologies applied.
- Data recording work in train in relation to theatre sessions recorded on WebV. Currently sessions are not differentiated between day case and elective theatres, which creates significant issues based on Model Hospital calculation methodologies.
- Implementation of 1 extra patient per day case list for any list at <85% capped utilisation

13. Pathway Summary – Benchmark Report – Diagnostics

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

HUTH

Indicator	Period	Target		SPC	Last 12 Months	Centile
Audiology	Nov 24	5.00%	1.8%			79
Barium Enema	Nov 24	5.00%	0.0%			100
Colonoscopy	Nov 24	5.00%	**50.2%**			8
Computed Tomography	Nov 24	5.00%	**5.6%**			30
Cystoscopy	Nov 24	5.00%	**34.2%**			20
DEXA Scan	Nov 24	5.00%	**27.2%**			9
DM01 Waiting <13 Weeks	Nov 24	100.00%	**94.6%**			35
Diagnostic activity levels - Audiology Assessments	Nov 24	-	624			63
Diagnostic activity levels - Barium Enema	Nov 24	-	51			83
Diagnostic activity levels - CT	Nov 24	-	6,262			71
Diagnostic activity levels - Colonoscopy	Nov 24	-	206			33
Diagnostic activity levels - Cystoscopy	Nov 24	-	385			87
Diagnostic activity levels - Dexa Scan	Nov 24	-	579			90
Diagnostic activity levels - Echocardiography	Nov 24	-	652			36
Diagnostic activity levels - Endoscopy	Nov 24	-	1,089			53
Diagnostic activity levels - Flexi Sigmoidoscopy	Nov 24	-	106			55
Diagnostic activity levels - Gastroscopy	Nov 24	-	392			55
Diagnostic activity levels - Imaging	Nov 24	-	14,746			67
Diagnostic activity levels - Non Obstetric Ultrasound	Nov 24	-	4,750			60
Diagnostic activity levels - Total	Nov 24	-	17,761			63
Diagnostic activity levels - Urodynamics	Nov 24	-	54			78
Diagnostics - 6 Week Standard	Nov 24	5.00%	**15.4%**			44
Diagnostics - 6 Week Standard Reversed	Nov 24	95.00%	**84.6%**			44
Echocardiography	Nov 24	5.00%	**42.0%**			20
Electrophysiology	Nov 24	5.00%	-			-
Gastroscopy	Nov 24	5.00%	**19.1%**			30
Magnetic Resonance Imaging	Nov 24	5.00%	1.6%			70
Neurophysiology	Nov 24	5.00%	**8.9%**			46
Non-obstetric Ultrasound	Nov 24	5.00%	**6.4%**			46
Urodynamics	Nov 24	5.00%	**64.5%**			15

NLAG

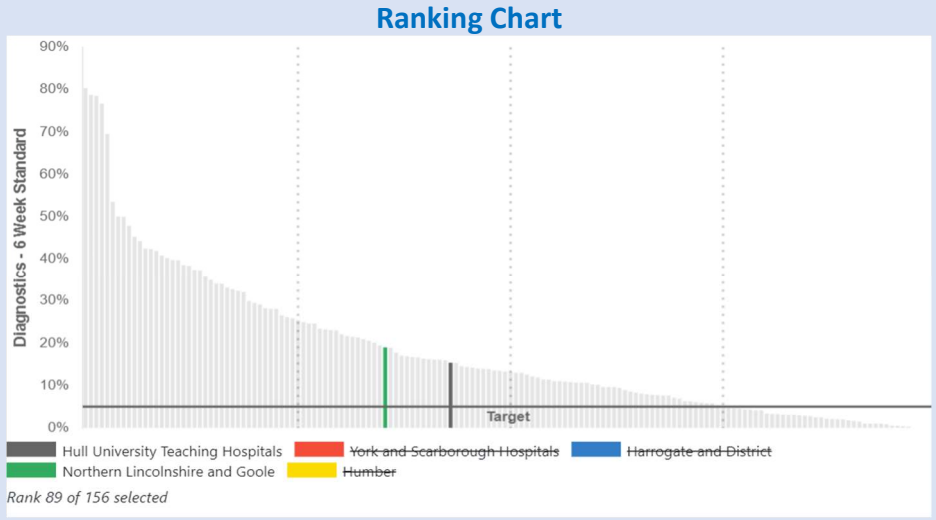
Indicator	Period	Target		SPC	Last 12 Months	Centile
Audiology	Nov 24	5.00%	**47.3%**			23
Barium Enema	Nov 24	5.00%	0.0%			100
Colonoscopy	Nov 24	5.00%	**14.7%**			42
Computed Tomography	Nov 24	5.00%	1.0%			55
Cystoscopy	Nov 24	5.00%	**16.6%**			48
DEXA Scan	Nov 24	5.00%	**26.9%**			10
DM01 Waiting <13 Weeks	Nov 24	100.00%	**95.6%**			40
Diagnostic activity levels - Audiology Assessments	Nov 24	-	437			50
Diagnostic activity levels - Barium Enema	Nov 24	-	146			97
Diagnostic activity levels - CT	Nov 24	-	10,958			96
Diagnostic activity levels - Colonoscopy	Nov 24	-	677			91
Diagnostic activity levels - Cystoscopy	Nov 24	-	576			97
Diagnostic activity levels - Dexa Scan	Nov 24	-	287			55
Diagnostic activity levels - Echocardiography	Nov 24	-	1,010			57
Diagnostic activity levels - Endoscopy	Nov 24	-	2,360			94
Diagnostic activity levels - Flexi Sigmoidoscopy	Nov 24	-	309			97
Diagnostic activity levels - Gastroscopy	Nov 24	-	798			90
Diagnostic activity levels - Imaging	Nov 24	-	19,808			87
Diagnostic activity levels - Non Obstetric Ultrasound	Nov 24	-	3,744			47
Diagnostic activity levels - Total	Nov 24	-	24,014			87
Diagnostic activity levels - Urodynamics	Nov 24	-	129			94
Diagnostics - 6 Week Standard	Nov 24	5.00%	**19.0%**			36
Diagnostics - 6 Week Standard Reversed	Nov 24	95.00%	**81.0%**			36
Echocardiography	Nov 24	5.00%	**37.2%**			23
Gastroscopy	Nov 24	5.00%	**14.1%**			43
Magnetic Resonance Imaging	Nov 24	5.00%	**19.6%**			21
Neurophysiology	Nov 24	5.00%	**38.9%**			20
Non-obstetric Ultrasound	Nov 24	5.00%	4.8%			47
Urodynamics	Nov 24	5.00%	**18.4%**			63

14. Pathway Benchmarking & Trend – Diagnostics

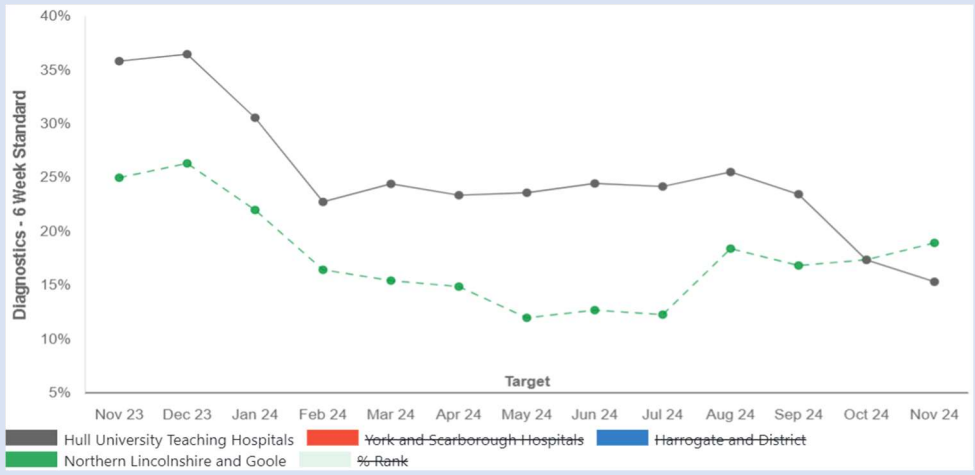
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

Diagnostics – 6 week Performance Standard

Ranking Chart

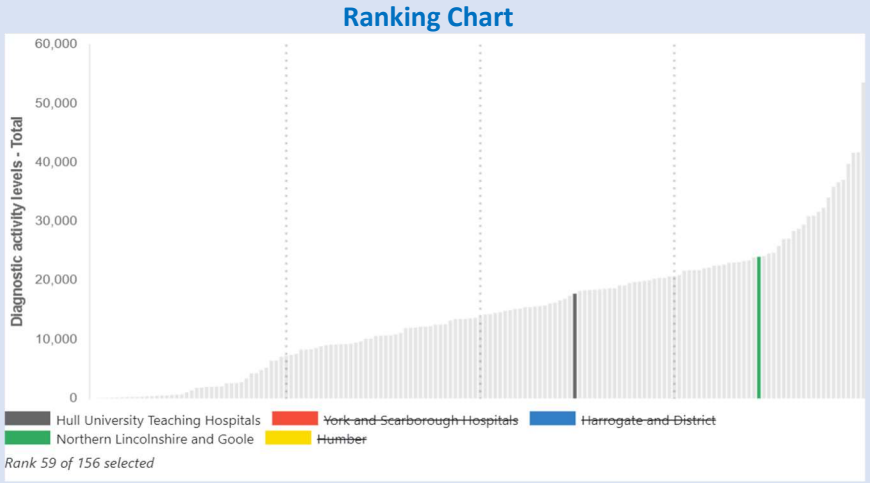


Trend Chart

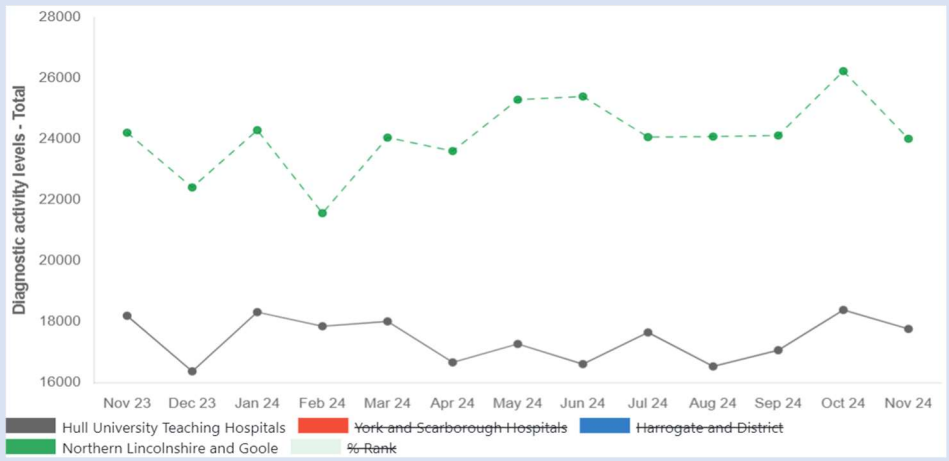


Diagnostics – Activity

Ranking Chart

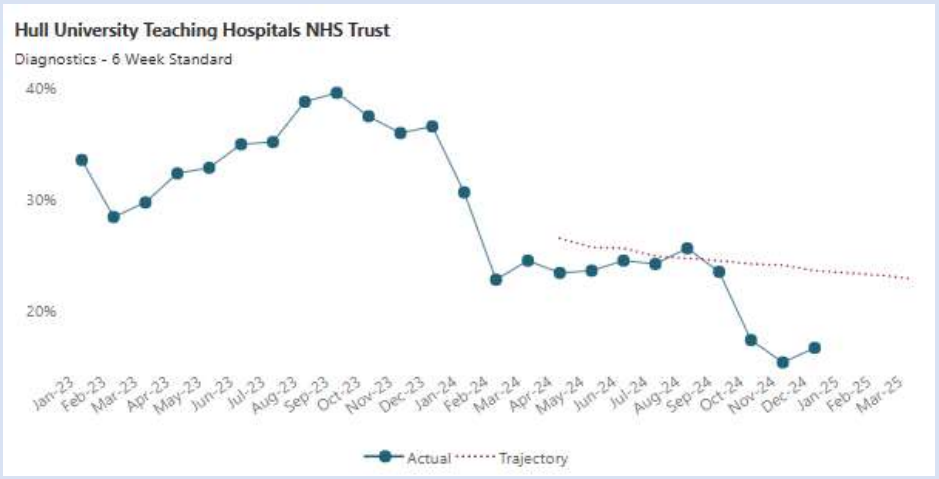


Trend Chart



15. Diagnostic 6 Week Standard - HUTH

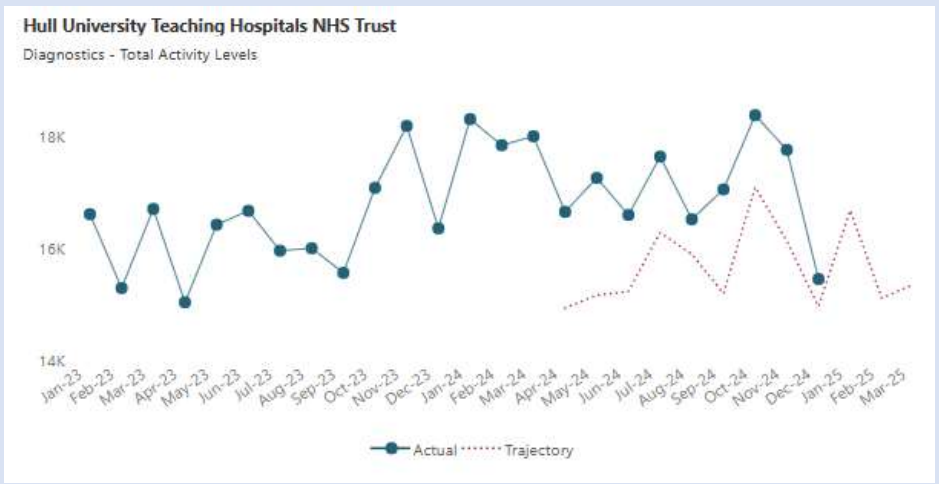
Compliance



Key Themes

- December saw a slight deterioration of 1.3% due to seasonality. HUTH is performing well ahead of planned trajectory.
- The most notable improvements in performance are DEXA at 16% compared with 27.2% in November, Urodynamics at 54% from 64.5% in November and Cystoscopy at 21.5% from 34.2% in November. Improvements were also seen in Neurophysiology from 8.9% now at 1.5% and Flexible Sigmoidoscopy down from 37% to 28.9%.
- Most modalities at HUTH increased activity levels over 23/24 and into 24/25. Whilst ahead of delivery trajectory, aggregate diagnostic compliance has remained static in recent months.
- Audiology – Data quality remains an ongoing issue in relation to the use of the Auditbase system and the ability to pull through data relating to overdue planned and paediatric patients. The Group is working with the supplier to resolve, however no definitive timescales have been identified due to wider discussions between the supplier and NHSE.

Critical Enabler

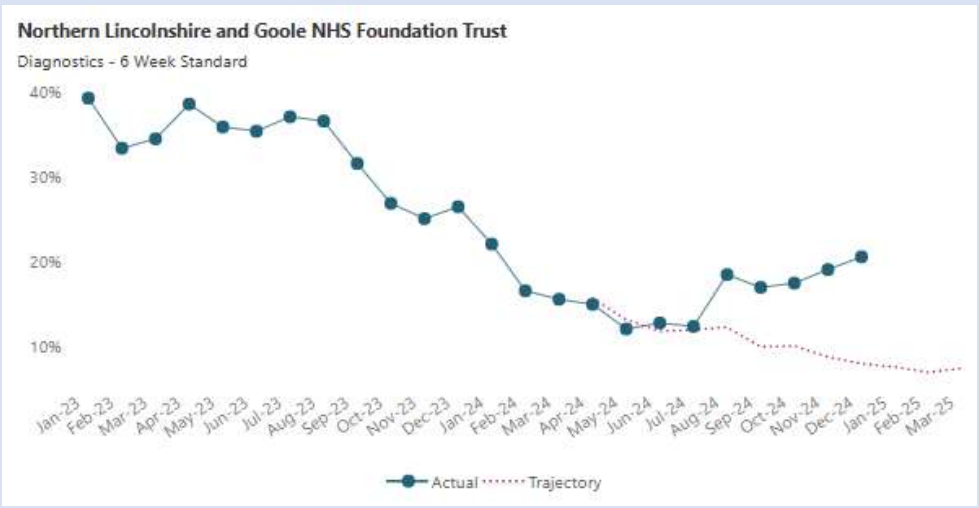


Actions

- Critical actions in place:
  - Services have developed improvement plans to create additional diagnostic activity levels and utilise mutual aid opportunities across the Group.
  - Dedicated investment case approved to address DEXA waiting list backlog via increased throughput and testing volume capacity.
  - Tender exercise completed for NOUS to create additional capacity.
  - Validation of DMO1 activity recording underway to support performance and forecasting going forward.

16. Diagnostic 6 Week Standard - NLAG

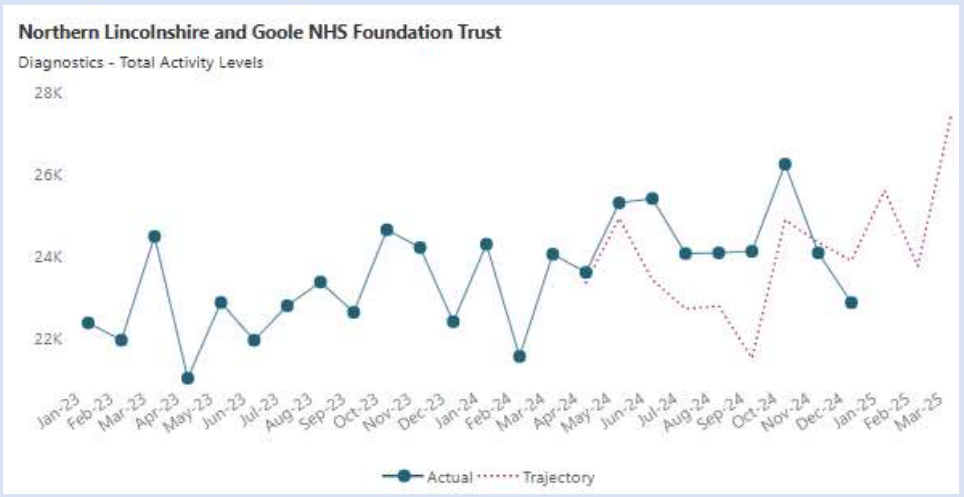
Compliance



Key Themes

- November saw a decline in performance with the percentage seen in 6 weeks increasing to 20.5%. 19%. This reflects a 1.5% shift from 19.0% in the previous month. This places the Trust behind trajectory but reflects, in large part, a managed process of access equalisation across the Group.
- Notable reduction in performance was in Urodynamics which saw decreasing performance during November and December from a position of 7.1% in October to 19.2% in December and MRI decreasing from 10.6% in October to 30.1% in December.
- Aggregate (all modality) compliance is supported through the increased activity levels in imaging.
- Imaging activity recording varies at both Trusts. NLAG reports based on body parts scanned, rather than overall scan volume, which leads to NLAG having higher reported activity levels than HUTH. Both practices technically align to national guidance.

Critical Enable



Actions

- Operating Plan commitments significantly extend diagnostic activity levels in 24/25.
- Further activity stretch plans have been deployed to create additional diagnostic activity levels above the annual plan and utilise mutual aid opportunities across the Group. Where associated investment plans have been approved operational teams are commencing implementation either through use of WLIs, locums, substantive appointments, or Independent Sector.
- To mitigate capacity shortfalls relating to staffing in Neurophysiology on the South Bank enhanced workforce arrangements have been deployed to reduce backlog.
- Ultrasound increasing capacity with use of IS. CDC comes online in November which will start to improve the position.

17. Pathway Summary – Benchmark Report – Cancer Waiting Times

HUTH

Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Nov 24	93.00%	**76.2%**			1
Cancer 2 Week Wait Breast Symptomatic	Nov 24	93.0%	**45.0%**			24
Cancer 28 Day Faster Diagnosis	Nov 24	75.0%	79.3%			57
Cancer 28 Day Faster Diagnosis - Acute Leukaemia	Nov 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Brain Tumours	Nov 24	75.0%	75.0%			31
Cancer 28 Day Faster Diagnosis - Breast Cancer	Nov 24	75.0%	93.4%			46
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Nov 24	75.0%	93.3%			41
Cancer 28 Day Faster Diagnosis - Children's Cancer	Nov 24	75.0%	77.8%			17
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Nov 24	75.0%	**64.1%**			38
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	Nov 24	75.0%	**25.0%**			11
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Nov 24	75.0%	88.7%			91
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Nov 24	75.0%	**49.3%**			11
Cancer 28 Day Faster Diagnosis - Lung Cancer	Nov 24	75.0%	80.5%			45
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Nov 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Other Cancer	Nov 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Skin Cancer	Nov 24	75.0%	96.0%			85
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Nov 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Nov 24	75.0%	91.6%			94
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Nov 24	75.0%	**51.2%**			16
Cancer 31 Day All Stages	Nov 24	96.0%	**72.3%**			0
Cancer 31 Day First Treatment	Nov 24	96.00%	**76.2%**			1
Cancer 31 Day Subsequent Treatment	Nov 24	96.0%	**68.1%**			2
Cancer 31 Day Subsequent Treatment - Drugs	Nov 24	96.0%	97.6%			17
Cancer 31 Day Subsequent Treatment - Radiotherapy	Nov 24	96.0%	**57.1%**			4
Cancer 62 Day All Routes	Nov 24	85.00%	**52.9%**			3
Cancer 62 Day Consultant Upgrade	Nov 24	85.0%	**39.0%**			1
Cancer 62 Day Screening	Nov 24	90.0%	**54.2%**			20
Cancer 62 Day Urgent Suspected	Nov 24	85.00%	**54.1%**			14
Cancer of bronchus; lung	Sep 24	1.00	**1.1**			32

NLAG

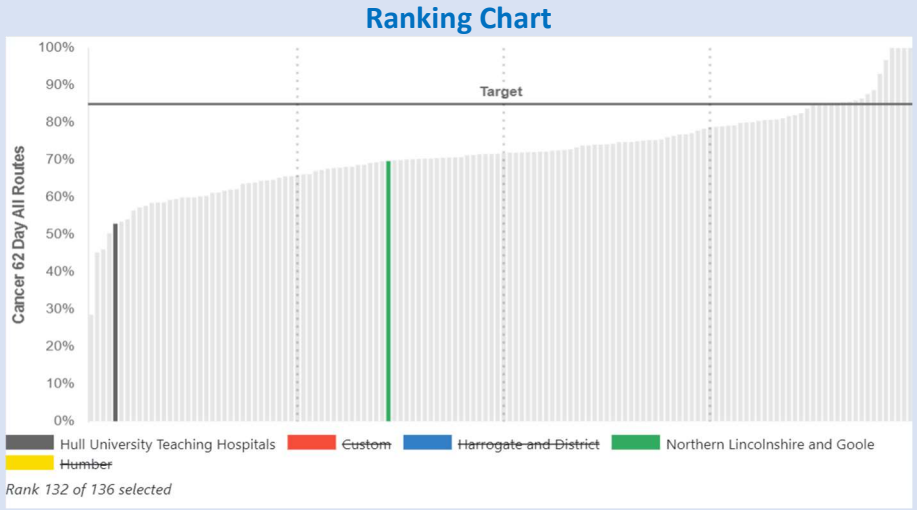
Indicator	Period	Target		SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Nov 24	93.00%	97.6%			78
Cancer 2 Week Wait Breast Symptomatic	Nov 24	93.0%	**76.9%**			37
Cancer 28 Day Faster Diagnosis	Nov 24	75.0%	76.1%			32
Cancer 28 Day Faster Diagnosis - Breast Cancer	Nov 24	75.0%	94.3%			51
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Nov 24	75.0%	100%			100
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Nov 24	75.0%	**71.8%**			56
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	Nov 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Nov 24	75.0%	**60.7%**			11
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Nov 24	75.0%	**67.5%**			51
Cancer 28 Day Faster Diagnosis - Lung Cancer	Nov 24	75.0%	**61.1%**			12
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Nov 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Other Cancer	Nov 24	75.0%	100%			100
Cancer 28 Day Faster Diagnosis - Sarcoma	Nov 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Skin Cancer	Nov 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Nov 24	75.0%	100%			100
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Nov 24	75.0%	81.7%			57
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Nov 24	75.0%	**72.0%**			67
Cancer 31 Day All Stages	Nov 24	96.0%	97.7%			79
Cancer 31 Day First Treatment	Nov 24	96.00%	97.6%			78
Cancer 31 Day Subsequent Treatment	Nov 24	96.0%	97.8%			65
Cancer 31 Day Subsequent Treatment - Drugs	Nov 24	96.0%	98.2%			25
Cancer 31 Day Subsequent Treatment - Radiotherapy	Nov 24	96.0%	-			-
Cancer 62 Day All Routes	Nov 24	85.00%	**69.7%**			36
Cancer 62 Day Consultant Upgrade	Nov 24	85.0%	91.3%			81
Cancer 62 Day Screening	Nov 24	90.0%	**50.0%**			19
Cancer 62 Day Urgent Suspected	Nov 24	85.00%	**67.8%**			59
Cancer of bronchus; lung	Sep 24	1.00	**1.1**			38

18. Pathway Benchmarking & Trending – Cancer Waiting Times

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

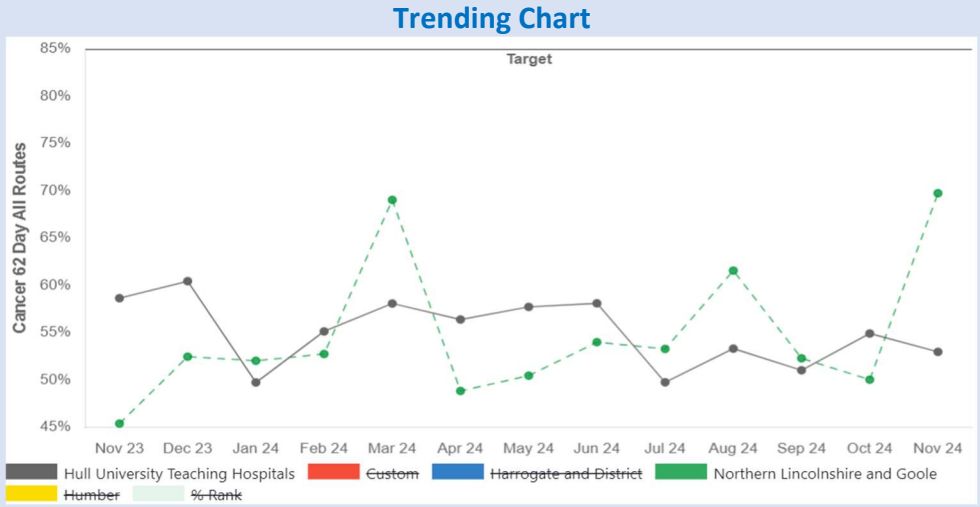
62 Day Performance

Ranking Chart



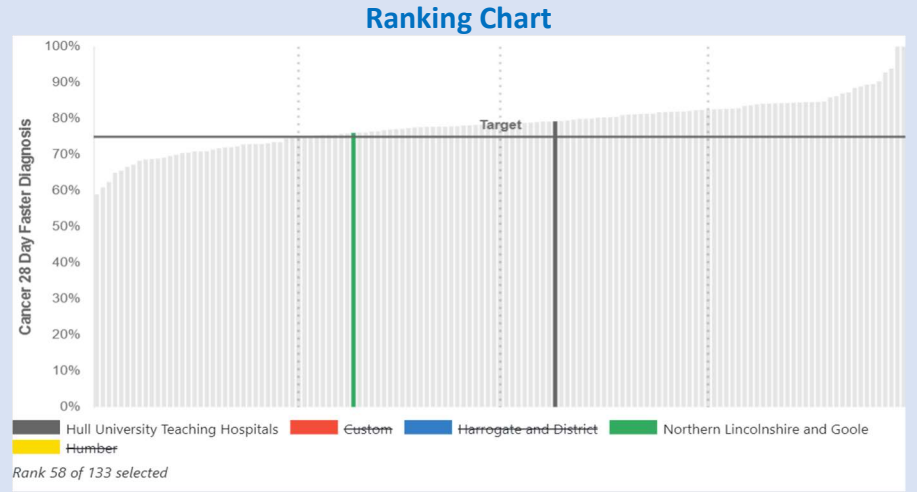
Rank 132 of 136 selected

Trending Chart



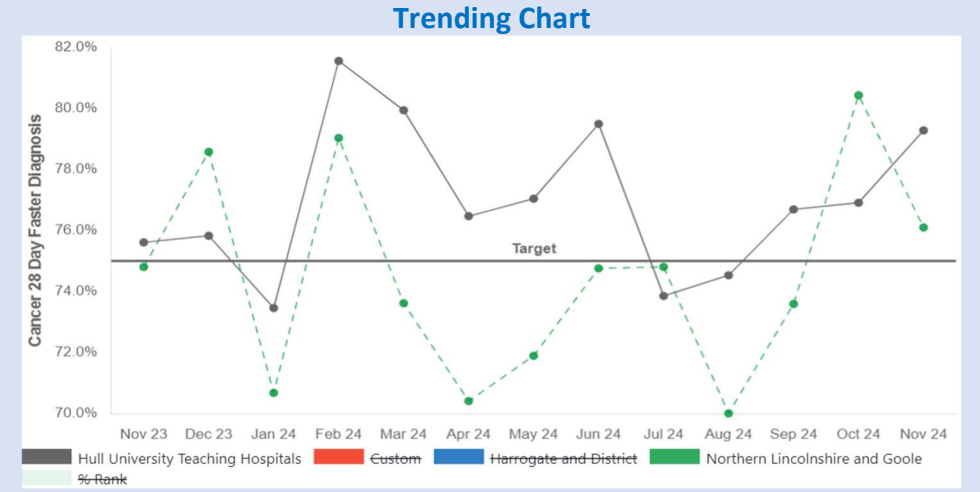
Faster Diagnosis Performance

Ranking Chart



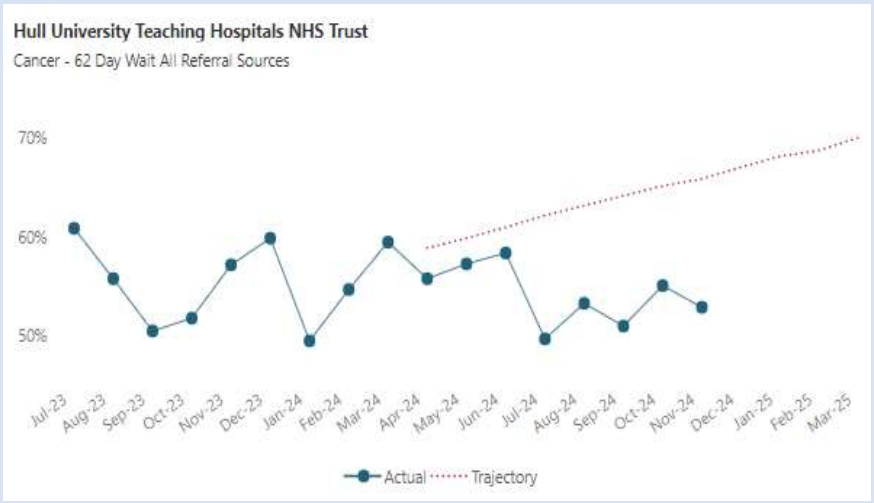
Rank 58 of 133 selected

Trending Chart



19. 62 Day Cancer Performance - HUTH

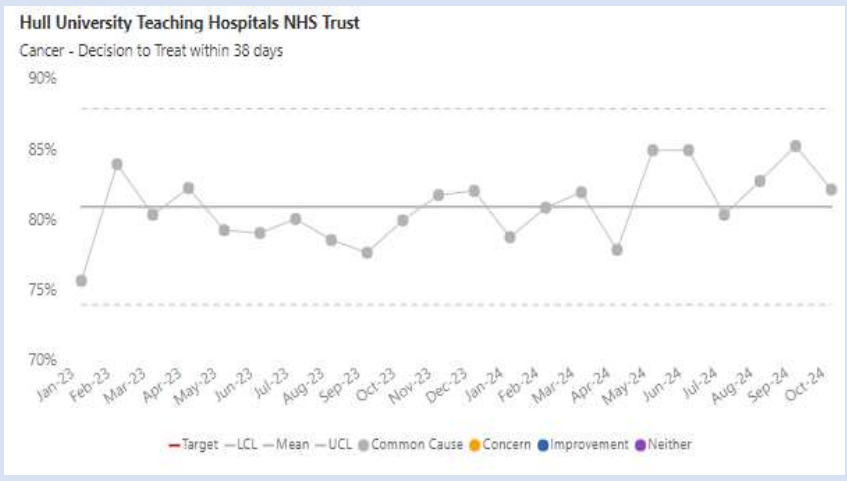
Compliance



Key Themes

- 52.9% performance for November 2024 set against a +6% increase in Cancer Referrals compared to previous year
- Breast – Improvement in pathway related to 1st OPA capacity however, November dip due to screening first results capacity continues to impact 62-day RTT
- Gynaecology – Diagnostic GA Hysteroscopy and histology reporting delays impacts on delay for confirmed cases
- Skin - delays in pathway related to 1st OPA capacity; consultant dermatologist & plastic surgeon vacancies – recovering in FDS & 62-day RTT
- Lung/Thoracic –Pooling patients to avoid differential waiting times in Thoracic service plus late IPTs and impact of radiotherapy/SABR capacity
- LGI – Therapeutic Endoscopy diagnostic capacity plus patient fitness, Histology reporting delays; patient compliance & consultant capacity
- Upper GI Deterioration seen in September and October – delays in front end triage highlighted to the Care Group. Significant improvement seen in November performance
- Radiotherapy recovery plan continues (12 months from November 2023) & mutual aid from Lincoln
- Oncology capacity (vacancies plus increased demand) – clinical prioritisation in Breast & Urology
- Histology TATs - SHYPS TAT Improvement Plan; escalation to Tiering for system wide approach
- Late IHTs – Lung, Head & Neck, Gynae and Urology: focussed work in Urology within the Group & Lung with Y&S Trust

Critical Enabler



Actions

IHTs

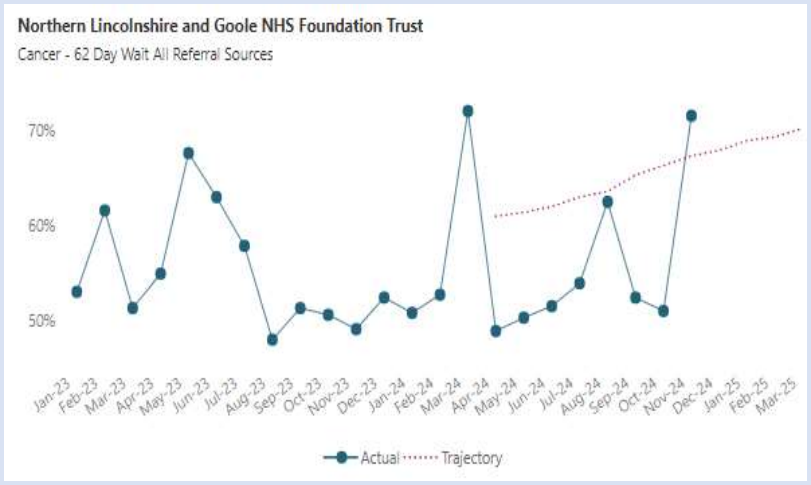
• Inter-Group review of the Urology IPTs – urology improvement group extended to cover the Group
• Joint work with Y&S on Lung late IPTs, no specific themes identified
• Lung whole pathway issues still remain in terms of late transfer for treatment
• Gynaecology (South Bank) workshop from 11/09/2024 – action plan: Admin/Referral work stream commences 4/11 plus clinical pathway work stream in Dec 2024

Workforce

• Plastic Surgery & Dermatology capacity – x4 vacant consultant posts wef mid-April 2024; focussed effort to maintain PTL
• Urology consultant vacancies – significant delays with outpatient & surgical capacity; 3rd & 4th pelvic oncology surgeon (new pelvic surgeon recruitment from January 2025)
• Radiotherapy recovery plan mobilised – however increased referrals & increased complexity; formal review September 2024 at 9 months; staff have agreed to continue overtime until March 2025 subject to funding by NHSE resources bid in October 2024
• Head & Neck – Max Fax capacity only 1 consultant and Thyroid capacity

20. 62 Day Cancer Performance - NLAG

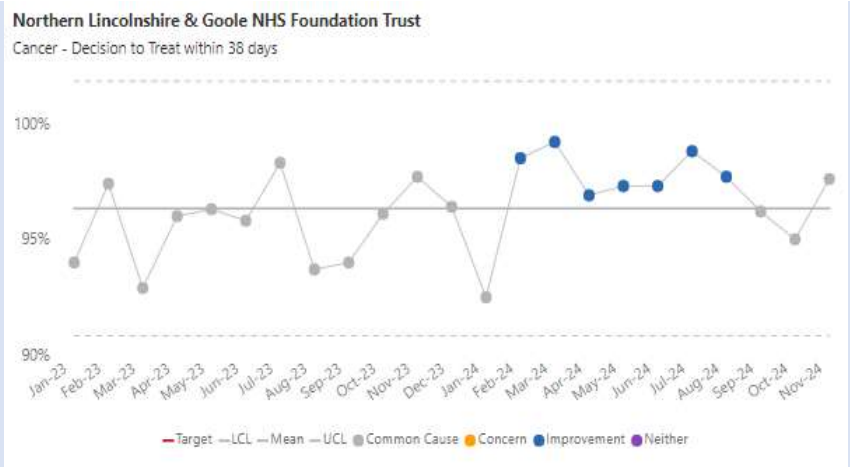
Compliance



Key Themes

- November performance at 71.5% (20.9% improvement on October 2024 performance).
- IPT transfer delays continue, performance impact 7-10% due to breach attribution in Lung & Urology pathways; both have continued front end pathway delays
- Lung - capacity for OPAs, diagnostics & oncology appointments (to determine surgical vs. oncology treatment). Lung physician vacancies x 2 – in recruitment, previous difficulties and retention issues Additional support for Lung cancer pathway tracking identified and in place
- LGI – endoscopy capacity/patient-initiated delays continue during October/November 2024 and Urology surgical capacity (vacancy)
- H&N – pathway issues to resolve; multiple diagnostics and histology not marked 31/62 and work continuing to improve this. Thyroid consultants annual leave impact on 62 day pathway
- Gynaecology – OPA and diagnostic capacity issues, review of tracking/pathway management underway. Additional tracking support identified and in place to the end of March 25.
- Histology TATs - % within 10 days and overall TATs being analysed by Path Links; provider continues to be below the England average for 10 day TATs
- Delays with some tumour sites for MRI reporting and also dating of diagnostic investigations taking up to 14 days in many areas

Critical Enabler

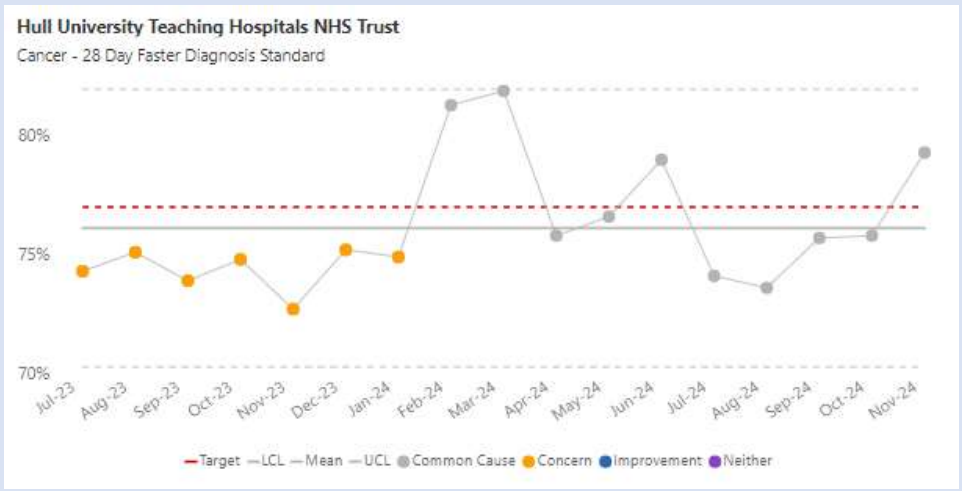


Actions

- Capacity constraints – consultant vacancies, imaging/diagnostic delays & pathology TATs
- Engagement with front end pathway improvement opportunities
- Histology TATs – TAT recovery plan Path Links
- Impact of Targeted Lung Health checks – increasing volume of patients on Screening pathway
- PET CT capacity constraints and PMSA dose limitations
- IPT – factors affecting the inter-Group performance

21. 28 Day Faster Diagnosis Standard - HUTH

Compliance

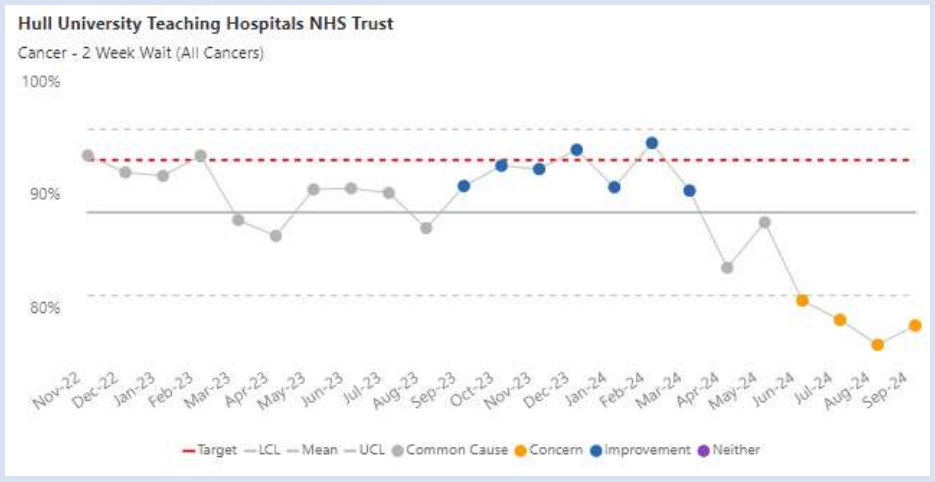


Key Themes

FDS Delivery Improvement plans – to sustain performance at least 80% monthly

- November FDS performance at HUTH 79.3%.
- Continual improvement of the FDS pathway seen in Gynae, and Breast
- Head and Neck – significant capacity constraints for 1st seen appointment impacting on FDS performance
- Ongoing issues with Breast radiology capacity impacting on 1st seen one stop ability – FDS impact
- Breast screening results clinic delays current wait of 2 to 3 weeks
- Endoscopy recovery plan and actions to support LGI USC and Bowel Screening pathways
- LGI & Urology – on-going improvement projects, plus consultant recruitment

Critical Ena



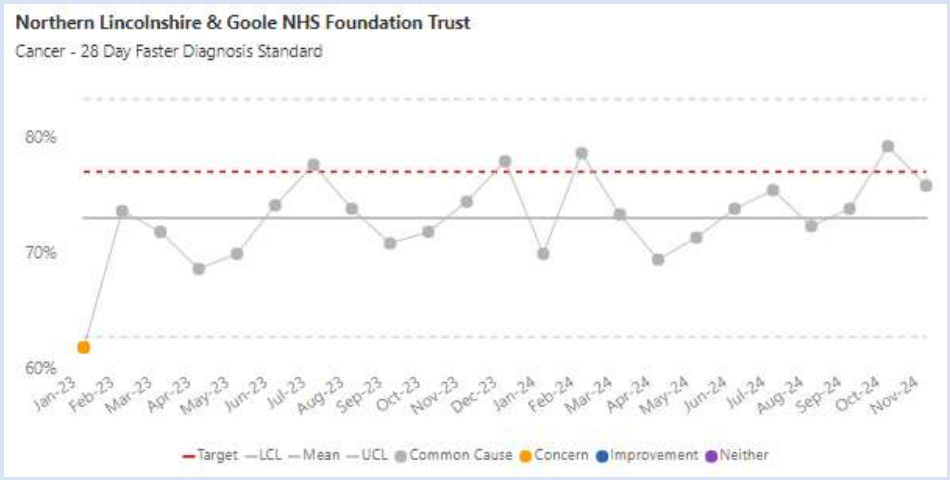
Actions

To sustain performance at least 80% monthly

- Continual improvement seen in Breast across both organisation
- Head and Neck – significant capacity constraints for 1st seen appointment impacting on FDS performance
- Improvement seen in Breast for November 2024 (provisional)
- Breast screening results outpatient capacity (2 to 3 week wait) which is currently impacting on screening FDS performance
- Endoscopy recovery plan and actions to support LGI USC and Bowel Screening pathways

22. 28 Day Faster Diagnosis Standard - NLAG

Compliance

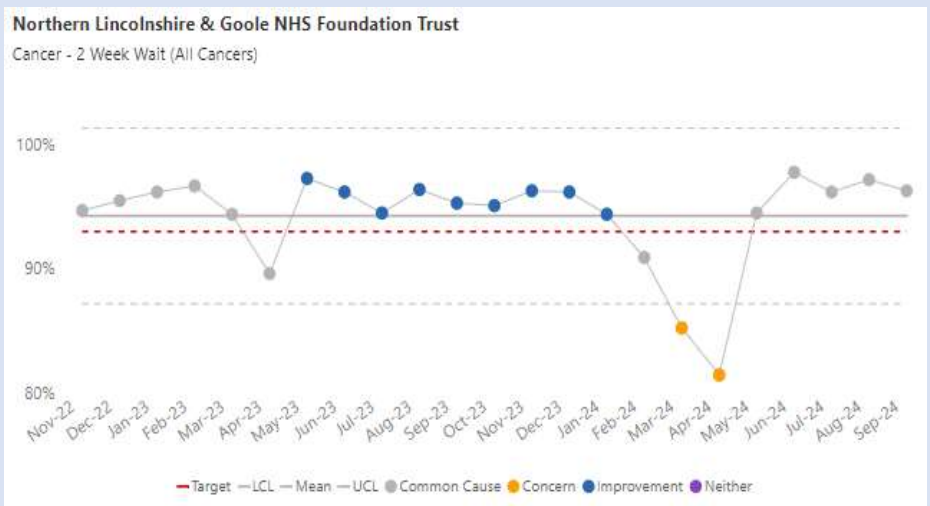


Key Themes

FDS Delivery Improvement plans – to sustain performance at least 80% monthly

- November FDS performance at NLAG 75.8%
- Continual improvement of the FDS pathway seen in Gynae, and Breast,

Critical Enabler



Actions

FDS Delivery Improvement plans developed and signed off via the Cancer Delivery Group – priorities:

- Screening service breach review (Bowel and Cervical) and actions from themes
- Timely outcome processes – Gynae, Lung and Head & Neck
- Lung – TAT for surgical out-patient appointments pre Nav Bronch (capacity)
- Histology – need to be marked 31/62 or stepped down to benign pathway - ongoing
- Improvement project group actions delivered – Lung, Gynae & Urology

23. Pathway Summary – Benchmark Report – Unscheduled Care

HUTH

Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Dec 24	78.00%	**54.1%**			3
A&E - 4 Hour Standard (Type 1)	Dec 24	78.0%	**35.7%**			0
A&E - 4 Hour Standard (Type 2 or 3)	Dec 24	95.0%	**92.8%**			20
A&E - Conversion Rate	Dec 24	25.0%	24.0%			23
A&E - DTA to Admission >12 Hours	Dec 24	0.0%	**23.0%**			22
A&E - DTA to Admission >12 Hours#	Dec 24	0.0	**776.0**			16
A&E - DTA to Admission >4 Hours	Dec 24	10.00%	**49.3%**			27
A&E - Left Without Being Seen	Nov 24	5.00%	**9.9%**			5
A&E - Reattendance Rate	Nov 24	5.0%	**8.8%**			49
A&E - Time to Initial Assessment	Nov 24	15.0	**23.0**			10
A&E - Time to Treatment	Nov 24	60.0	**112.0**			14
A&E - Total Time in A&E	Nov 24	160.0	**251.0**			3
A&E - Total Time in A&E (Admitted)	Nov 24	180.0	**203.0**			82
A&E - Total Time in A&E (Non-Admitted)	Nov 24	140.0	**275.0**			2
A&E Attendances All	Dec 24	-	14,063			52
A&E Attendances Type 1	Dec 24	-	9,511			59
A&E Attendances Type 3	Dec 24	-	4,552			57
Emergency Admissions Type 1	Dec 24	-	3,378			40
Emergency Admissions via A&E	Dec 24	-	3,378			40
Friends & Family A&E Score	Nov 24	85%	**62%**			5
Other Emergency Admissions	Dec 24	-	2,375			8
Total Emergency Admissions	Dec 24	-	5,753			26

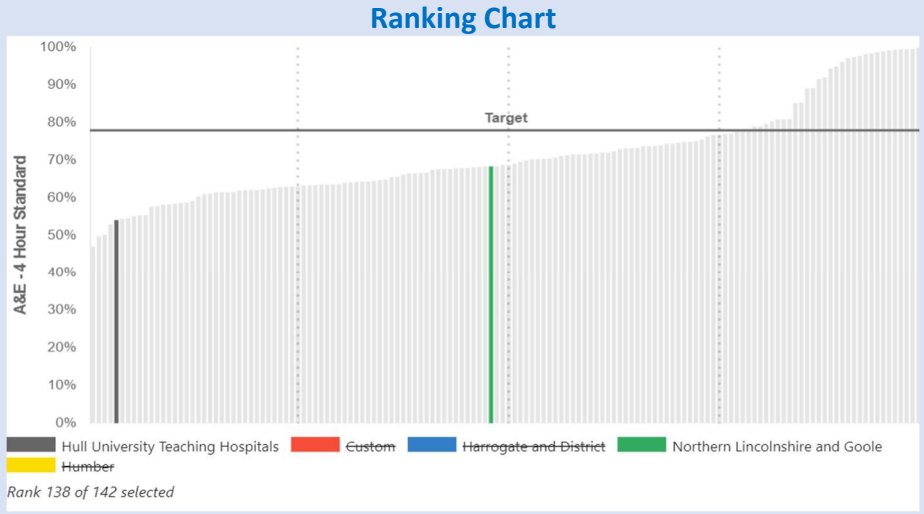
NLAG

Indicator	Period	Target		SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Dec 24	78.00%	**68.4%**			48
A&E - 4 Hour Standard (Type 1)	Dec 24	78.0%	**44.5%**			15
A&E - 4 Hour Standard (Type 2 or 3)	Dec 24	95.0%	99.3%			74
A&E - Conversion Rate	Dec 24	25.0%	**33.8%**			1
A&E - DTA to Admission >12 Hours	Dec 24	0.0%	**15.8%**			36
A&E - DTA to Admission >12 Hours#	Dec 24	0.0	**879.0**			11
A&E - DTA to Admission >4 Hours	Dec 24	10.00%	**26.2%**			72
A&E - Left Without Being Seen	Nov 24	5.00%	2.4%			83
A&E - Reattendance Rate	Nov 24	5.0%	**9.8%**			21
A&E - Time to Initial Assessment	Nov 24	15.0	**23.0**			10
A&E - Time to Treatment	Nov 24	60.0	57.0			70
A&E - Total Time in A&E	Nov 24	160.0	147.0			80
A&E - Total Time in A&E (Admitted)	Nov 24	180.0	**208.0**			81
A&E - Total Time in A&E (Non-Admitted)	Nov 24	140.0	133.0			78
A&E Attendances All	Dec 24	-	16,491			42
A&E Attendances Type 1	Dec 24	-	9,302			63
A&E Attendances Type 3	Dec 24	-	7,189			36
Emergency Admissions Type 1	Dec 24	-	5,577			10
Emergency Admissions Type 3	Dec 24	-	-			-
Emergency Admissions via A&E	Dec 24	-	5,577			9
Friends & Family A&E Score	Nov 24	85%	**79%**			53
Other Emergency Admissions	Dec 24	-	431			64
Total Emergency Admissions	Dec 24	-	6,008			20

24. Pathway Benchmarking & Trending – Unscheduled Care

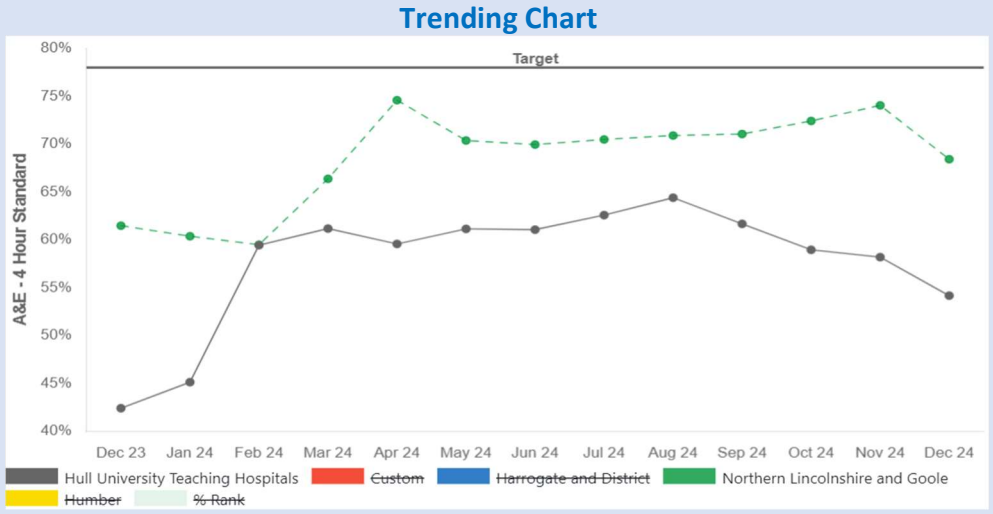
A&E - 4 Hour Performance

Ranking Chart



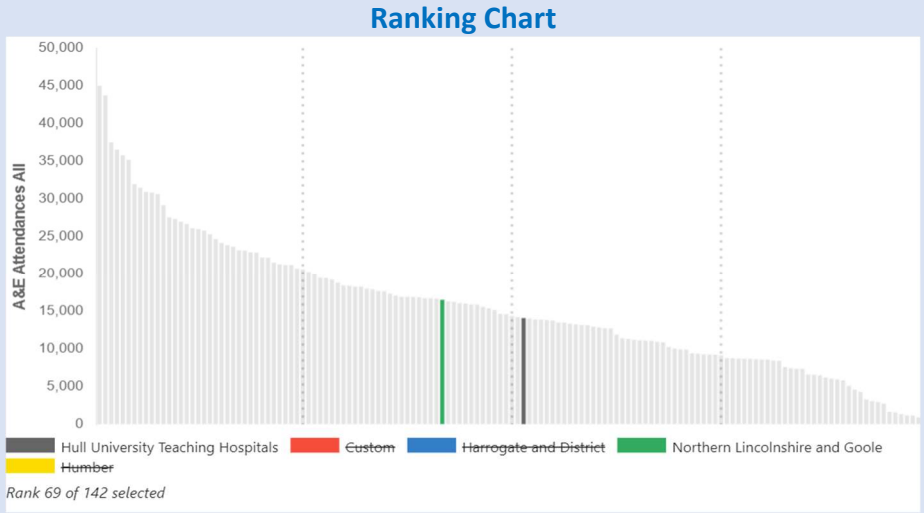
Rank 138 of 142 selected

Trending Chart



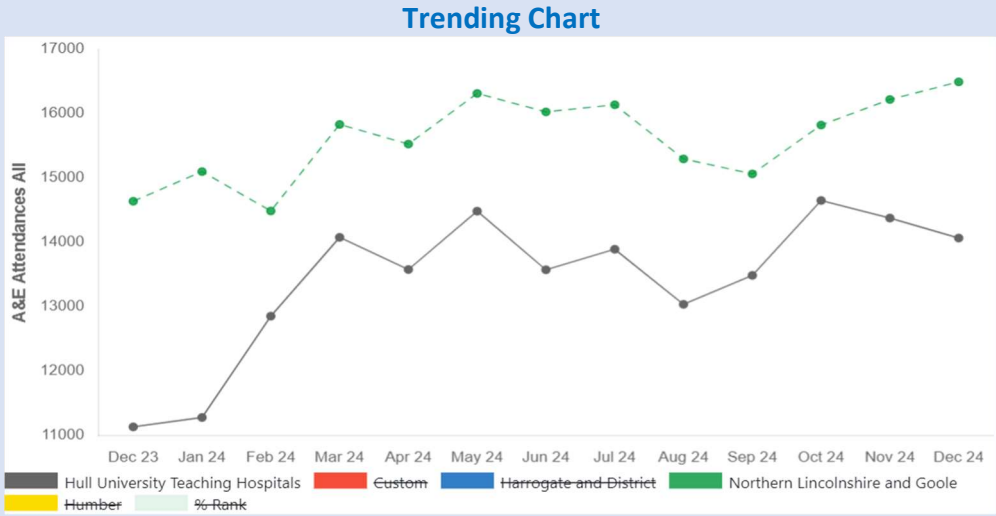
A&E – Attendances

Ranking Chart



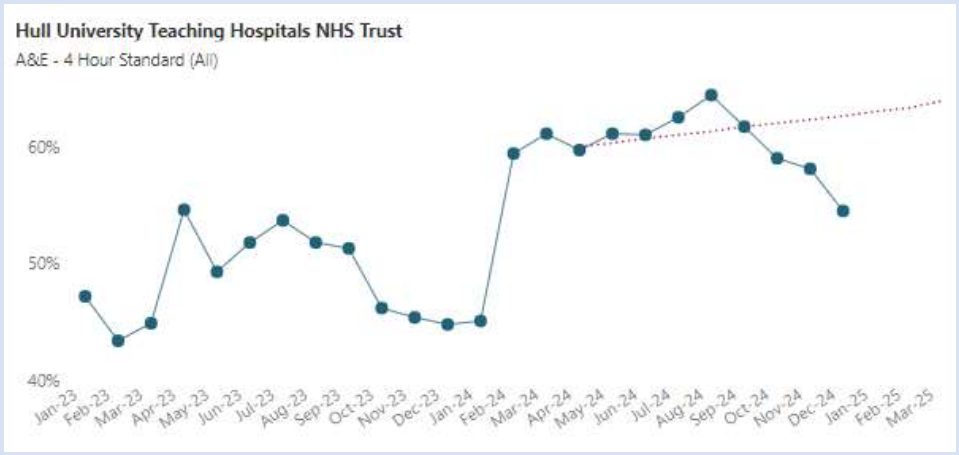
Rank 69 of 142 selected

Trending Chart



25. Emergency Care Standards – 4 hour Performance - HUTH

Compliance

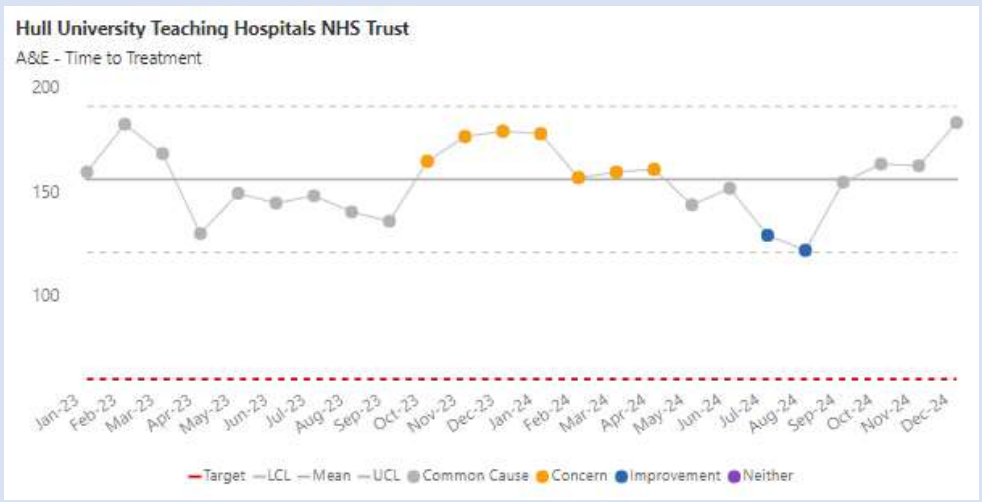


Key Themes

- A&E 4 Hour standard (all types) was 54.1% in December (plan 62.7%). Attendance
- Type 1 performance in December of 35.7% is below the 24/25 operating plan target of 39.7%. Type 1 attendances of 9,511 exceeded plan by 1,141 (13.6%)
- Type 3 performance (HRI UTC) was 92.9% in December against the 97% target. Attendances at UTC remain significantly below planned levels – 4678 seen in Decembers vs plan of 5580 (-902 attendances or -16.2%)
- HUTH remains within the lowest quartile for patients seen by a clinician within 60 minutes of arrival. Time to treatment was 183 minutes in December against 60 minutes internal target time.

Note: Feb '24 compliance step change relates to inclusion of HRI UTC in HUTH formal reporting

Critical Enabler



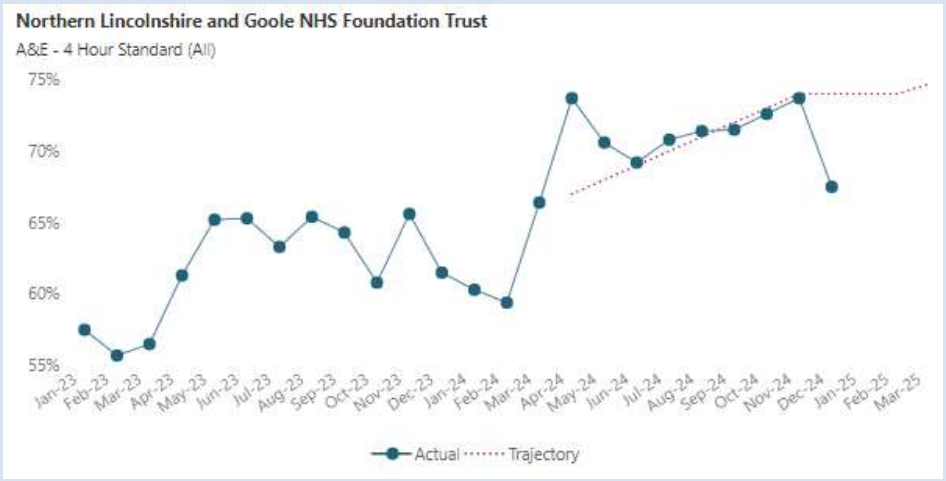
Actions

3 critical objectives identified. Improvement since project initiation in February 2024, however flow pressures experienced within the ED have led to a deterioration in performance from Aug '24:

1. Reducing non-admitted breaches: - Increased from 2,497 in August to 3,759 in December
2. Time to first clinician: - Deterioration from mean of 121.9 in August to mean of 183 in December
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)
4. Patient flow outside ED also being prioritised: - Implementation of SAFER Bundle, Discharge Lounge, Surgical SDEC, designated cover of GIM wards and reduction of NCTR.
5. Community capacity including diversionary pathways from ED being progressed with partners

26. Emergency Care Standards – 4 hour Performance - NLAG

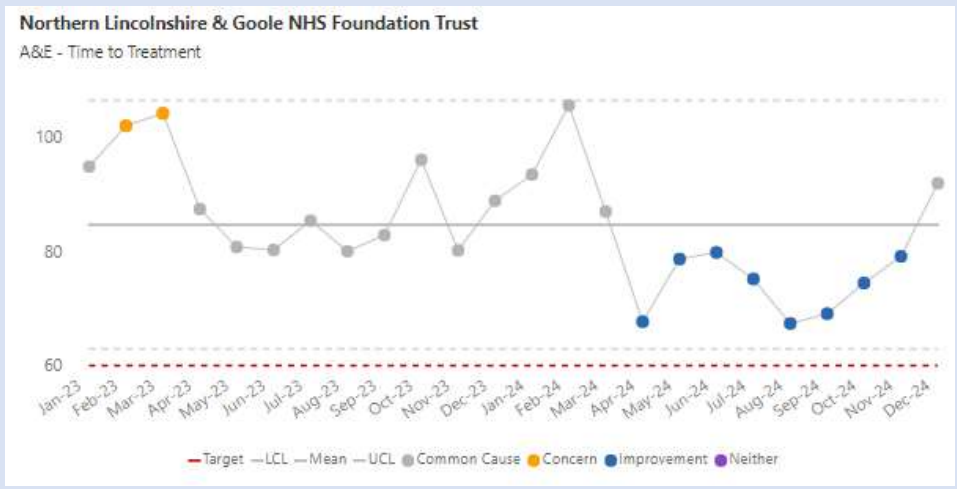
Compliance



Key Themes

- Combined type 1 and 3 performance was 67.5% in December against a target of 74%. This marked a significant deterioration in performance compared to previous months.
- Compliance is set against a significant and sustained increase in attendances in 24/25 with the December 2024 attendance volume of 16,031 being 1,078 cases (7.2%) above plan and 1,396 cases (9.5%) greater than December 2023. The majority of this growth is in Type 3 attendances.
- Time to treatment was 92 minutes in December versus the internal plan of not more than 60 minutes

Critical Enabler



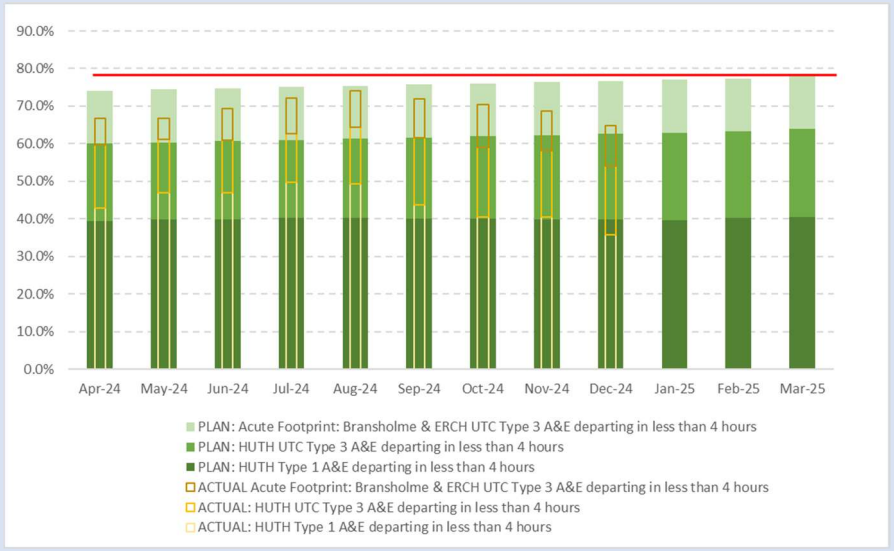
Actions

3 critical objectives identified.

1. Reducing non-admitted breaches: - Increase in breaches in December to 3,219
2. Time to first clinician: - Further deterioration in performance against this metric in December (92 minutes compared to 67.4 mins in August)
3. Improved frailty assessment: - Increase in waiting time from 239.3mins in August to 277 minutes in December for total time in department for patients >65 years of age (target time of 160 minutes)
4. Patient flow outside ED also being prioritised: - CDU now functional across both sites, impact being monitored. Patient flow outside ED also being prioritised. Implementation of SAFER Bundle, designated cover of GIM wards and reduction of NCTR.

27. Acute Footprint Compliance – A&E

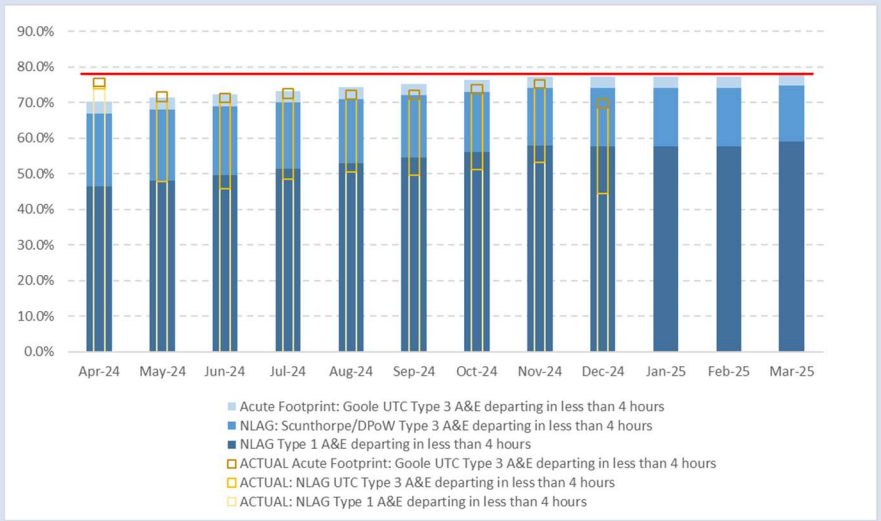
Compliance - HUTH



Key Themes

- As per NEY Region/HNY ICB instruction, 2024/25 trajectories are predicated on 78% delivery as an Acute Footprint by March '25.
- Acute footprint delivery of 64.9% against a plan of 76.7%.
- Breaking the plan/delivery into constituent parts:
  - Type 1 compliance of 35.7% was below the plan of 39.7%.
  - Type 3 co-located activity compliance of 18.5% versus plan of 22.9%
  - Non-co-located compliance was 10.7% versus plan of 14.1%

Compliance - NLAG

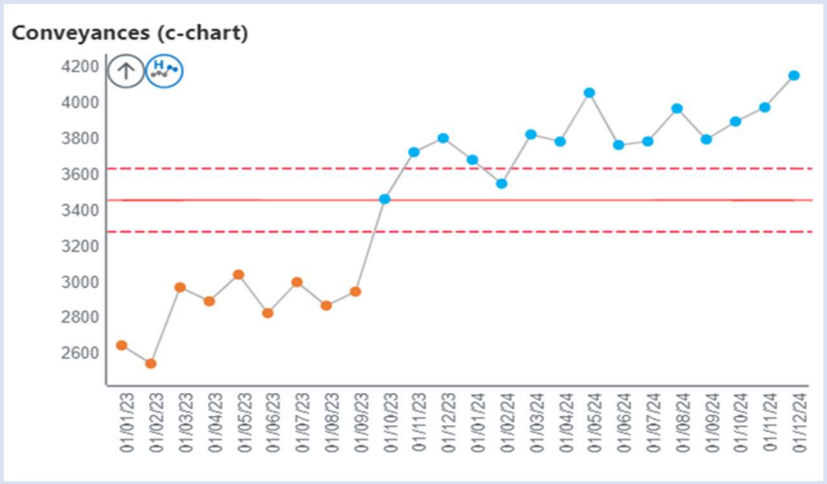


Key Themes

- Acute footprint delivery of 71% against a plan of 77.3%
- Breaking the plan/delivery into constituent parts:
  - Type 1 compliance was 44.5% versus plan of 57.8%.
  - Type 3 co-located activity compliance of 23.9% versus plan of 16.2% - largely driven by the increase in Type 3 attendances.
  - Non-co-located compliance was 2.6% versus plan of 3.3%

28. Ambulance Conveyances

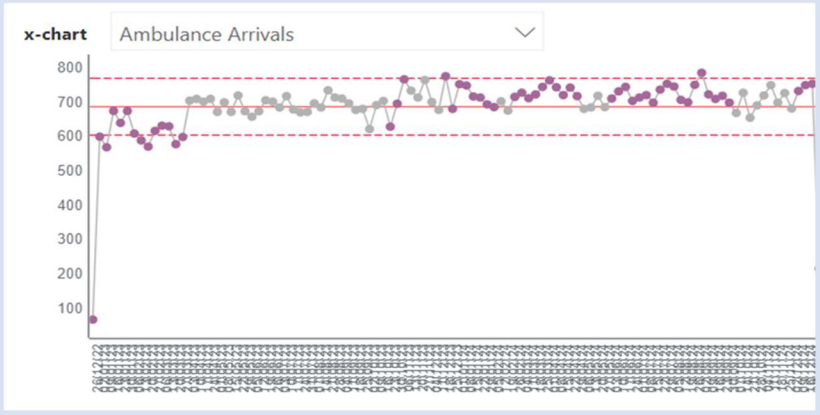
HUTH - Ambulance conveyances Jan 2023 to Dec 2024



Key Themes

- Ambulance conveyances to the ED at HRI increased from 2,648 in January 2023 to 4,155 in December 2024
- A comparison with overall attendances to the ED during the same period cannot be made due to the counting change from February 2024 when the UTC opened at HRI.

NLaG - Ambulance conveyances Jan 2023 to Dec 2024

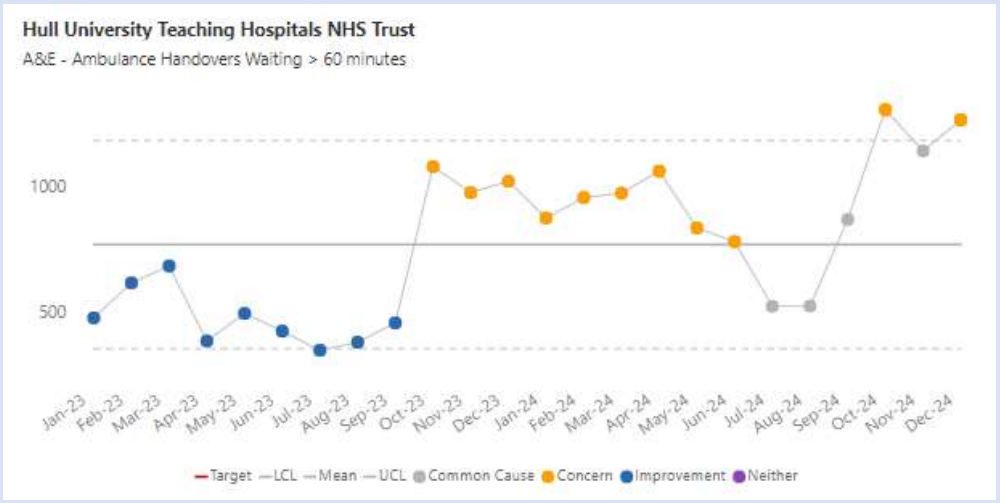


Key Themes

- Ambulance conveyances to the EDs at SGH and DPoW have remained within control limits between Jan 23 and Dec 24.
- Attendances to the ED (Types 1 and 3) have increased from 12,006 in January 2023 to 16,031 in December 2024, the largest area of growth being in Type 3 attendances.

29. Ambulance Handovers >60 minutes - HUTH

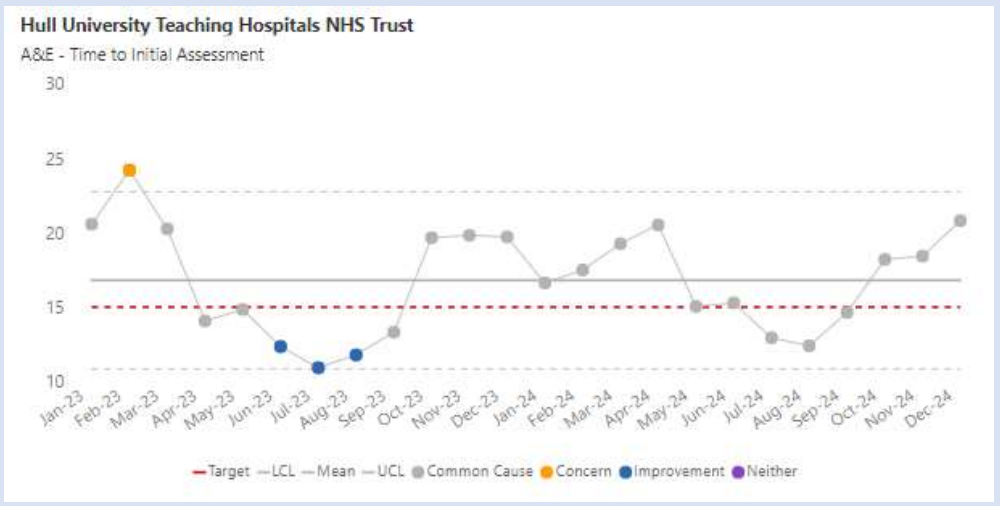
Compliance



Key Themes

- Month on month reduction in the number of ambulance handovers >60 minutes from Feb to August as part of recovery programme, however, notable deterioration at HUTH from September onwards (1,270 in December 2024).
- Root cause of handover delays linked to winter pressures and patient volumes in A&E, resulting in compression of available assessment spaces.
- Pressure on staffing levels that cover all elements of ED has increased due to an increase in non-admitted activity seen via ECA/ED. Action plan being progressed to align capacity and demand within ED establishment.

Critical Enabler

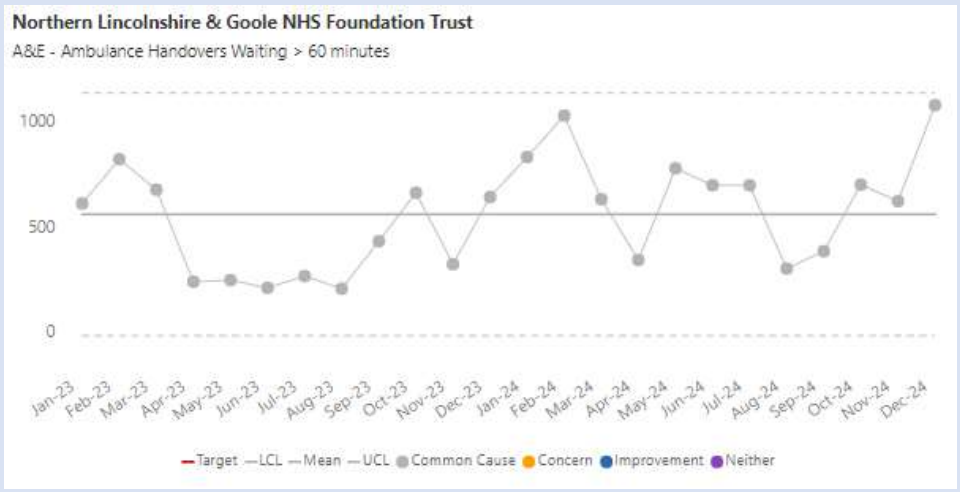


Actions

- Time to initial assessment in December was 21 minutes, a deterioration in performance compared to previous months
- Triggers and Escalation/SOP for ambulance handovers is being reviewed and adapted linked to national OPEL system, enabling 30-minute Cat 2 responses for YAS.
- Work with YAS to bring forward clinical assessment through proposing changes to current practice.

30. Ambulance Handovers >60 minutes - NLAG

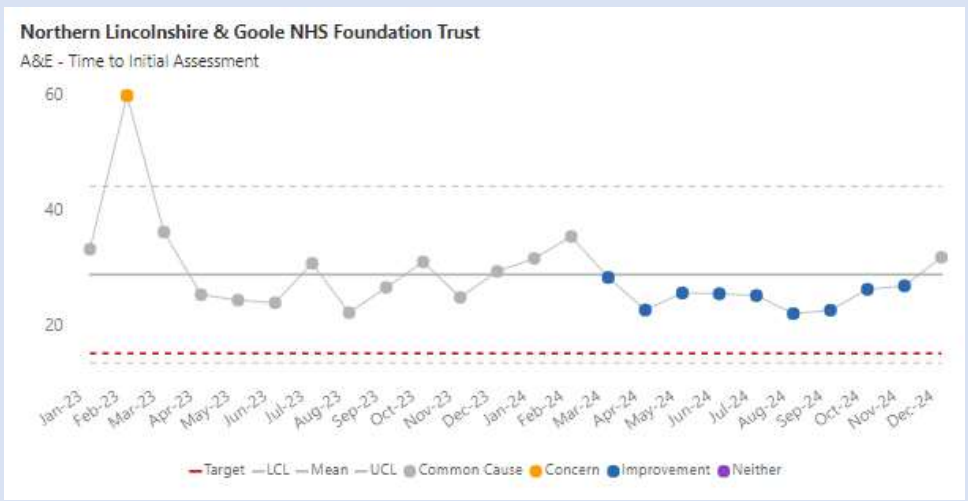
Compliance



Key Themes

- Performance in ambulance handovers >60 minutes has increased since August 2024, rising to 1,078 in December.
- Time to initial assessment in December was 32 minutes against target of 15 minutes, a deterioration on the previous month

Critical Enabler

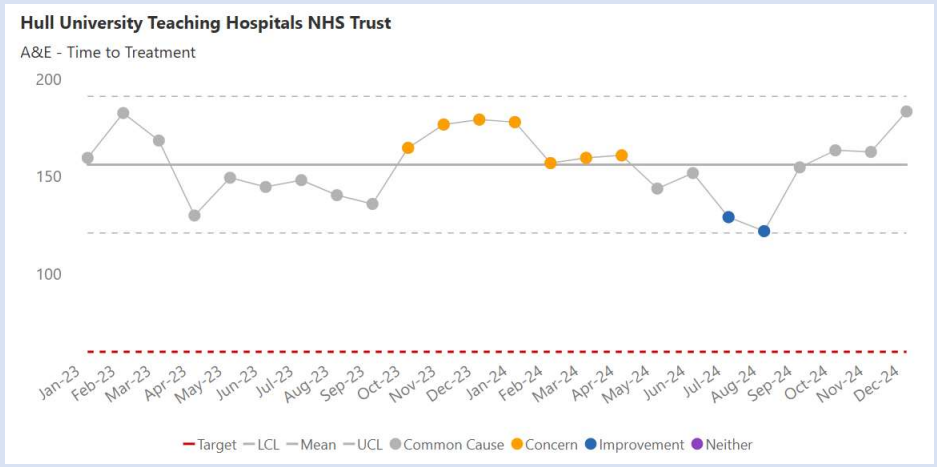


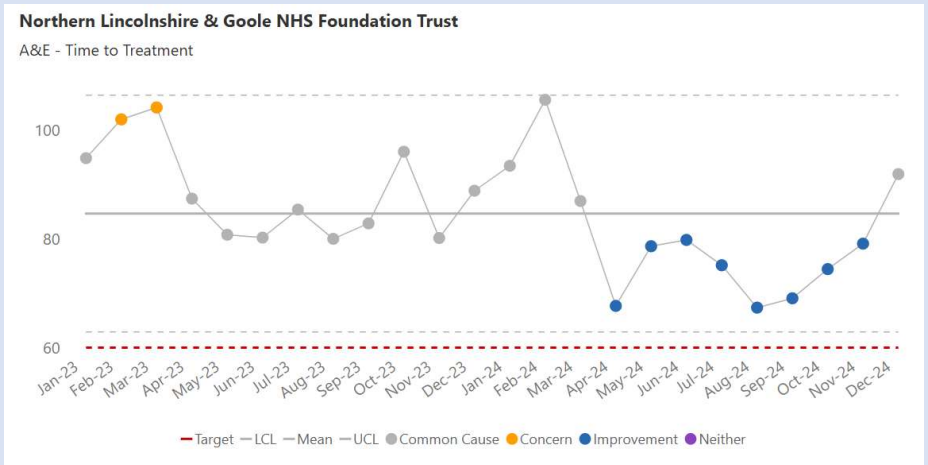
Actions

- Rapid Assessment and Treatment (RAT) model to be embedded to reduce waiting time to be seen.
- Audit of current practices planned to ensure handover principles are being adhered to. Working toward zero tolerance of >45-minute handover, aim to deliver 100% ambulance handovers under 45min and 80% under 30 minutes.
- Improvement of flow/ LOS through Discharge rounds in wards will reduce congestion.
- Impact and timelines for recovery programme being finalised with system partners.

31. Trend Diagrams – 3 Key ED Metrics

Objective 1: Time to first clinician maximum of 60 minutes. Seek to deliver mean of 30 mins.

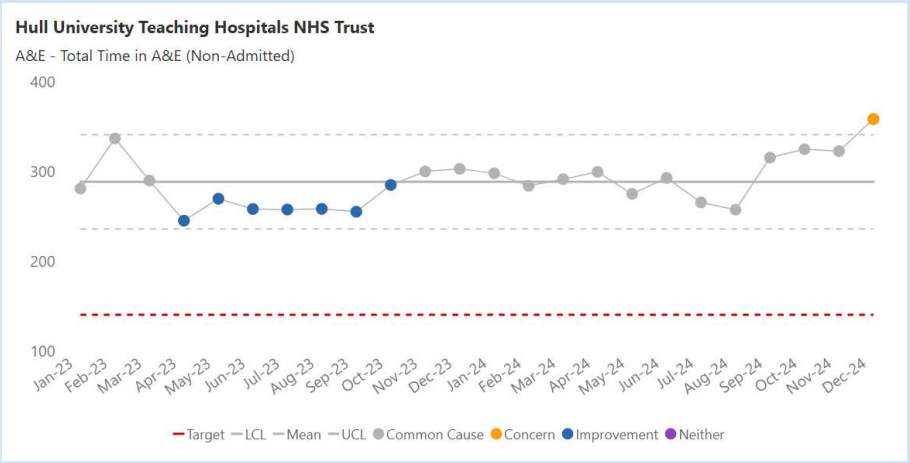


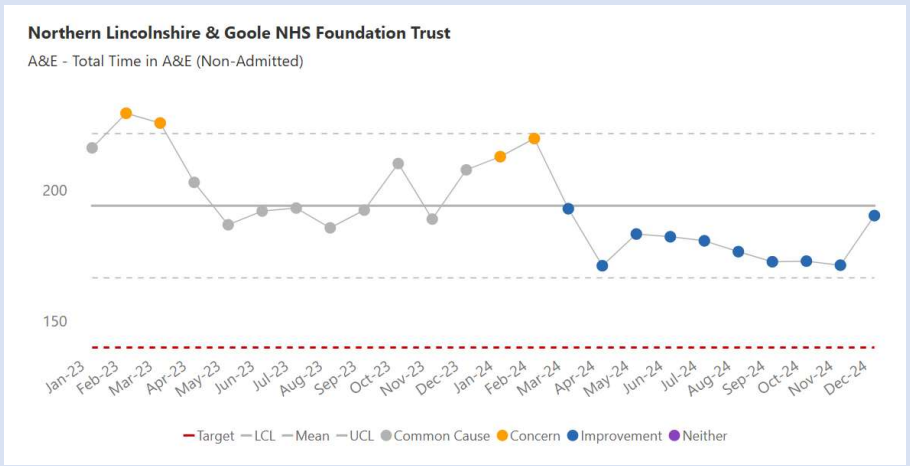


Key Themes

- Both HUTH and NLaG have seen a deterioration in performance against time to first clinician (time to treatment).
- HUTH mean = 156 minutes (December 183 minutes)
- NLaG mean = 84.67 minutes (December 92 minutes)

Objective 2: Reduction in the time spent in ED by Type 1 non-admitted patients

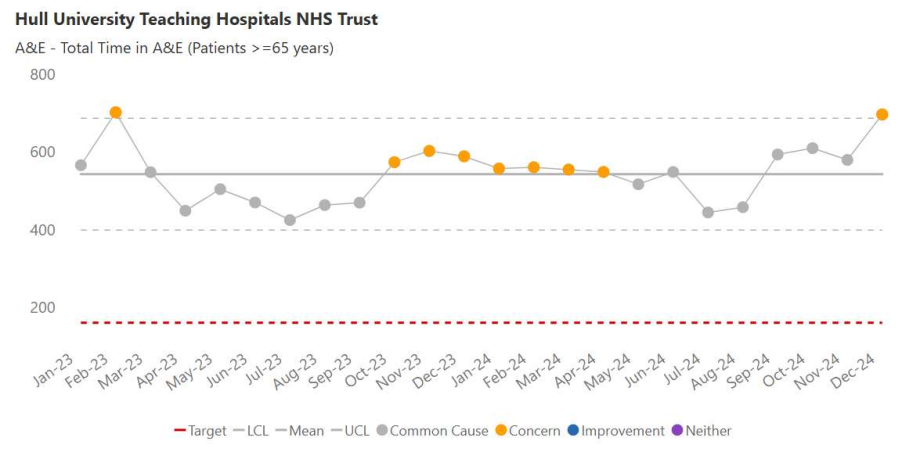


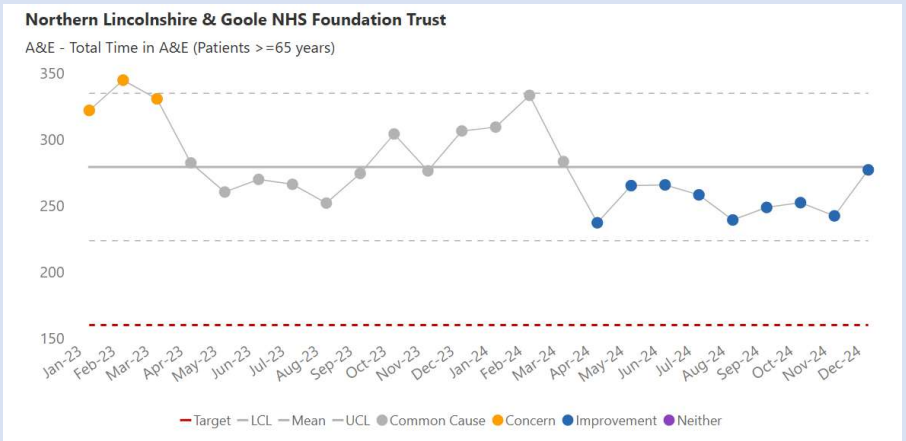


Key Themes

- The Group established a target of 140 minutes for time spent by non-admitted Type 1 patients in the ED.
- HUTH has seen a deterioration in performance against this metric reflecting the increased pressure in the ED since September 2024.
- NLaG has consistency in performance since late Spring, with a slight deterioration in December, but has still to realise the 140 minutes target time.

Objective 3: Improved assessment, decision making and flow of frail patients >=65 years





Key Themes

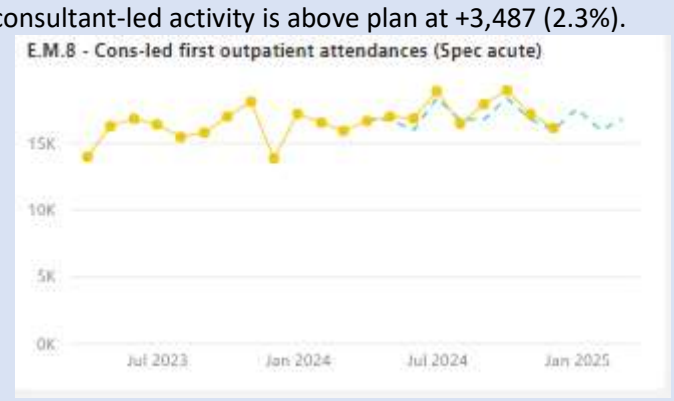
- The Group established a target of 160 minutes for total time in the ED for patients aged 65 years and over
- The mean for HUTH is 542 minutes, with December's performance highlighted as a concern at 696 minutes.
- The mean for NLaG is 279 minutes, with December performance at 277 minutes.

32. Activity

HUTH

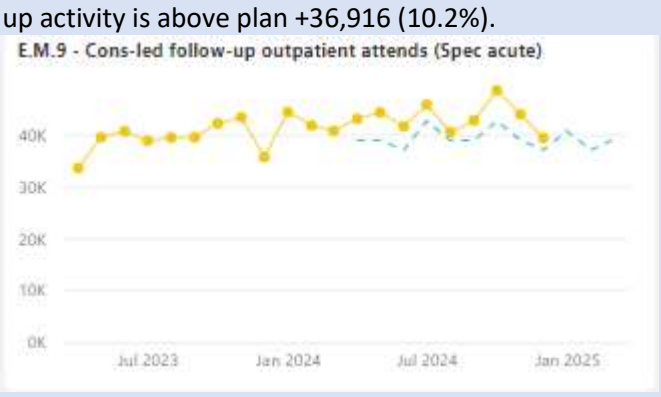
New Outpatient Attendances vs Plan

YTD New consultant-led activity is above plan at +3,487 (2.3%).



Follow up Outpatient Attendances vs Plan

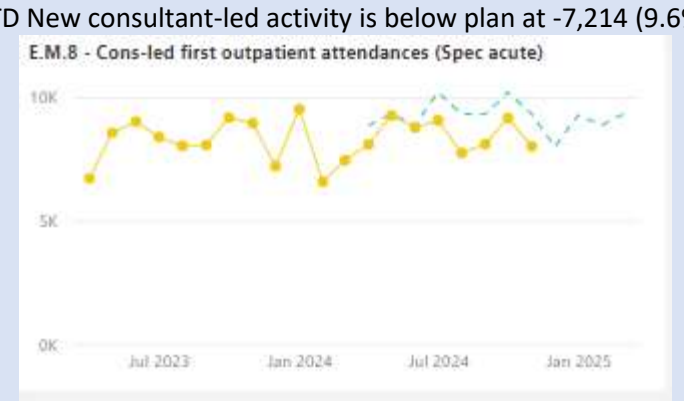
YTD Follow up activity is above plan +36,916 (10.2%).



NLAG (data shown to Month 8)

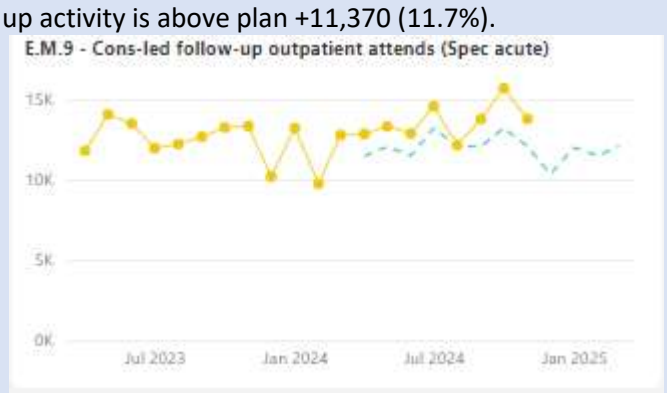
New Outpatient Attendances vs Plan

YTD New consultant-led activity is below plan at -7,214 (9.6%).



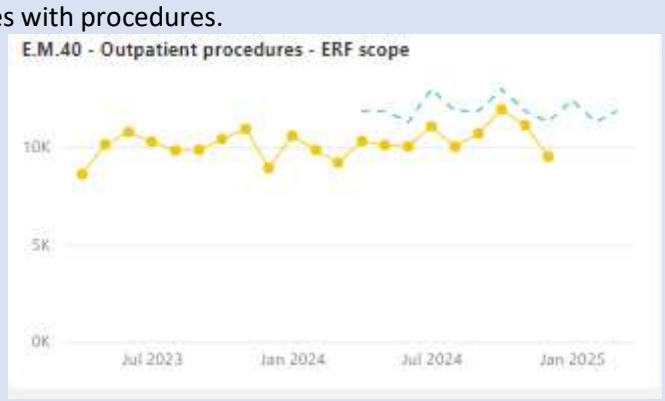
Follow up Outpatient Attendances vs Plan

YTD Follow up activity is above plan +11,370 (11.7%).



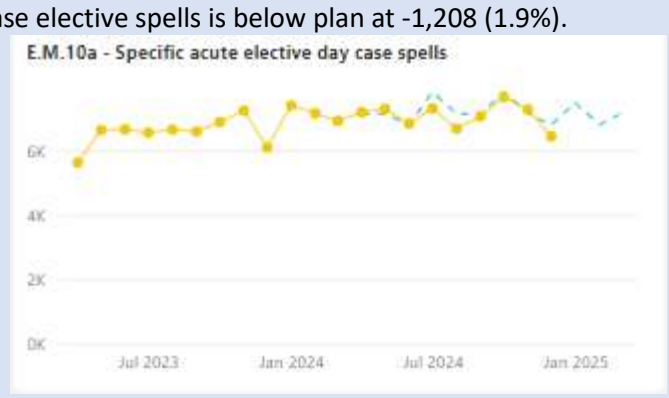
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -13,012 (12.1%). Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



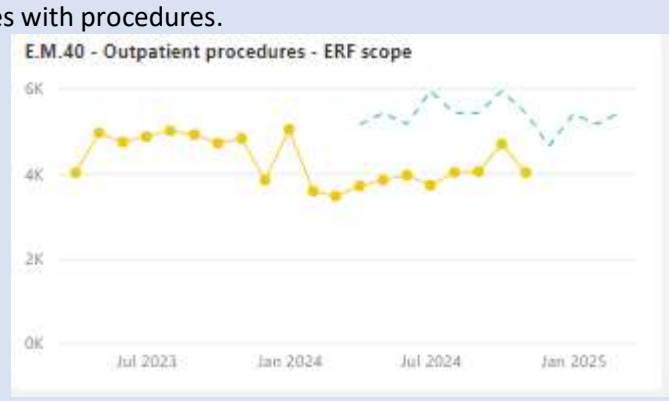
Day Case Admissions vs Plan

YTD Day case elective spells is below plan at -1,208 (1.9%).



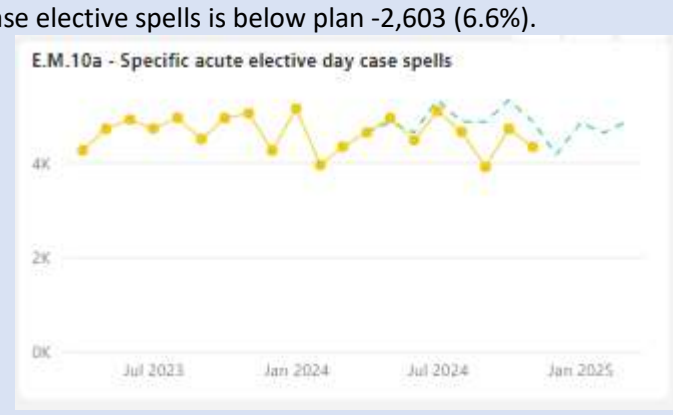
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -11,855 (27.1%). Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



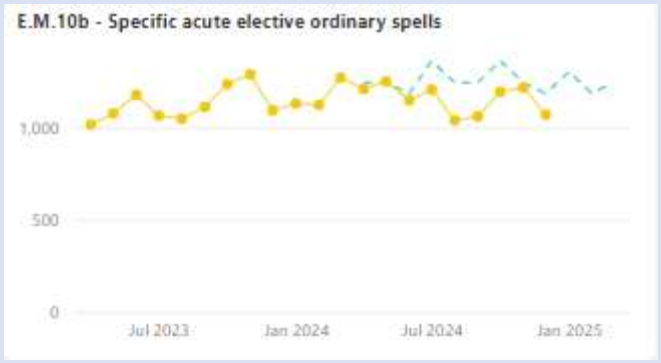
Day Case Admissions vs Plan

YTD Day case elective spells is below plan -2,603 (6.6%).



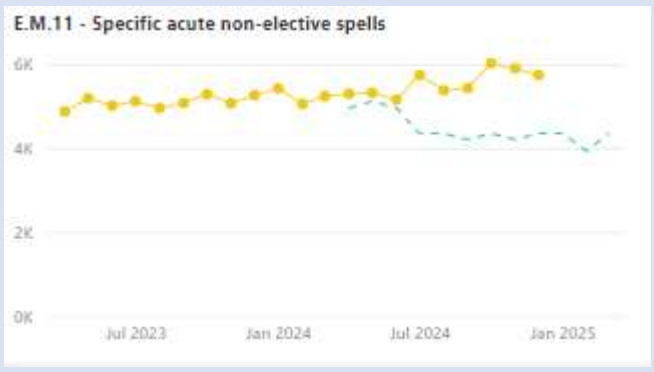
Elective Admissions vs Plan

YTD Inpatient spells is below plan at -919 (8.1%).



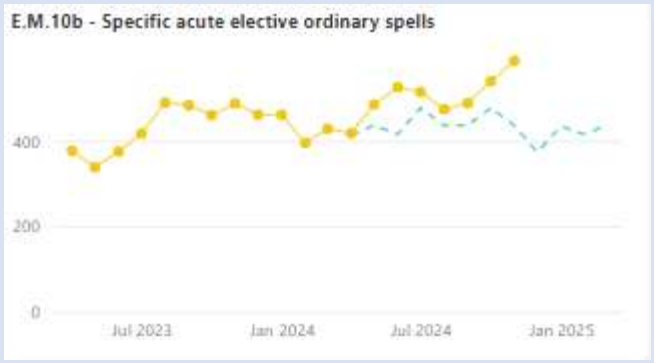
Non-Elective Admissions vs Plan

YTD non-elective spells +9,157 (22.4%) over plan. This reflects a delay in reporting of associated activity (SDEC) as A&E Type 5 attendances.



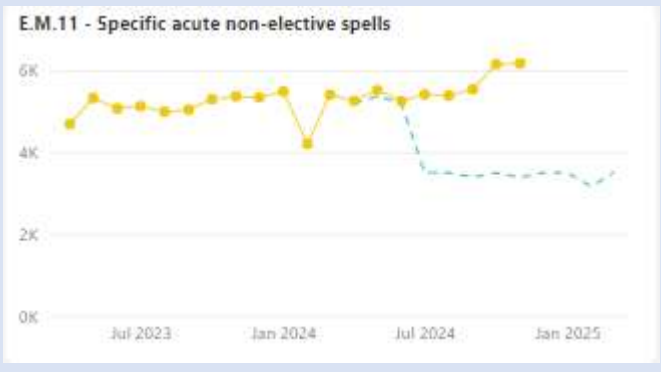
Elective Admissions vs Plan

YTD Inpatient spells is above plan +503 (14.3%), 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 +11,660 (35.4%). This reflects a delay in reporting of associated activity (SDEC) as A&E Type 5 attendances.



33. Elective Recovery Fund - HUTH

Hull University Teaching Hospitals	ERF Performance (%)									
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD
DAYCASE	116%	119%	118%	105%	102%	117%	115%	121%	107%	113%
ELECTIVE	107%	109%	104%	93%	97%	94%	96%	108%	97%	100%
OP FIRST ATTENDANCE	112%	116%	117%	116%	107%	118%	119%	117%	117%	116%
OP FIRST PROCEDURE	119%	114%	117%	114%	112%	122%	113%	121%	107%	115%
OP F/UP PROCEDURE	161%	158%	163%	152%	157%	163%	171%	174%	157%	162%
Total	**114%**	**116%**	**115%**	**105%**	**104%**	**111%**	**111%**	**117%**	**107%**	**111%**

Notes

This data is an early pull of data and as such is not fully coded and may omit clinics/discharges that were cashed up late.

34. Elective Recovery Fund - NLAG

Northern Lincolnshire & Goole Hospitals	ERF Performance (%)									
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD
DAYCASE	118%	119%	115%	116%	121%	102%	114%	112%	112%	114%
ELECTIVE	103%	110%	126%	109%	119%	106%	114%	121%	111%	113%
OP FIRST ATTENDANCE	94%	106%	107%	96%	92%	87%	91%	88%	89%	94%
OP FIRST PROCEDURE	94%	98%	95%	86%	103%	86%	88%	92%	97%	93%
OP F/UP PROCEDURE	77%	73%	83%	73%	87%	84%	87%	79%	83%	81%
Total	**104%**	**109%**	**112%**	**105%**	**110%**	**97%**	**105%**	**105%**	**104%**	**106%**

Notes

This data is an early pull of data and as such is not fully coded and may omit some clinics/discharges that were cashed up late.

This data will not fully match to the SUS national position, as this the SUS position is being generated through the old Data Warehouse to avoid the known errors.

Known errors are:

- Length of stay is overstated where a second or subsequent critical care stay exists, this may overstate excess bed-day value.
- Treatment Function Code is feeding Main Specialty Code meaning Nurse led activity is being treated as consultant led in OP POD allocation.

The national SUS ERF valuation is coming out at around 1.3% lower than local ERF valuation - this is currently being investigated and is a risk to the delivery.

Quality Performance Metrics

November 2024 v1

NHS
Humber Health Partnership

United By Compassion: Driving For Excellence

Highlights and Lowlights

NHS Humber Health Partnership

The IPR is under development with the Information Team, building a refreshed reporting tool for the Group. Some of the content from the IPR is provided where it is available. Other data sources are used from legacy Trust systems and externally reported datasets. A review and sign off process has been undertaken and is being implemented for the HUTH data, with NLAG to follow.
Timing of the report provision for an earlier than usual QSCiC meeting in December has limited a number of available data sources, with validation and BI reporting processes expected to be completed in the coming week. Verbal updates on the SHMI HSMR and IPC metrics can be provided at the meeting

	HUTH	NLAG
Highlights	• HSMR has reduced, although higher than average. • Bateraemia rates for E.coli, Pseudomona and Klebsialla remain below trajectory.	• SHMI value is 0.97, below the 1.00 national average, continuing improved performance seen over recent months. • HSMR rate is 89 for the rolling 12 months, below the 100 national average. • FFT rates for Inpatient, Maternity and Outpatients remain above the national target

Lowlights	• Duty of candour compliance is lower than target and undergoing a change in process to ensure compliance with Regulation 20.
	• HUTH is identified as having a 'higher than expected' SHMI, with an overall SHMI of 1.1536. The HHP Mortality Improvement group is targeting areas for improvement, including those diagnosis groups where SHMI is "higher than expected":
	  • Secondary malignancies
	  • Septicaemia
	• VTE data remains below the 95% target.
	• IPC, C.Difficile rate is over the target for the year.
	• There was one MRSA bacteraemia case in October, making 5 in the year to date against a zero target.
	• Patient complaint rate of completion within timescales remains below target consistently.
		• Residual issues to resolve the medical beds, trolleys and equipment entrapment or falls reduction Patient Safety Alert are progressing with collation of evidence to assure closure of the alert actions.
		• VTE data validation and reporting capture being pursued following change to capture from ePMA, since Lorenzo implementation.
		• IPCC C.difficile rate is higher than trajectory target for the year.
		• IPCC P.aeruginosa is higher than the trajectory target for the year.
		• Infection rates are above trajectory targets for Klebsiella and E Coli.

Group Integrated Performance Report | Trust Level Scorecard

Trust Scorecard | Care Group Scorecard | Data Table | Metadata | Spotlight (BETA)

Metric Group: All

Trust | Group

Hull University Teaching Hospitals NHS Trust

Metric (right click to drill through to SPC chart)	Month	Target	Result	Variation
Complaints - 40 day compliance	Oct-24	90.0%	25.0%	Common Cause
Complaints - 60 day compliance	Oct-24	90.0%	47.2%	Common Cause
Complaints - PALS	Oct-24		201	Common Cause
Complaints - Received	Oct-24		49	Common Cause
Complaints - Received (per 1,000 bed days)	Oct-24		1.57	Common Cause
Complaints - Reopened	Oct-24		6	Common Cause
Falls - per 1,000 bed days	Oct-24		7.82	Improvement (Lo...
Friends & Family - A&E Score	Sep-24	85.0%	67.7%	Common Cause
Friends & Family - Inpatient Score	Sep-24	95.0%	91.5%	Improvement (Hi...
Friends & Family - Maternity Score	Sep-24	95.0%	100.0%	Improvement (Hi...
Friends & Family - Outpatient Score	Sep-24	95.0%	94.7%	Improvement (Hi...
Infections - C.Difficile	Sep-24		8	Concern (High)
Infections - C.Difficile (per 1,000 bed days)	Sep-24		0.32	Concern (High)
Infections - E.Coli	Sep-24		8	Common Cause
Infections - E.Coli (per 1,000 bed days)	Sep-24		0.30	Common Cause
Infections - Klebsiella	Sep-24		1	Common Cause
Infections - Klebsiella bacteraemia (per 1,00...	Sep-24		1.00	Common Cause
Infections - MRSA	Sep-24		0	Common Cause
Infections - MRSA (per 1,000 bed days)	Sep-24		0.00	Common Cause
Infections - MSSA	Sep-24		6	Common Cause
Infections - MSSA (per 1,000 bed days)	Sep-24		5.00	Common Cause
Infections - Pseudomonas aeruginosa	Sep-24		1	Common Cause

Northern Lincolnshire and Goole NHS Foundation Trust

Metric (right click to drill through to SPC chart)	Month	Target	Result	Variation
Complaints - 40 day compliance	Oct-24	90.0%	41.9%	Common Ca
Complaints - 60 day compliance	Oct-24	90.0%	77.4%	Common Ca
Complaints - PALS	Oct-24		277	Common Ca
Complaints - Received	Oct-24		31	Common Ca
Complaints - Received (per 1,000 bed days)	Oct-24		16.27	Common Ca
Complaints - Reopened	Oct-24		5	Common Ca
Friends & Family - A&E Score	Sep-24	85.0%	81.7%	Common Ca
Friends & Family - Community Score	Sep-24	95.0%	95.6%	Common Ca
Friends & Family - Inpatient Score	Sep-24	95.0%	96.8%	Improvemen
Friends & Family - Maternity Score	Sep-24	95.0%	100.0%	Improvemen
Friends & Family - Outpatient Score	Sep-24	95.0%	97.0%	Common Ca
Infections - C.Difficile	Sep-24		0	Common Ca
Infections - C.Difficile (per 1,000 bed days)	Sep-24		0.00	Common Ca
Infections - E.Coli	Sep-24		8	Common Ca
Infections - E.Coli (per 1,000 bed days)	Sep-24		0.44	Common Ca
Infections - Klebsiella	Sep-24		4	Common Ca
Infections - Klebsiella bacteraemia (per 1,00...	Sep-24		4.00	Common Ca
Infections - MRSA	Sep-24		0	Common Ca
Infections - MRSA (per 1,000 bed days)	Sep-24		0.00	Common Ca
Infections - MSSA (per 1,000 bed days)	Sep-24		1.00	Common Ca
Infections - Pseudomonas aeruginosa bacter...	Sep-24		1.00	Common Ca
Mortality - HSMR	May-24	100	92.3	Improvemen

Hull University Teaching Hospitals NHS Trust

Metric (right click to drill through to SPC chart)	Month	Target	Result	Variation
Mortality - HSMR	Jul-24	100	105.0	Improvement (Lo...
Mortality - SHMI	May-24	1	1.153	Concern (High)
Never Events	Oct-24		0	Common Cause
Pressure Ulcers - Category 1	Oct-24		9	Common Cause
Pressure Ulcers - Category 2	Oct-24		38	Common Cause
Pressure Ulcers - Category 3	Oct-24		0	Common Cause
Pressure Ulcers - Category 4	Oct-24		0	Common Cause
Pressure Ulcers - Device related	Oct-24		15	Common Cause
Pressure Ulcers - Hospital acquired	Oct-24		73	Concern (High)
Pressure Ulcers - Suspected deep tissue injury	Oct-24		23	Common Cause
Pressure Ulcers - Total community acquired	Oct-24		397	Concern (High)
Pressure Ulcers - Unstageable	Oct-24		3	Common Cause
VTE risk assessment	Sep-24	95.0%	92.7%	Improvement (Hi...

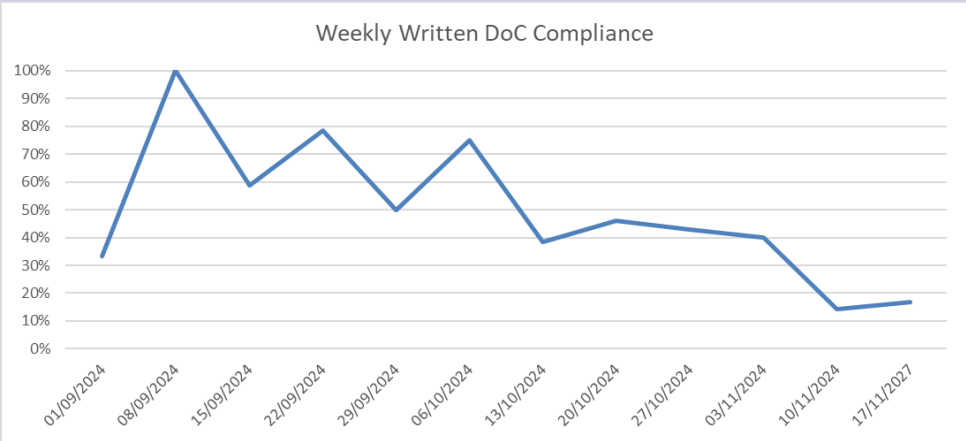
Northern Lincolnshire and Goole NHS Foundation Trust

Metric (right click to drill through to SPC chart)	Month	Target	Result	Variation
Mortality - HSMR	May-24	100	92.3	Improvement (Lo...
Mortality - SHMI	Mar-24	1	0.990	Improvement (Lo...
Never Events	Sep-24		0	Common Cause
Pressure Ulcers - Category 1	Sep-24		8	Common Cause
Pressure Ulcers - Category 2	Sep-24		51	Common Cause
Pressure Ulcers - Category 3	Sep-24		2	Common Cause
Pressure Ulcers - Category 4	Sep-24		1	Concern (High)
Pressure Ulcers - Device related	Sep-24		12	Common Cause
Pressure Ulcers - Hospital acquired	Sep-24		88	Common Cause
Pressure Ulcers - Suspected deep tissue injury	Sep-24		24	Improvement (Lo...
Pressure Ulcers - Total community acquired	Sep-24		80	Common Cause
Pressure Ulcers - Unstageable	Sep-24		2	Common Cause
VTE risk assessment	Oct-24	95.0%	91.1%	Common Cause

- The development of the national reporting quality metrics has progressed with more of the metrics now available for the HUTH sites, and the expansion of this is ongoing. This view reflects where the metrics are commonly presented for the Group on the IPR. Other metrics such as Duty of Candour are locally available and in process of being uploaded to IPR for both Trusts.
- There are still some challenges with drill down into care group splits across both Trusts.
- Weekly touch points between the Interim Group Director of Quality Governance and Information team continue.
- Some data refresh periods vary and depending on the source of data feed to the dashboards may be updated between production of this report.
- IPC metrics are annual target focused, so will need reporting on cumulative trajectory rate for the year to date.
- A key focus is to incorporate the metrics underpinning the Group's 2024/25 Quality Priorities, in addition to key metrics for Maternity.

Duty of Candour

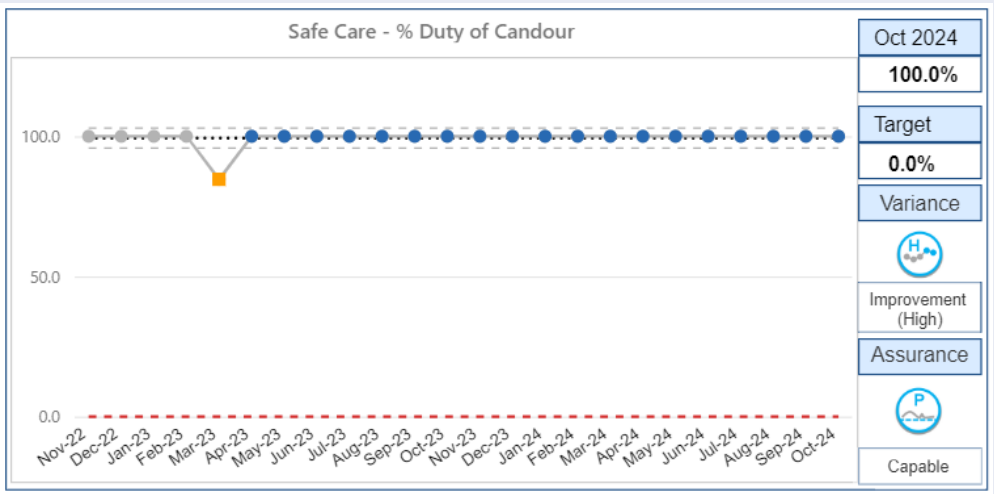
HUTH



Key themes

Alignment of monitoring and reporting processes across the Group is underway, with a number of immediate measures effective from 20 September 2024
Weekly rates utilised as part of enhanced monitoring are shown with an increase seen from the 2nd week of September 2024 onwards, although more recent incidents see a lag in demonstrated completion, with improvement seen gradually each week.
Education and engagement activities from the Patient Safety Team have helped some staff understand the changes needed in processes, but further focused work is required by some of the care groups with low compliance rates.
Review of actual harm caused, including individual patient impact is being promoted, rather than a blanket harm for an incident category, such as pressure ulcer healing and recovery projections.

NLAG



Key themes

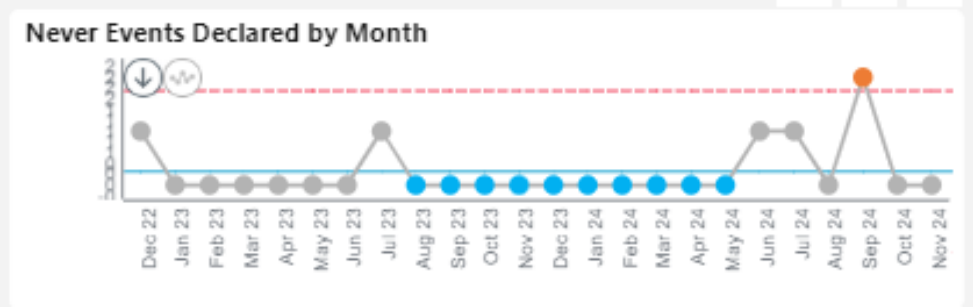
100% for November 2024 for the proportional investigation and PSII/SI casework.

Tracking of each case continues as part of the incident and patient safety teams duties, working with colleagues in care groups to complete and progress verbal and written duty of candour.

The BI dashboard is being developed to provide this data for NLAG for all incidents, rather than the casework managed under PSII and Patient Safety Team facilitated learning responses.

Never Events

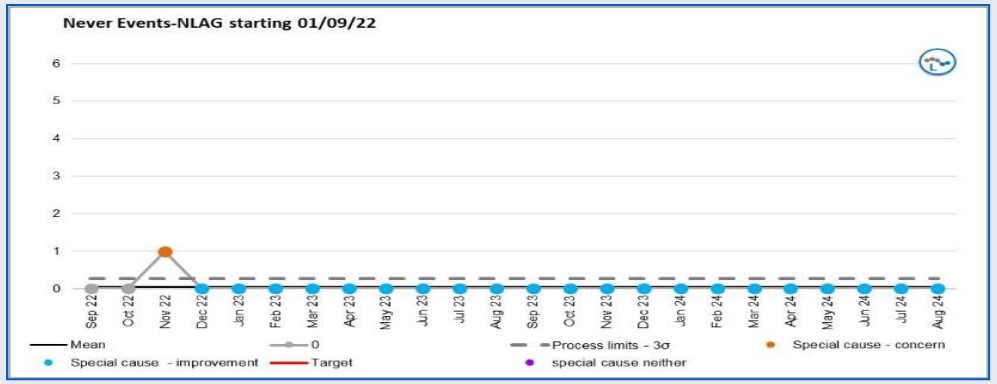
HUTH



Key themes

- The Trust has reported 4 Never Events in 2024/25 to date (1 April 2024 to 30 September 2024). The Trust had previously reduced the number of never events to 1 in 2023/24, following 7 in 2022/23.
- There have been two never events declared in September 2024, following previous declarations in June and July 2024.
- NE case 1 – Laterality error - incorrect femoral component was used, recognised after iatrogenic injury in theatre. Delayed recovery as a consequence.
- NE case 2 - Retained swab post caesarean section, requiring return to theatre when developed pain and some deterioration, following CT scan identification. Good recovery once removed.

NLAG



Key themes

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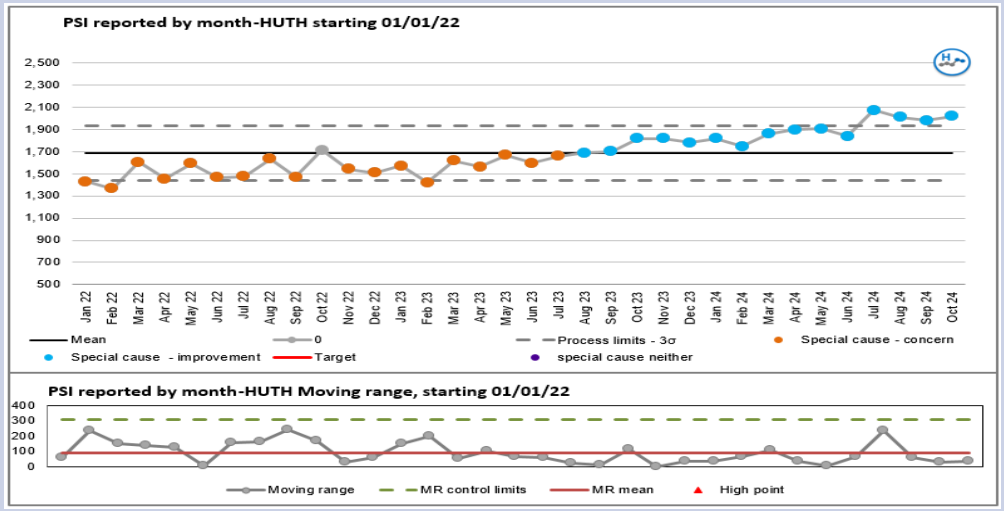
- The Trust has had a Never Event in October 2024, Retained Guidewire following CVP Line insertion. No harm identified, with thorough clinical review and assessment. Investigation underway as PSII.
- Review with the service and Deputy CMO undertaken to assess immediate actions and risk.
- BI data refresh for November is not yet available, but there are no Never events to report for November 2024.

Patient Safety Incident (PSI) reporting

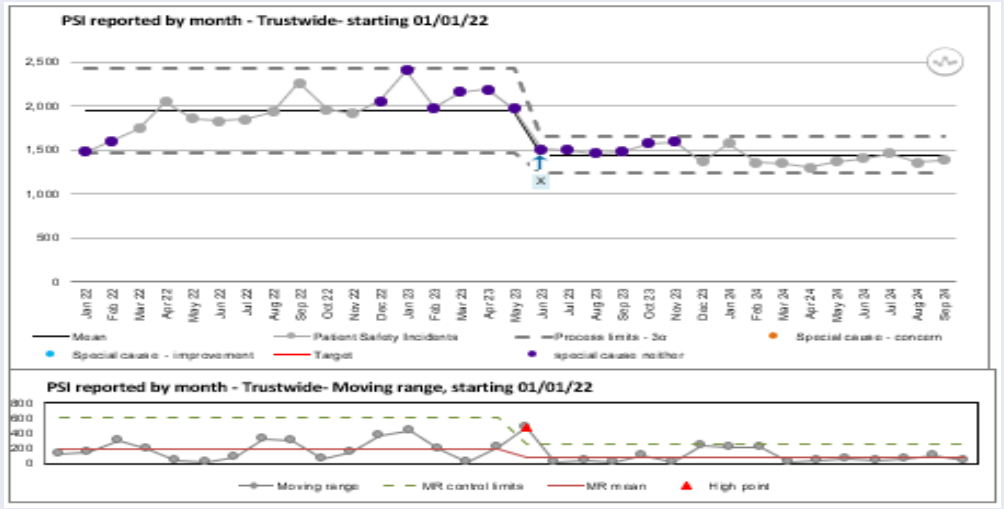
HUTH



Key themes

- The rate of patient safety incident reporting has risen over time, following the CQC report publication, action planning that followed and subsequent developments of the group arrangement.
- Reporting incidents, including no harm and near misses is a property of the safety culture and so the intent is to continue promoting incident reporting.
- Benchmarking data is limited currently due to NRLS changes to LFPSE and the transition period.
- BI data refresh for November is not yet available

NLAG

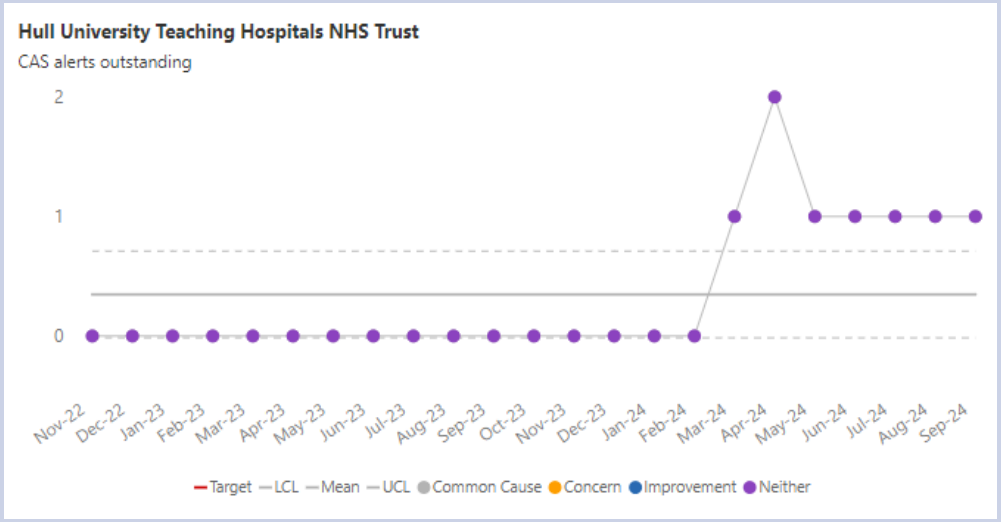


Key themes

- The chart illustrates historical step changes when ED 12 hour waits were changed to cumulative daily reports rather than individual patient reports. Subsequently this has moved to capture only patients where harm is identified, with DTA delays reported though other methods.
- Reporting incidents, including no harm and near misses is a property of the safety culture and so the intent is to continue promoting incident reporting.
- Direct comparison methods are being explored to enable effective benchmarking.
- BI data refresh for November is not yet available

Patient Safety Alerts

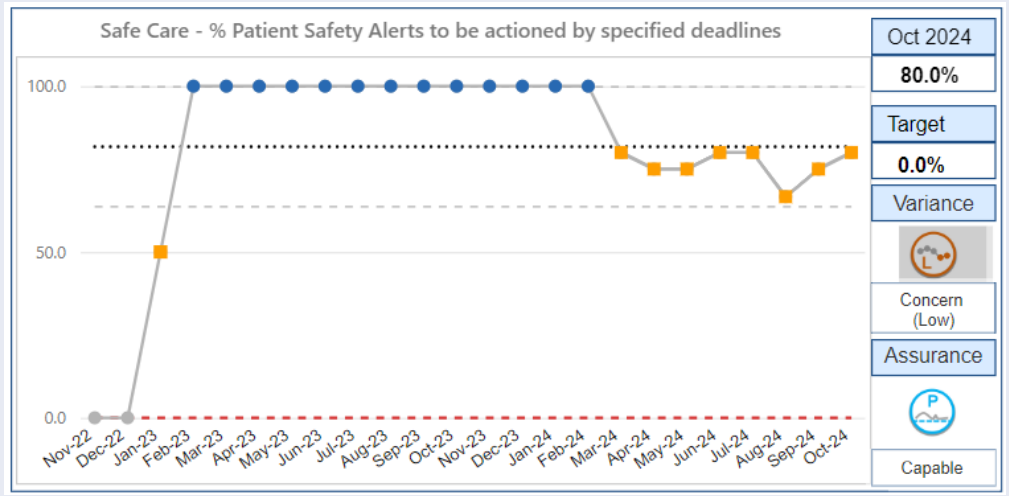
HUTH



Key themes

The one Patient Safety Alert that remains open is in relation to Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls. This breached the deadline of 1 March 2024 across both Trusts. The ICB have stood down their working group and issued a letter advising on the locally agreed approach. HUTH/ NLAG meeting monthly to progress.
Policy work is positioned to take forward with input from Paediatric and Maternity teams to complete and enable implementation across the Trust.
BI data refresh for November is not yet available

NLAG



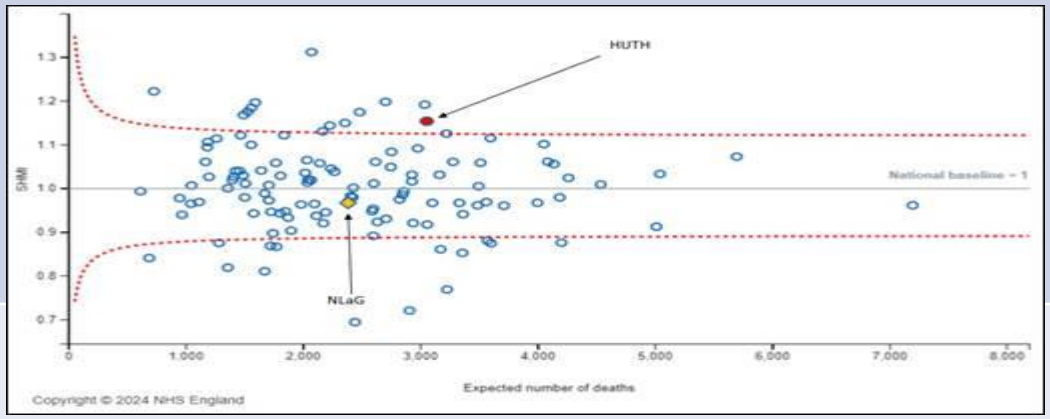
Key themes

The one Patient Safety Alert that remains open is in relation to Medical beds trolleys bed grab handles and lateral turning devices: risk of death from entrapment or falls. This breached the deadline of 1 March 2024 across both Trusts. The ICB have stood down their working group and issued a letter advising on the locally agreed approach. HUTH/ NLAG meeting monthly to progress.
NLAG has evidence to agree for closure and going through sign off process.

BI data refresh for November is not yet available

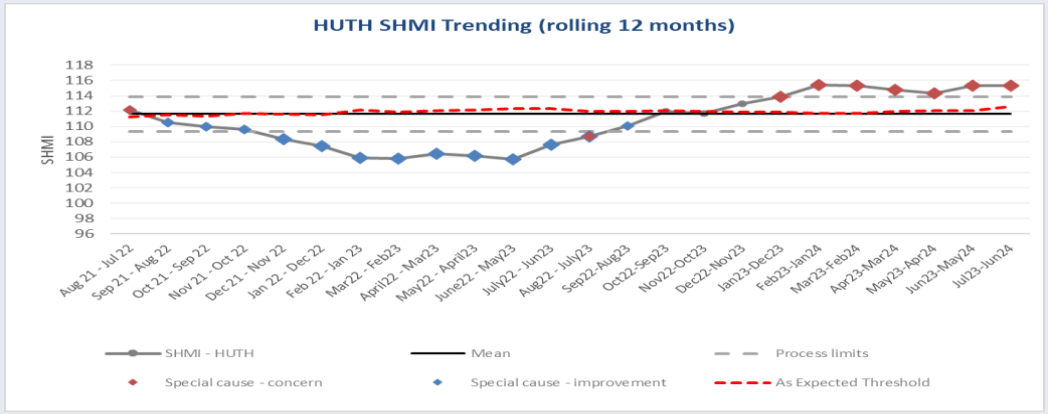
Mortality - SHMI

Benchmark



SHMI values include the episode of care and 30 days following discharge survival and deaths risk ratings.
The latest SHMI values for each site are:
Castle Hill – 1.3452; 'higher than expected' (previously 1.3490 and 'higher than expected')
Hull – 1.0987; 'as expected' (previously 1.0971 and 'as expected')
Grimsby – 0.9296; 'as expected' (previously 0.9563 and 'as expected')
Scunthorpe – 1.0010; 'as expected' (previously 1.0201 and 'as expected')
Goole – insufficient activity for SHMI to be calculated

HUTH



Key themes

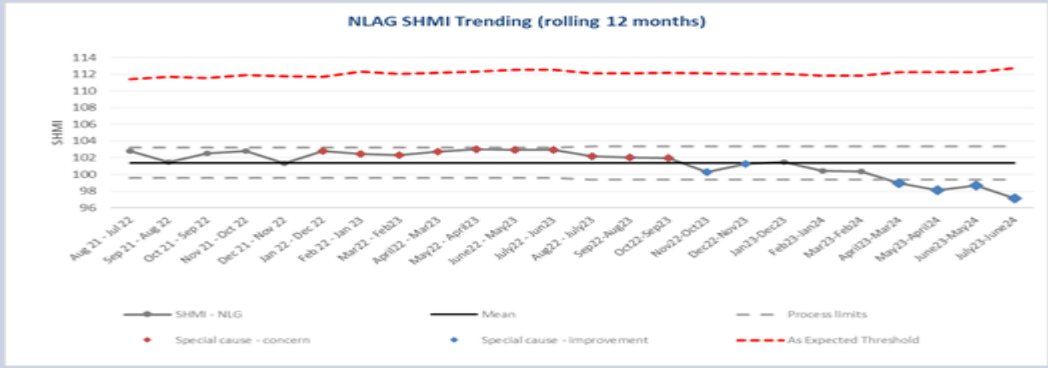
HUTH identified as having a 'higher than expected' SHMI, with an overall SHMI of 1.1536. This is higher than last month's value of 1.1529 and is in the 'higher than expected' banding. There are nine Trusts with a higher SHMI Score than HUTH (out of 119 Trusts).

For the conditions for which SHMI is calculated by NHS Digital - HUTH is identified as having a higher than expected SHMI for:

- Secondary malignancies - most recently 1.38 to June 2024. Detailed work has been undertaken and presented to Mortality Improvement Group in respect of pathway changes and recording of admissions at the Queen's Centre (which impacted on the denominator). It is anticipated that the corrections to recording from July 2024 will be reflected in the data published for that period from Dec 24.
- Septicaemia - most recently 1.31 to June 2024 which reflects significant reduction since 2021 but remains one of the Group's quality priorities for 2024/25 and workstreams have been cascaded to reinforce progress.

Within month, Fracture Neck of Femur has reduced to a SHMI of 1.28, down from 1.7 in November 2023 and is now "as expected". A detailed action plan is in place to address further opportunities identified for improvement.

NLAG



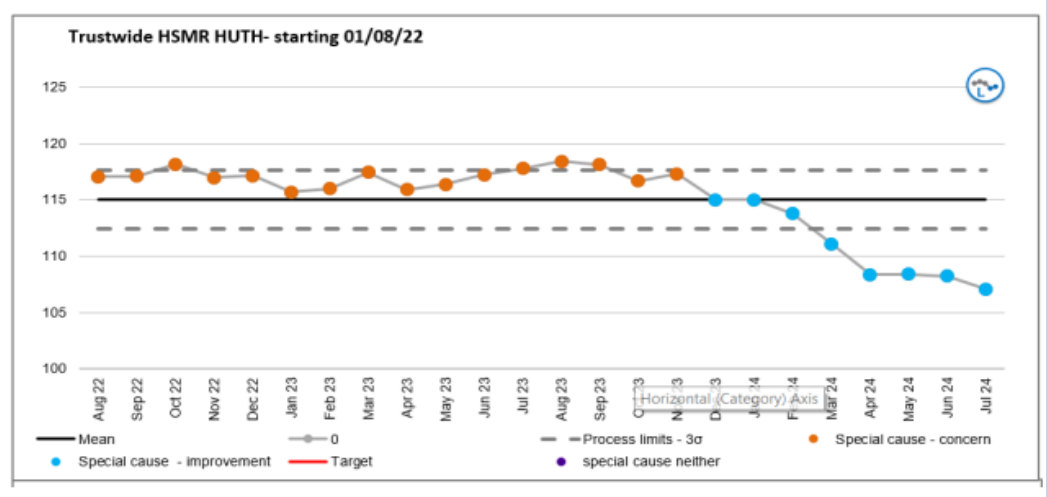
Key themes

NLaG is identified as having a 'as expected' SHMI, with an overall SHMI of **0.9714**. This is lower than last month's value of 0.9870.
All diagnosis group specific SHMI values are 'as expected'.

Data release for SHMI is 12/12/2024 so no update available at the time of report provision.

Mortality - HSMR

HUTH



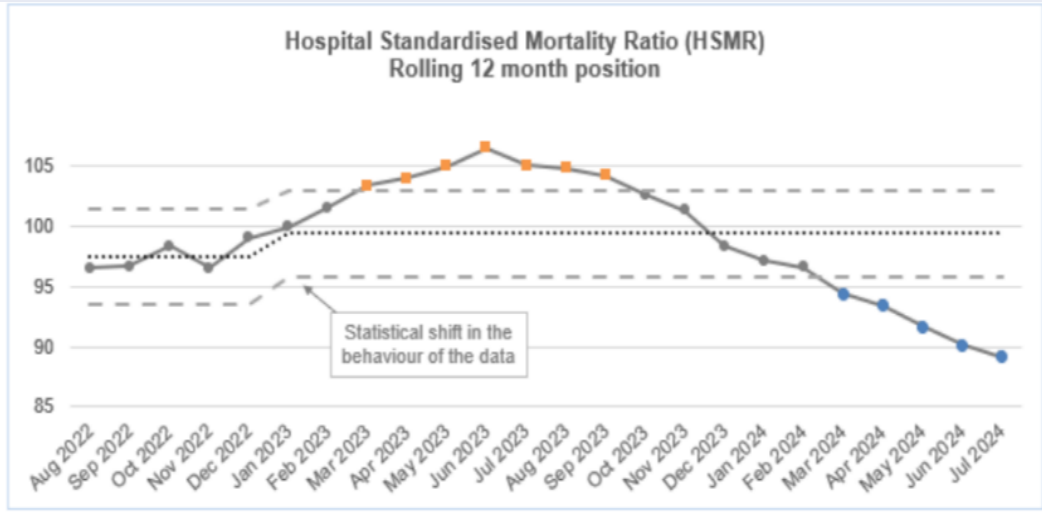
HSMR is a risk adjusted mortality index for a basket of 56 diagnosis groups. The risk adjusted tool uses 100 as the national baseline, focusing on the inpatient episode, and therefore the inpatient risk of death.

Key themes

The latest HSMR data available is July 2024, with a 12 month rolling value of 107.09. There has been statistically significant improvement with the past 6 points below the mean and the latest 5 points also below the lower control limit.

CHKS data refresh is due on 12/12/2024

NLAG



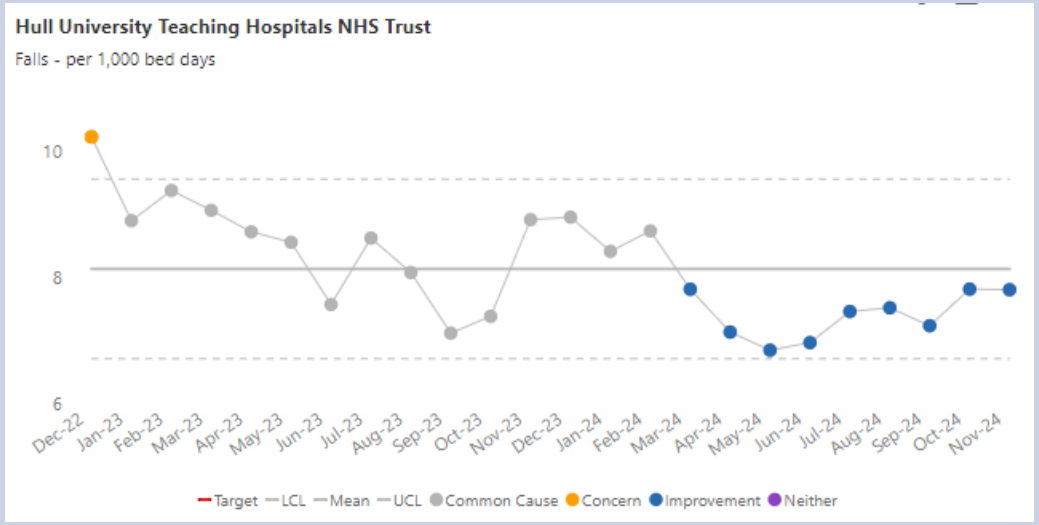
Key themes

The latest HSMR data available is July 2024, with a 12-month rolling value of 89.15. There has been a statistically significant improvement with successive reduction in the HSMR over the past thirteen months.

CHKS data refresh is due on 12/12/2024

Falls

HUTH

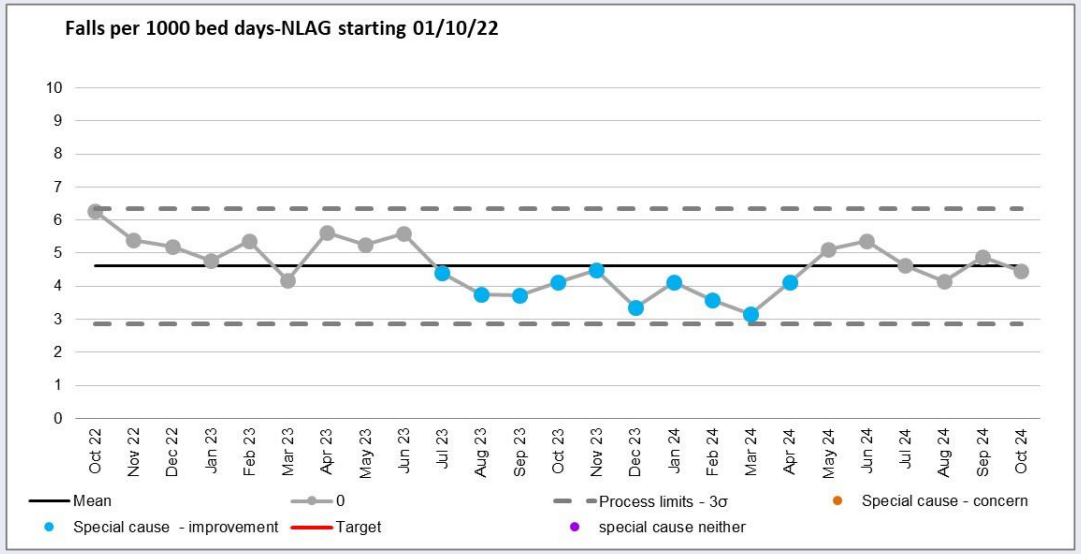


Key themes

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 a moderate reduction in the rate of falls per 1000 bed days, demonstration the impact of focused falls reduction activities and falls prevention policies. This requires a step change in the control limits from March 2024.

NLAG



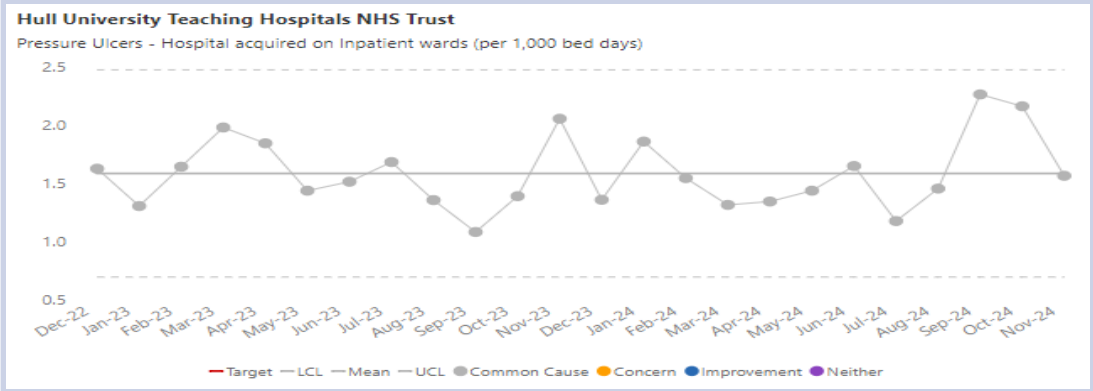
Key themes

NLAG Falls rate data shows common cause variation following a reduction in rate evident from July 2023. Repeated fall cases are reviewed by Matrons and Swarm huddles are used to review care provision. A strategic action plan is in place. Note: the rate is all falls regardless of harm caused.

BI data refresh for November is not yet available

Pressure Ulcers

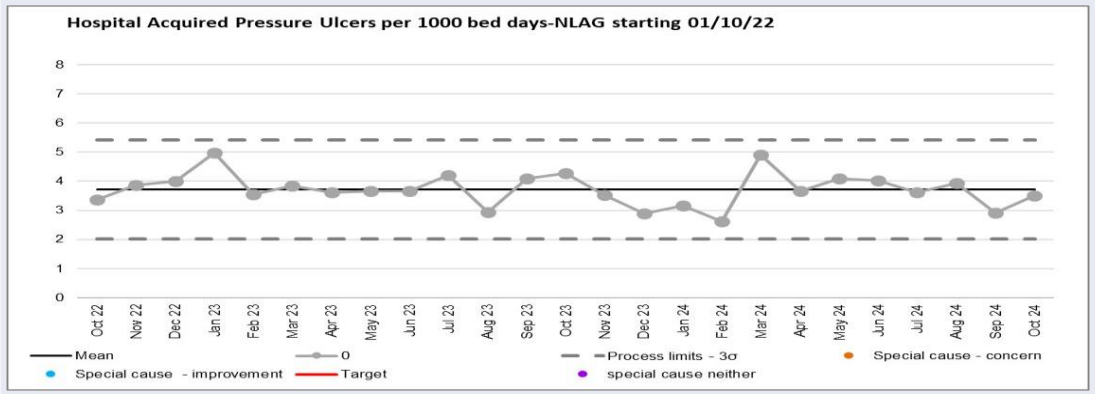
HUTH

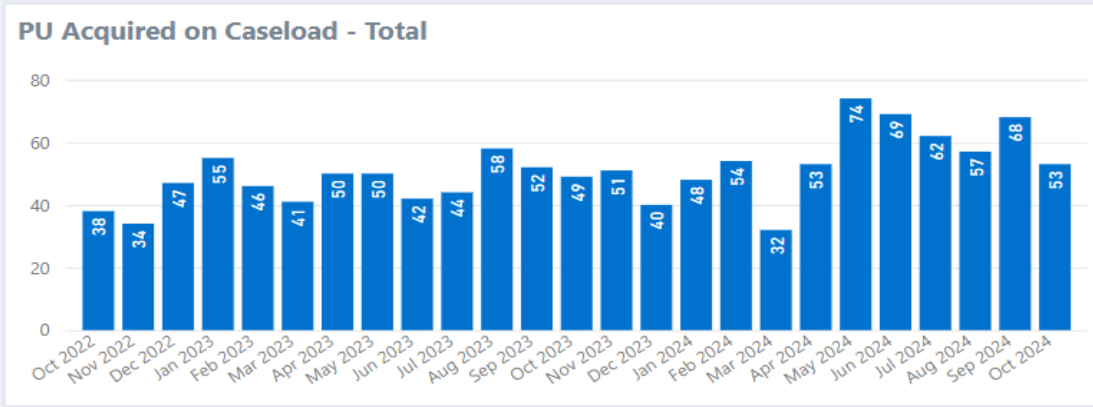


Key themes

- There is normal variation seen in the rate per 1000 bed days.

NLAG



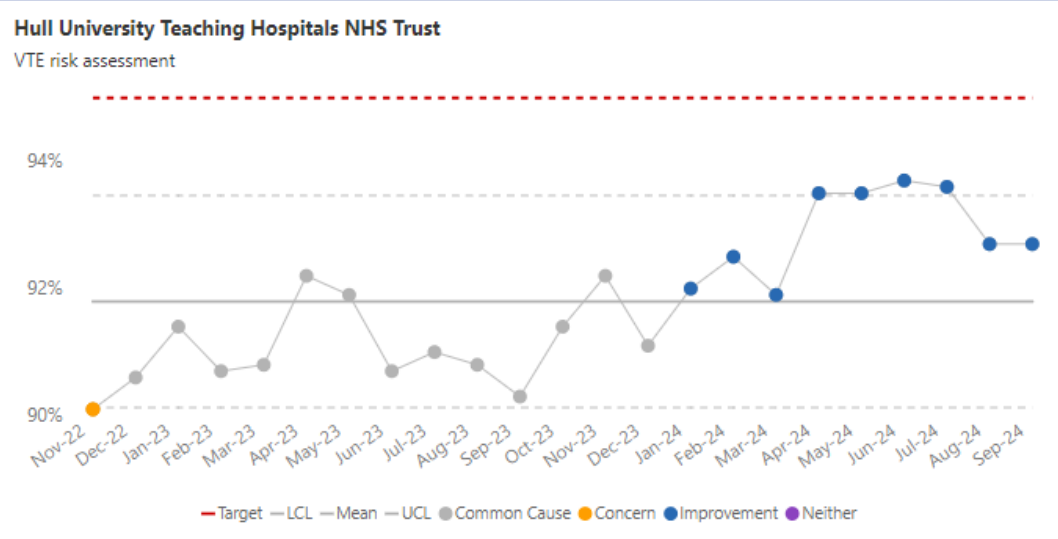


Key themes

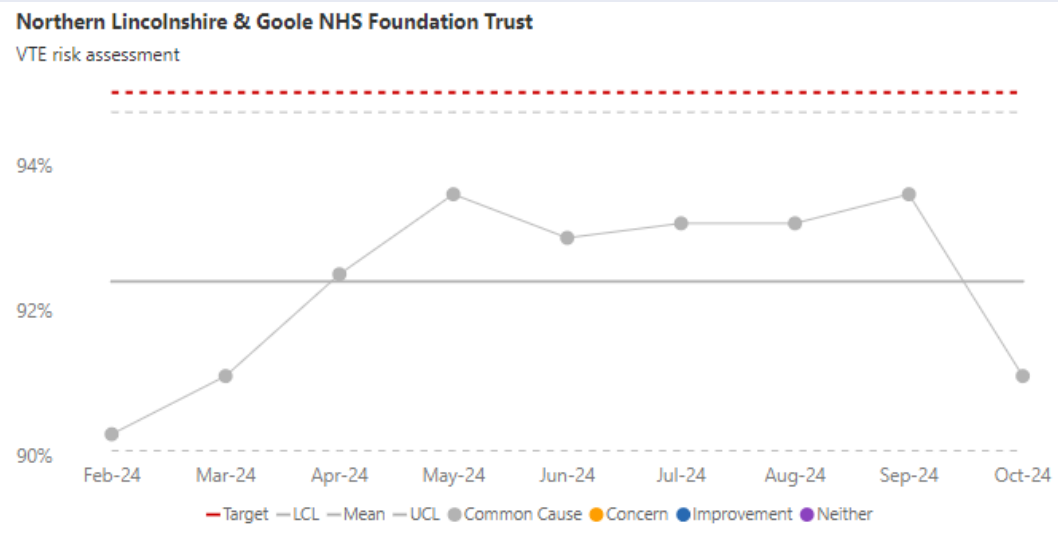
- The November data is not available yet in the BI reports.
- The top chart is hospital data. Pressure ulcer rate demonstrates normal variation.
- North Lincolnshire Community - The bar chart illustrates the data. Development to use SPC is being explored.

VTE Risk assessment rate

HUTH



NLAG



Key themes

In 2024/25, VTE support has been provided by the Quality Improvement team targeted at HUTH to roll out a series of improvement actions previously put in place at NLAG. Pilot wards were agreed in March 2024, working with digital nurse team some areas of non-compliance to target further improvement.

During the year, the support has reverted to a Group focus on the basis of:

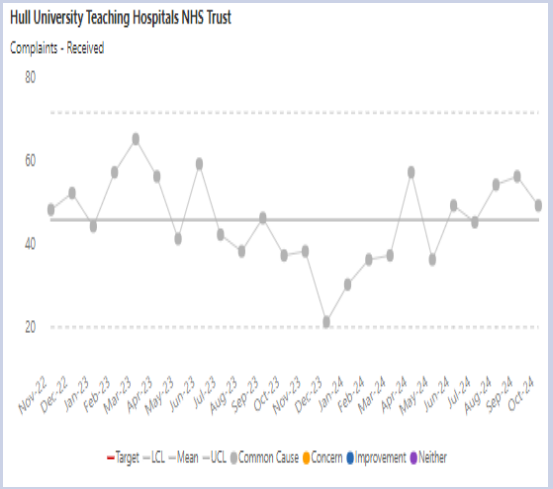
- The NLAG Lorenzo implementation resulted in a period where data was received less timely and resulted in some resource changes. For example, ePMA became the main source of VTE assessment capture rather than Webv.
- During the year the national collection of VTE data (on a quarterly basis) has been re-established. This guidance is clear that providers should submit data reflecting the % of assessments completed within 14 hours of admission, recognising this is the specified time to start pharmacological thromboprophyxlasis should the assessment reflect this. It is important to note that the data reported in the IPR remains total assessments. The BI team are completing their work to align both HUTH and NLAG reporting to reflect compliance with VTE risks assessments within 14 hours (and then 24 hours) of admission in line with guidance.

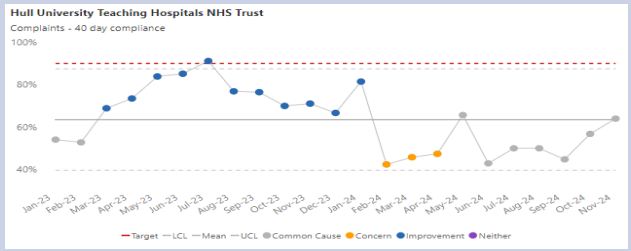
The revised data definition (reflecting cohorts pending Medical Director ratification) will be reflected in the December 2024 IPR.

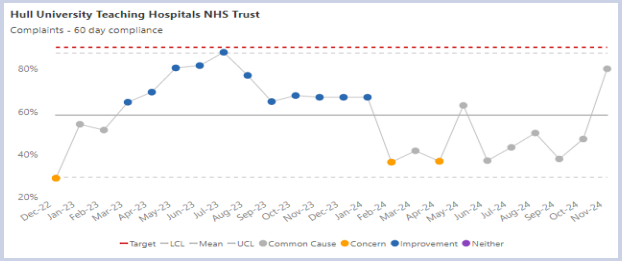
BI data refresh for November is not yet available

Patient Experience: Complaints – received and compliance with KPIs

HUTH



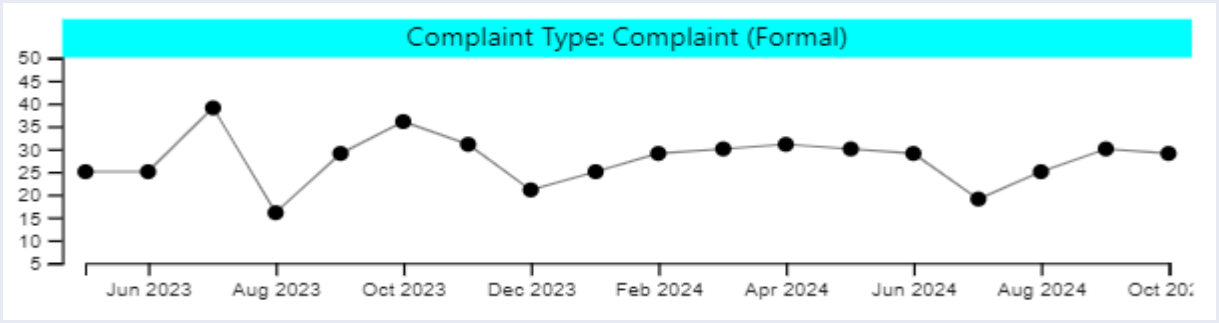


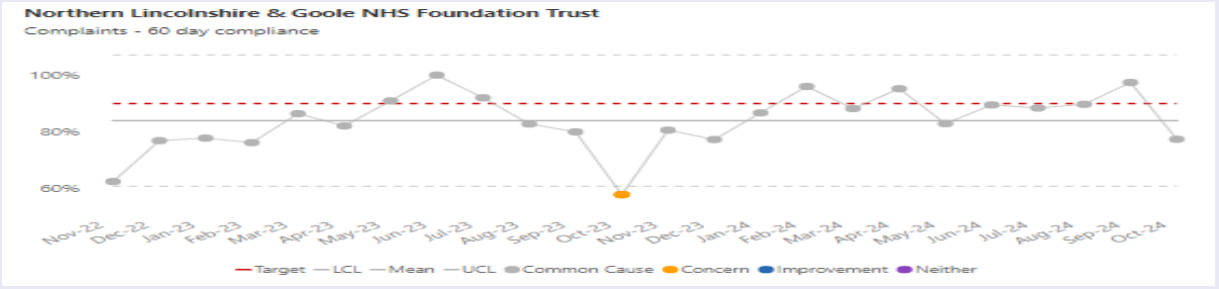


Key themes

- BI data for November received complaints is not available yet.
- 49 complaints were received in October 2024. Completion rates remain below the 60 day target, which is driven by the recovery of a backlog of complaints.
- There is improvement in the response time at 60 days, at 80% in November.
- It should be noted that although HUTH achieved high compliance rates in 2023, the quicker sign off was at the cost of quality. The Group Chief Executive sign off and additional quality checking has reduced the number of follow up complaints from c12 (20%) a month in Summer 2023.

NLAG





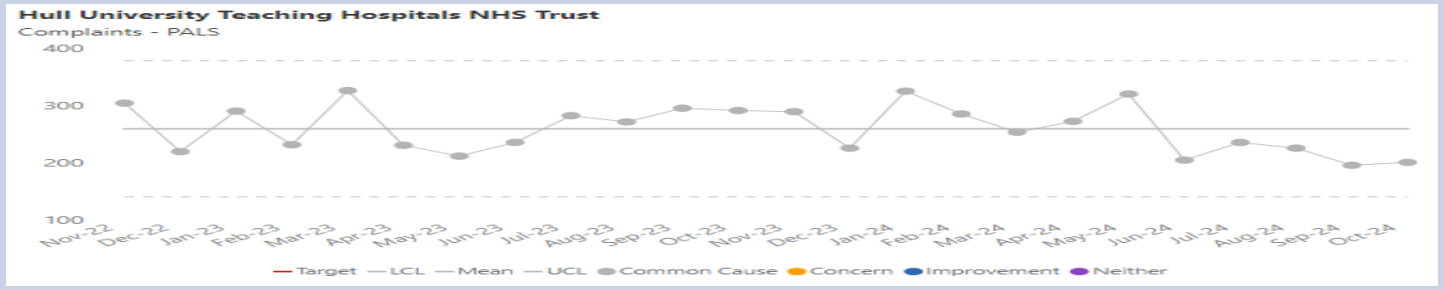
Key themes

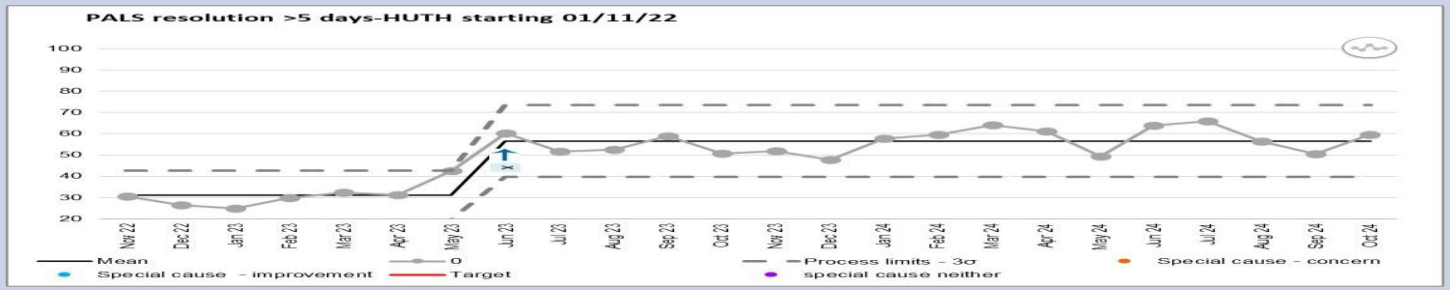
- 31 complaints were received in October 2024 and through a new Information Services SPC tool, this shows normal variation.
- Completion performance dipped in October 2024 due to staff sickness and cover across the Group.
- The Group will collectively adopt a 40-day target from April 2025 as part of improvement initiatives. Staff across the Group have been aligned to care groups, with established meetings now in place and the roll out of the NLAG letters now in progress.

- BI data not available for November yet.

PALS – received and compliance with KPIs

HUTH

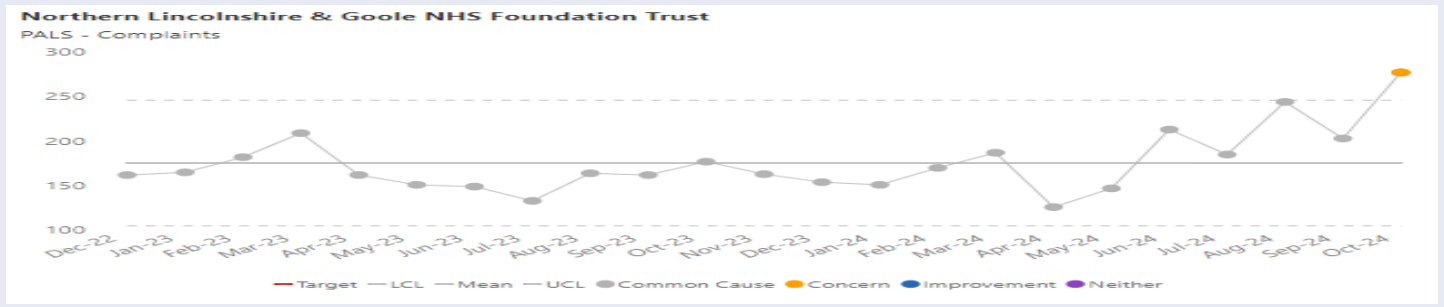


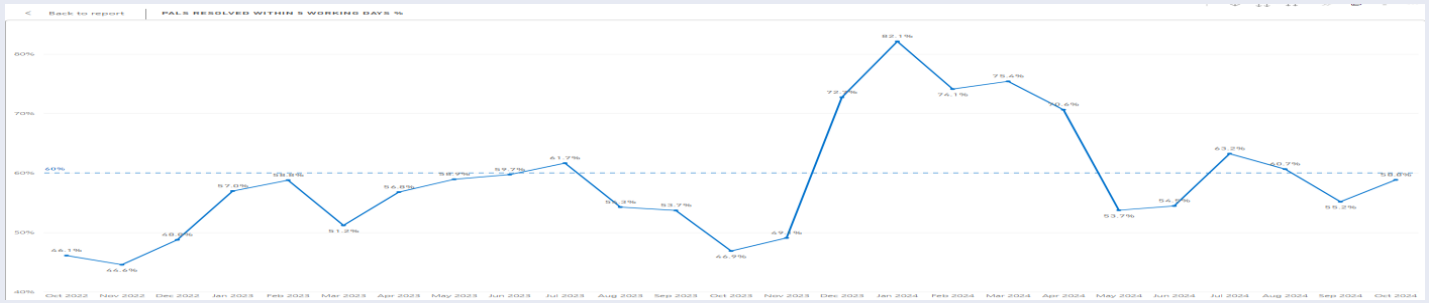


Key themes

- There is normal variation in the rate of PALS contacts for the most recent period. This does show potential for a sustained reduction in PALS contacts.
- Resolution timescales are remain static with normal variation, but below the target.
- BI data for November is not yet available.

NLAG



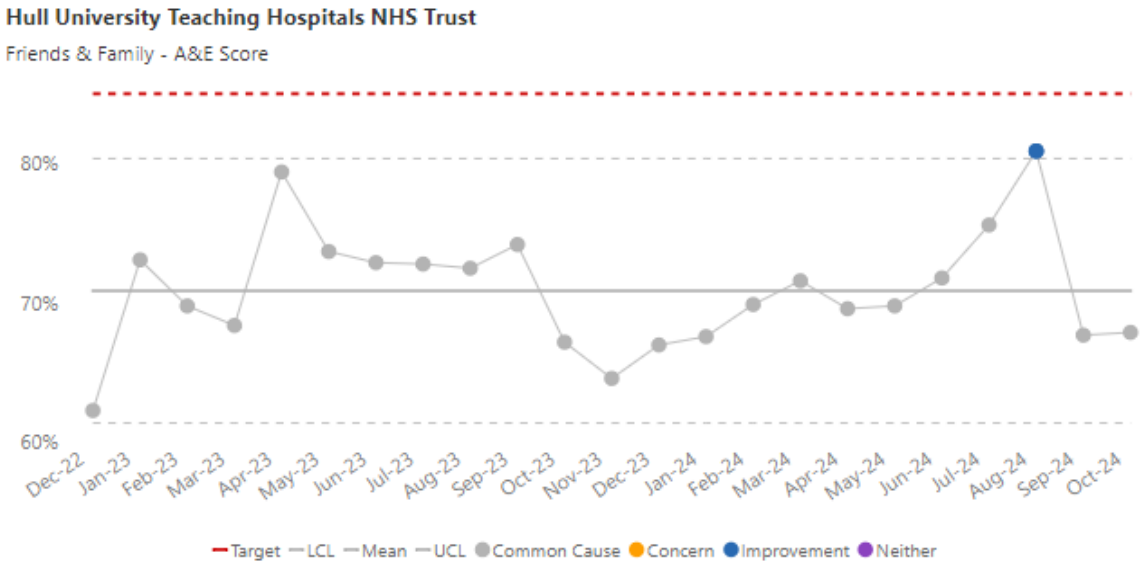


Key themes

- Information services have introduced a different SPC tool, which uses colours to show changes of significance and black is normal variation,
- The top chart shows the rate of PALS contacts.
- The bottom chart shows completion with 5 days at 59%
- The Group is exploring consolidated telephony options to be able to more flexibly share capacity to respond to demand.
- BI data for November is not yet available.

Patient Experience – Friends and Family Test A&E

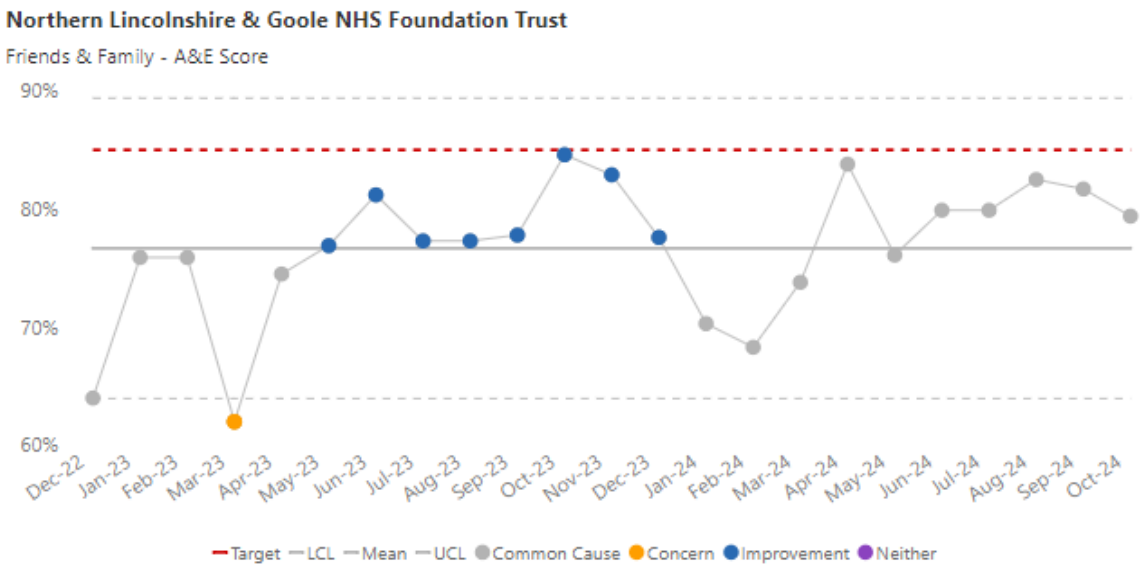
HUTH



Key themes

- 67.9% of responses provide positive feedback
- The Trust's feedback improved over the summer period, with August achieving the highest positive feedback in the three years since adopting SMS anonymous feedback.
- The top 3 themes continue to be Staff Attitude, Waiting times, environment.
- The additional pressures seen in October 2024, particularly waiting times are reflected in the feedback scores provided

NLAG

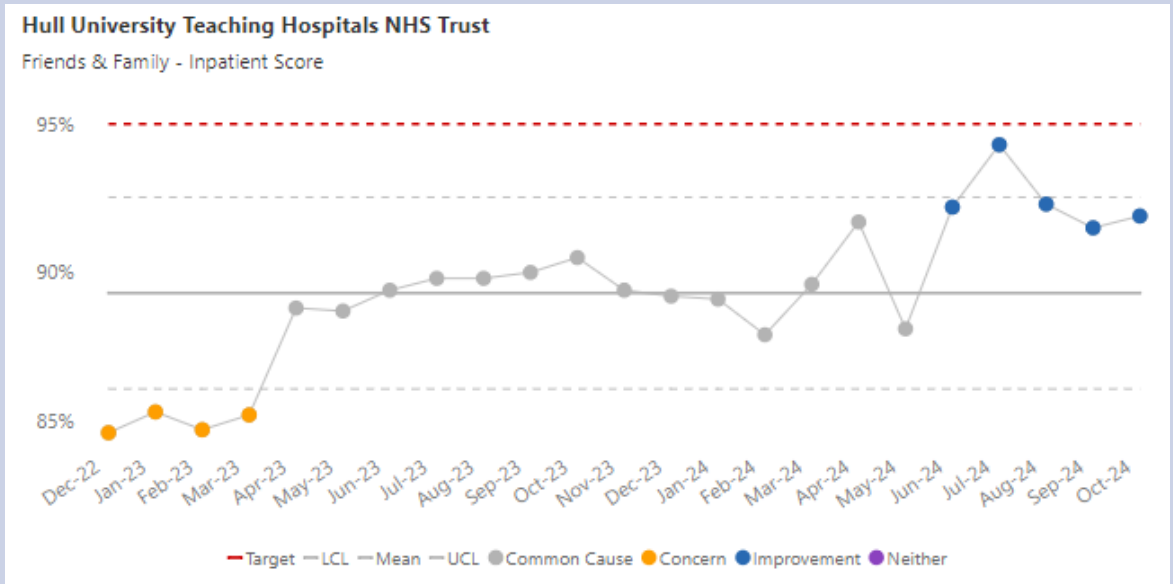


Key themes

- 79.4% of responses providing positive feedback, although lower than the target.

Patient Experience – Friends and Family Test Inpatient and daycase

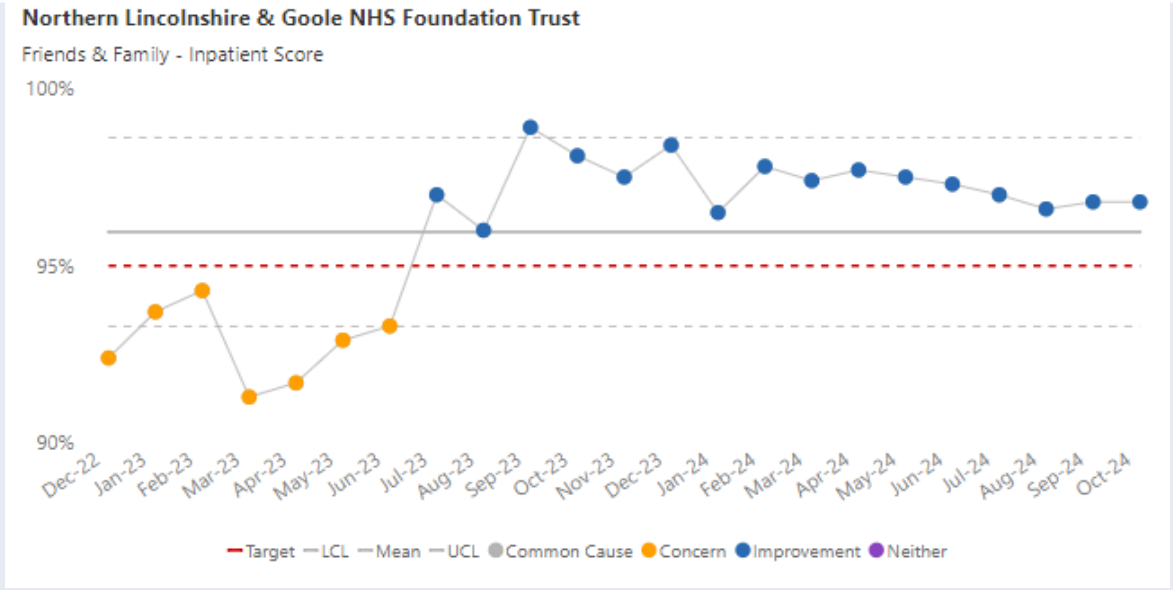
HUTH



Key themes

- In October 2024, there was 91.9% positive feedback.
- The Trust remains below the national target of 95% and remains in the bottom quartile,
- Negative responses are disseminated to care groups for learning which is a key focus of improvement across the themes of staff attitude, communication and environment.

NLAG

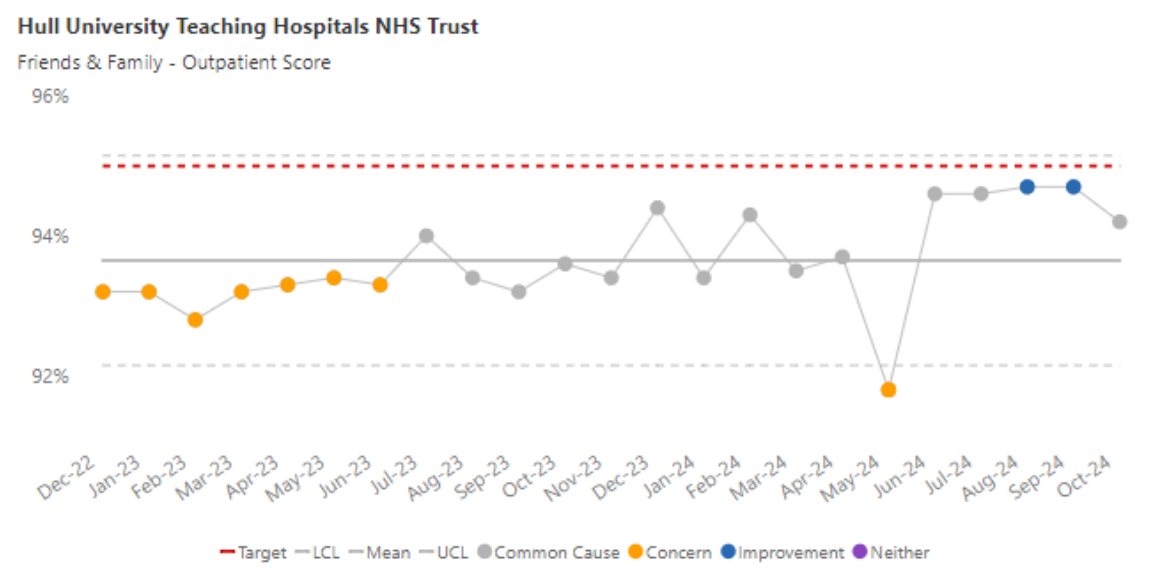


Key themes

- In October 2024, with 96.8% providing positive feedback, demonstrating consistency in achievement of the 95% target. The chart can be recalculated to demonstrate the stable performance position
- There is a desire to increase response rates through the anonymous SMS platforms. Phase 2 of the roll out (including inpatient and outpatient areas) has been delayed due to Information Service priorities but this support has been escalated in order to redeploy manual collection activity to proactive work to improve patient experience across the Group.

Patient Experience – Friends and Family Test Outpatient

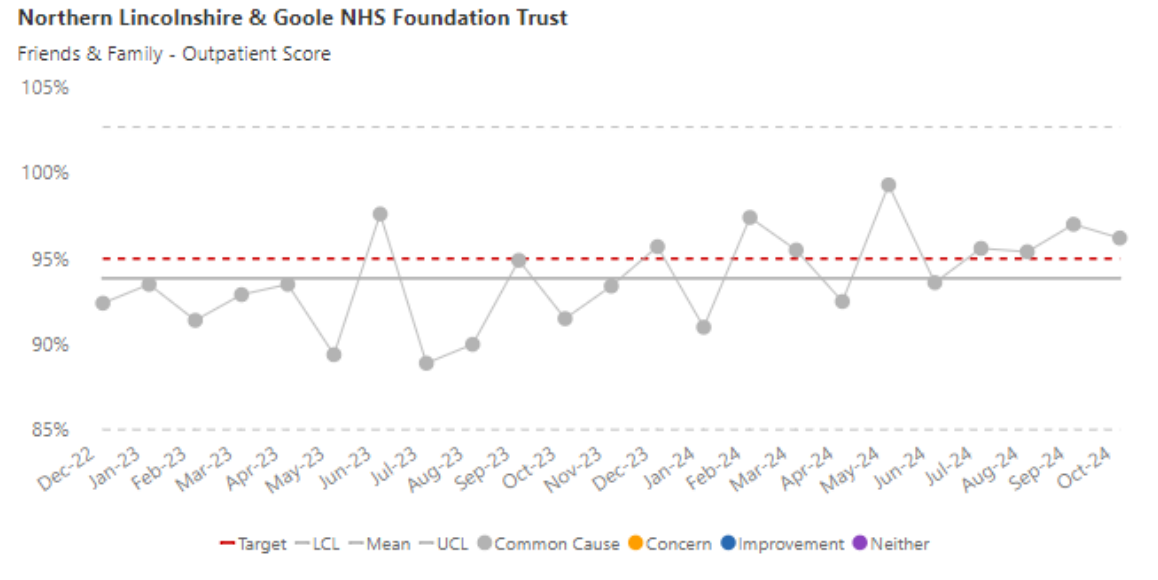
HUTH



Key themes

- In October 2024, there was 94.2% positive feedback.
- The Trust's position has incrementally improved since 2022 towards the 95% target, with the exception of May 24 which was due to a supplier collection issue of our SMS responses.
- The Trust is gradually seeing a reduction in the number of negative responses for waiting times, but communication and environment remain key themes.

NLAG



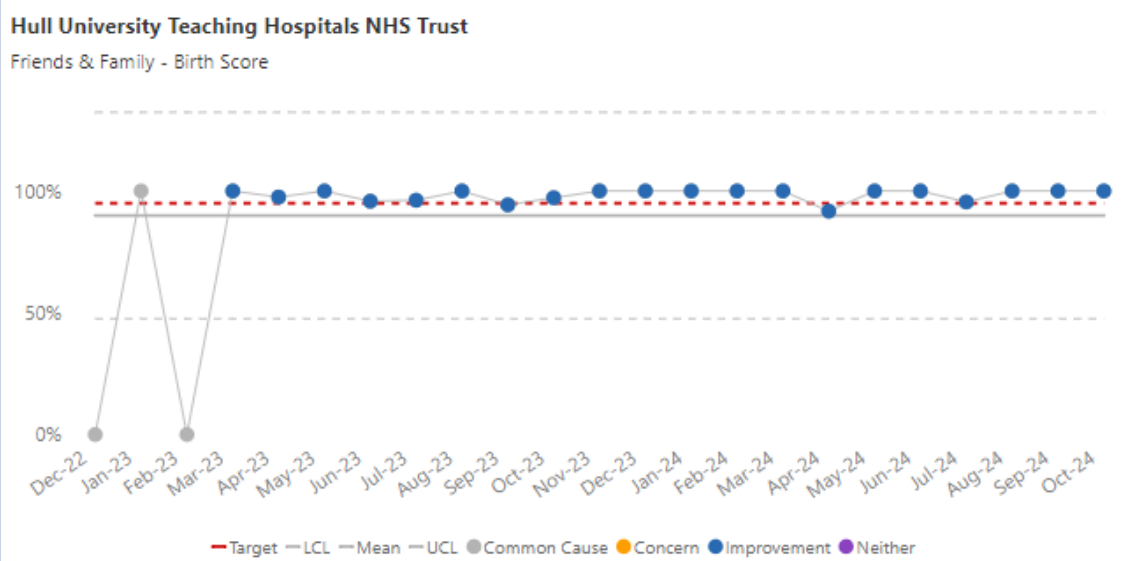
Key themes

- In October 2024, there was 96.2% positive feedback.
- Responses are collected manually through a paper based system. The Trust has plans in place to utilise SMS to increase its response rate which it is seeking to prioritise with Information Services support.

Across the NHS HHP Group, negative responses are shared with care groups to form the basis of future improvement.

Patient Experience – Friends and Family Test Maternity (Birth)

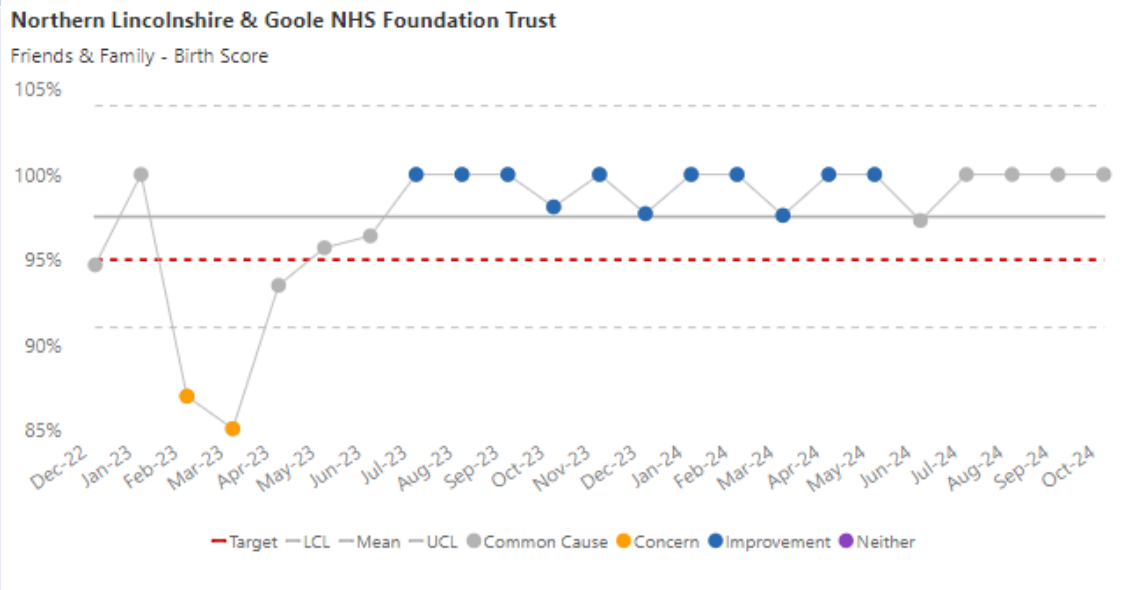
HUTH



Key themes

- In October 2024, 100% positive feedback was given.
- The Trust is focusing on increasing its response rates post badgernet implementation and is working with BI teams to ensure the SMS system is utilised (currently feedback is predominantly received via thank you cards and facebook groups).

NLAG

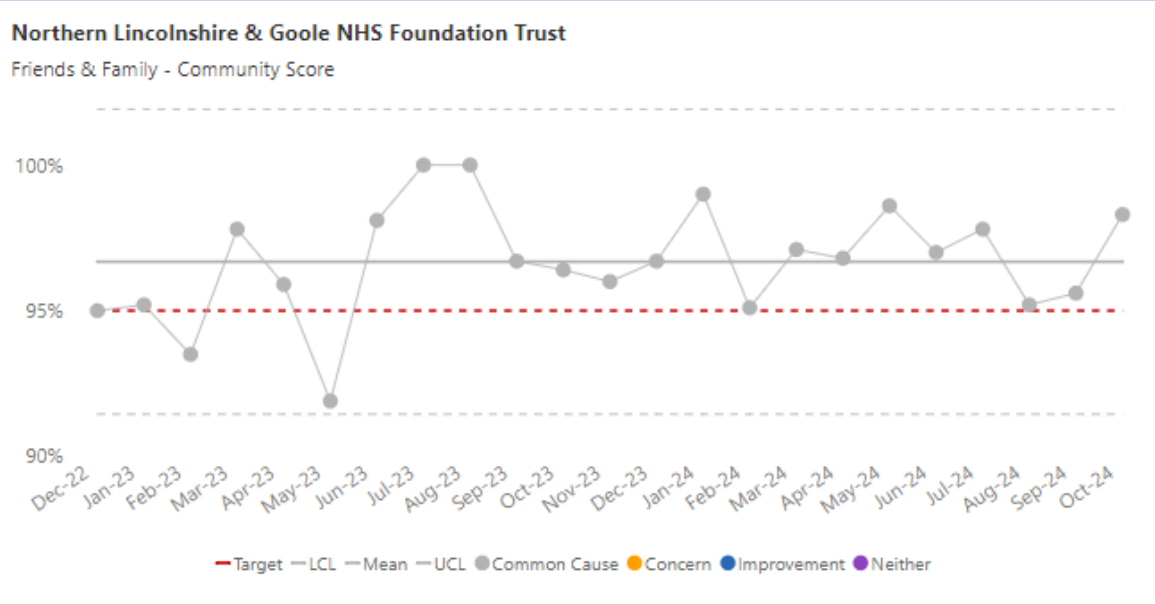


Key themes

- In October 2024, 100% positive feedback was given.

Patient Experience – Friends and Family Test Community (NLAG only)

NLAG

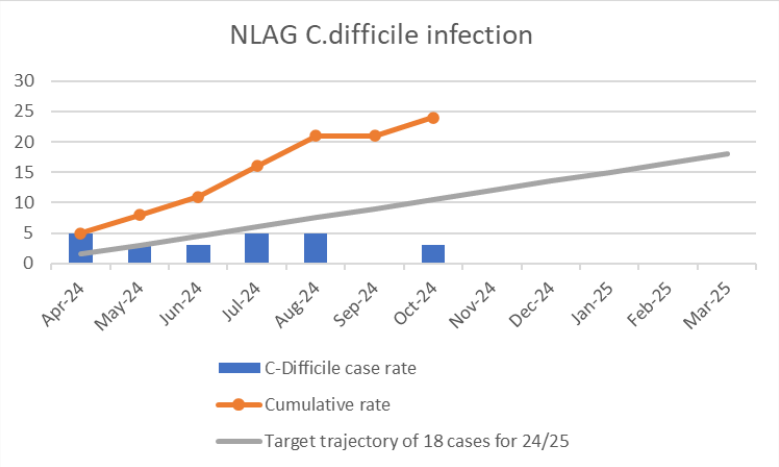


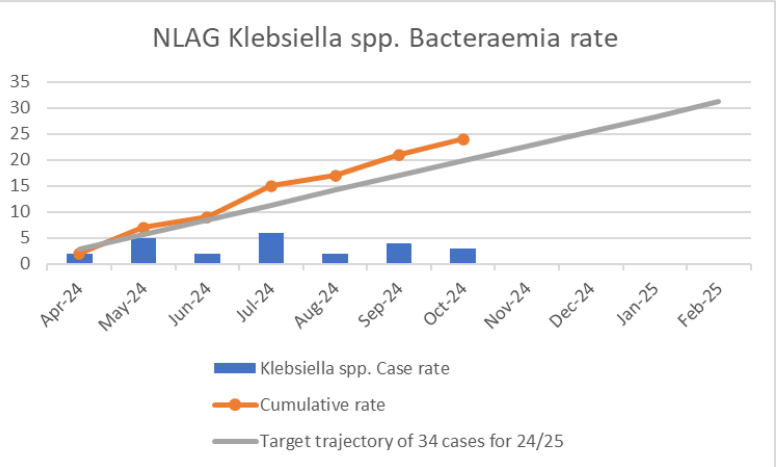
Key themes

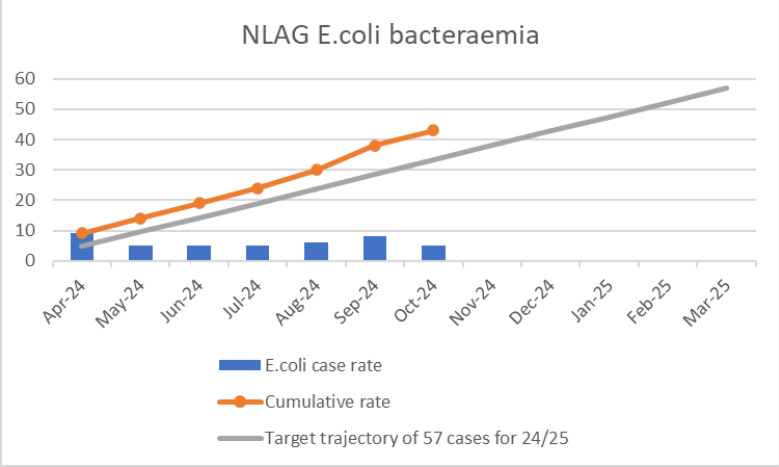
- In October there was 98.3% positive feedback.
- The Trust is consistently achieving the 95% target.
- Responses are collected manually through a paper based system. The Trust has plans in place to utilise SMS to increase its response rate.

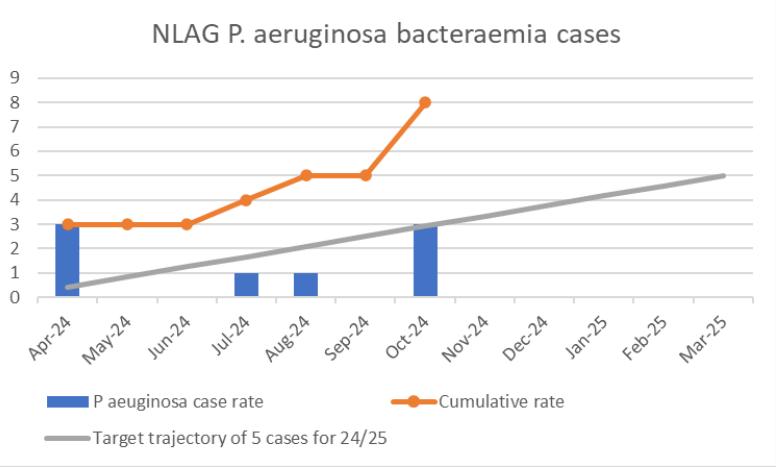
Infection Control - NLAG

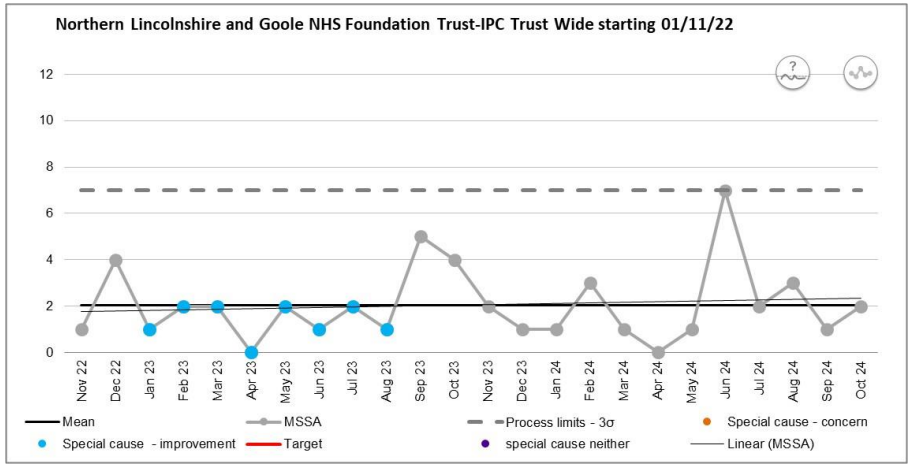
Humber Health Partnership





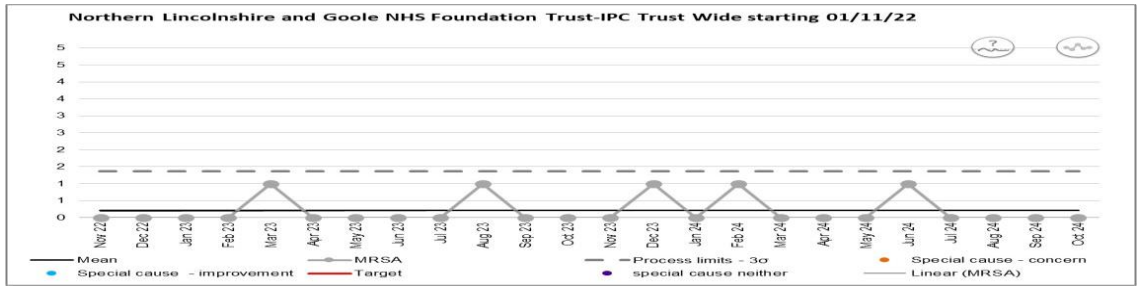






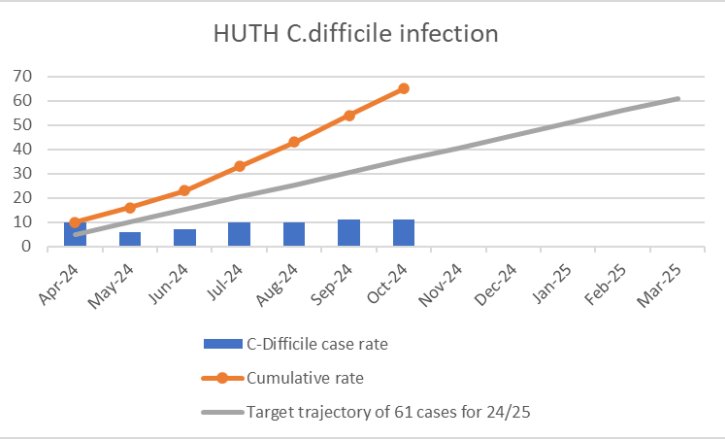
Alert organism	2024 Target	M7	YTD rate	Trajectory RAG
C. Difficile	18	3	24	
E. Coli	57	5	43	
P. Aeruginosa	5	3	8	
Klebsiella spp.	34	3	13	
MRSA bacteraemia	0	0	1	
MSSA bacteraemia	No target	1	13	NA

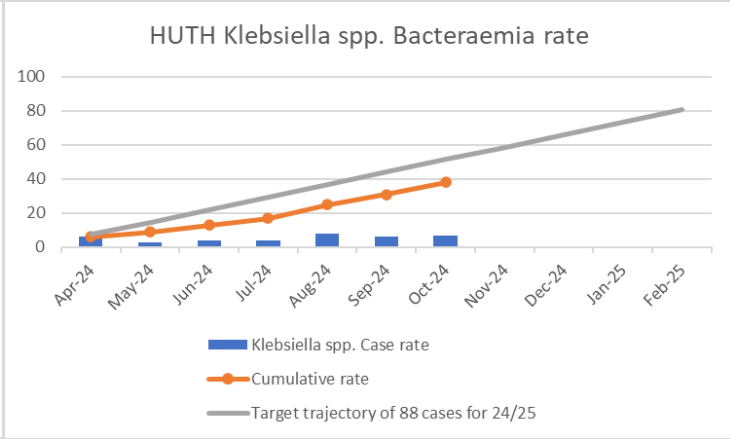
Key: Red – over annual target; Amber - over trajectory; Green – within trajectory

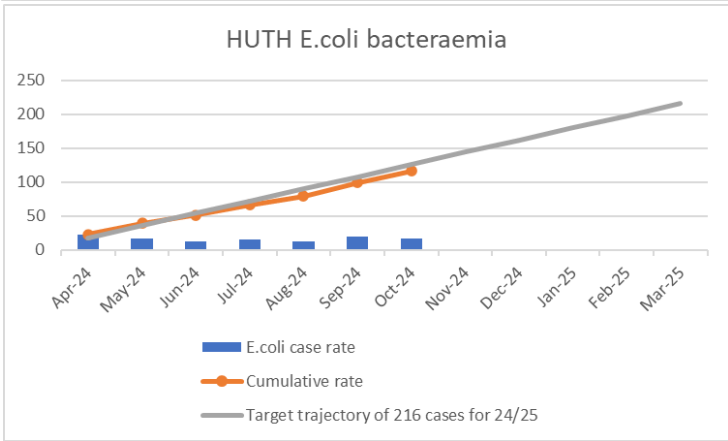


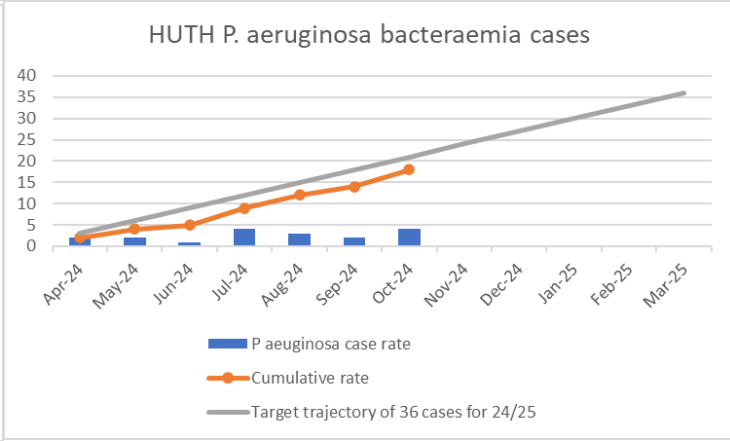
- C.difficile – this now over the target for the year with increases reported nationally. Further investigation of issues is being identified through PIR investigation processes.
- P. Aeruginosa – three cases in October have taken the cumulative rate over the annual target. The cases are in different departments and no apparent links. PIR processes will explore if there are learning opportunities from this.
- E-coli and Kelbisella are both over the trajectory but have not breached the annual target at Month 7.
- MRSA bacteraemia - No cases during October 2024.

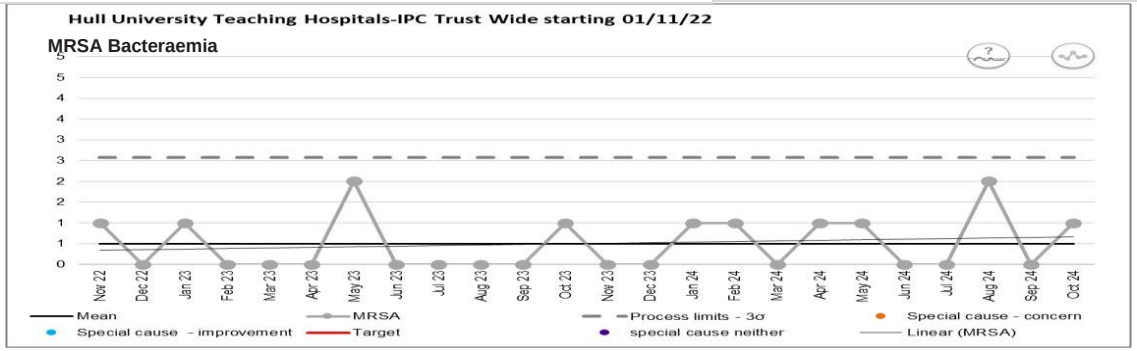
Infection Control - HUTH

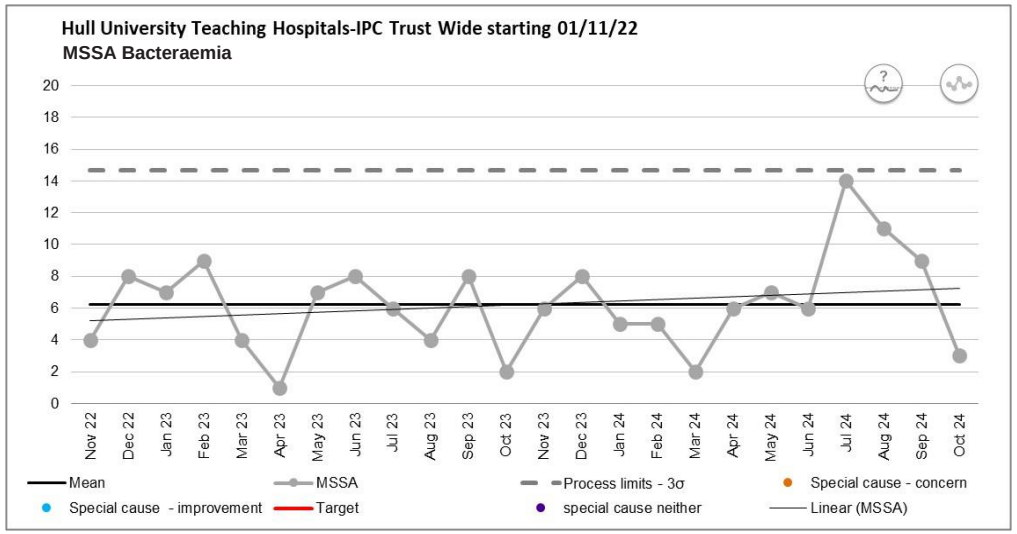












Alert organism	2024 Target	M6	YTD rate	Trajectory RAG
C. Difficile	61	11	65	
E. Coli	216	17	116	
P. Aeruginosa	36	4	18	
Klebsiella spp.	88	7	38	
MRSA bacteraemia	0	1	5	
MSSA bacteraemia	No target	3	56	NA
Key: Red – over annual target; Amber - over trajectory; Green – within trajectory				

- C.difficile – This has now breached the annual target. national increase reported, with further investigation of issues identified in PIR investigation processes.
- MRSA bacteraemia – One case during October 2024, five reported to in the year to date. PIR investigation undertaken to identify concerns in relation to practice and risk factors, IPC and clinical teams meeting to review.
- The other organisms remain below trajectory targets.

Committees-in-Common Front Sheet

Agenda Item No: 4.2

Name of the Meeting	Workforce, Education and Culture **Committees-in-Common**
Date of the Meeting	Wednesday 29th January 2025
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer/Author	Paul Bunyan, Deputy Chief People Officer – South
Title of the Report	Workforce Integrated Performance Report
Executive Summary	This report presents the Group Workforce position as part of monthly reporting cycles. **Key points to note:** • NLaG Consultant vacancy position is still higher than HUTH's - work is ongoing to review medical establishments at a Group level. The Group consultant vacancy rate is under the 15% target at 13.6%, however the HUTH position is balancing the NLaG position. The main vacancy rate is within the Acute and Emergency Medicine across Operations South. There are currently 22 consultants in the pipeline awaiting starts within the next three months. • The Group Band 5 Registered Nursing vacancy rate is currently over established at -0.6%. • Agency usage has seen a slight increase over the last three months, but the adjusted vacancy rate remains low at 0.3%. This indicates that although agency usage has risen, overall staffing levels and vacancy rates are still manageable. • Turnover across the Group is decreasing and is well below the target at 8.7%. The decrease in turnover is a positive outcome of improved retention strategies and a more stable workforce environment. • The sickness rate has risen to 4.6% (0.6% above target) due to seasonal illnesses such as colds, coughs, and flu, which are common at this time of year. Measures are in place to support staff well-being and manage sickness absence.
Background Information and/or Supporting Document(s) (if applicable)	The report is presented as part of normal monthly business.
Prior Approval Process	NA
Financial implication(s) (if applicable)	Vacancy position is responsible for the majority of Agency spend and remains a priority.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	No specific considerations within this report, however as part of future reporting EDI data sets will be made available.
Recommended action(s)	☐ Approval ☐ Information

V2

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

Humber Health Partnership

Group People Directorate
Workforce Integrated Performance Report

December 2024

Workforce Intelligence

HR Workforce Reports - Power BI Report Server (hey.nhs.uk)

Exception Report

Vacancy Rate

The Group overall vacancy factor is at 4.6%, an increase of 0.1% in month. NLAG has a vacancy factor of 7% and HUTH 2.7%. When adjusted for bank and agency usage, the Group vacancy factor is 52.7WTE. NLAG currently has an adjusted vacancy factor of -14.5 WTE & HUTH have an adjusted vacancy factor of 67.2 WTE. Add Prof Scientific and Technic staff group shows the highest vacancy factor within staff groups at 14.7%, but when adjusted for bank usage reduces to 12.9%.

Current actions in place?

Consultant recruitment remains a priority, with 22 Consultants currently in the pipeline awaiting start dates. Recruitment efforts continue for vacant positions, with Operations South being the primary area of concern, facing a 46.4 FTE vacancy factor, significantly affecting Acute and Emergency Medicine Care Groups. Measures to address this include a redesigned campaign, engaging previous candidates, networking, marketing, and converting locum Consultants to substantive roles. The overall medical and dental vacancy rate has improved significantly, now holding steady at approximately 5.4%. 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 substantive vacancy FTE of 64.9. The 2025 NQN intake campaign is set to launch in February 2025. Challenges persist in Additional Clinical Services due to market conditions, particularly for unregistered nursing roles. A redesigned cohort recruitment approach targeting specific areas will launch in February. Campaigns for priority roles in Additional Scientific and Technical Staff are being prepared for launch this month.

Operational Planning

Operational planning has commenced for 25/26. Planning will focus on efficient and cost-effective workforce design, and addressing transformational objectives. These include reforming elective care, moving from hospital to community, analogue to digital systems, and a much greater focus on prevention over sickness. The WF plan must focus on reducing agency reliance and ensuring that any new investments are offset by reductions elsewhere. There will likely be a targeted ask to reduce non-clinical head-count.

Current actions in place?

National guidance has yet to be released for workforce, finance and activity planning, this is delayed. ICB have stated that workforce KPIs should aim for a sickness reduction target of 4.8% and turnover at 12.2% these are been considered against People Strategy metrics. The return will be triangulated across ops activity and finance prior to exec sign off and submission.

Role Specific Training

NLAG reports that overall role specific compliance is 80.8% at the time of reporting (-0.5% from the previous report). This remains 5.2% below Trust target. HUTH reports 79.2% compliance for role specific 5.8% below the required target of 85%. The following two areas remain significantly below the Trust compliance target of 85%, and have seen some decline since the previous report.

Medical and Dental remain significantly below the role specific compliance target at 71%, however has made good progress since the last reporting (+11.3% from the previous report).

What actions are in place to mitigate?

The Groupwide L&D team is auditing role-specific required learning for all staff, including Medical and Dental, to align with NHSE guidelines. Non-essential learning will be removed, with the process set to conclude by March 2025, followed by annual quality reviews. A bespoke learning package for Medical and Dental staff includes individualised eLearning links and scheduled face-to-face sessions to address compliance gaps.

This slide represents the workforce of the NHS Humber Health Partnership Group. It includes details related to Staff in Post, Headcount and Establishment

December Workforce Position

Headcount 19,576
HUTH 10,794 NLAG 8,782

November 24 **19,548**

HUTH 10,803 NLAG 8,745

October 24 **19,460**

HUTH 10,775 NLAG 8,685

Est WTE 16,177.09
HUTH 9,036.95 NLAG 7,140.14

November 24 **16,144.25**

HUTH 9036.72 NLAG 7107.53

October 24 **16,084.62**

HUTH 8977.02 NLAG 7107.6

SIP WTE 15,436.08
HUTH 6,641.59 NLAG 8794.49

November 24 **15,428.72**

HUTH 8802.61 NLAG 6626.11

October 24 **15,294.12**

HUTH 8784.77 NLAG 6609.35

Leavers WTE (12m Avg) 1206.6
HUTH 661.6 NLAG 545

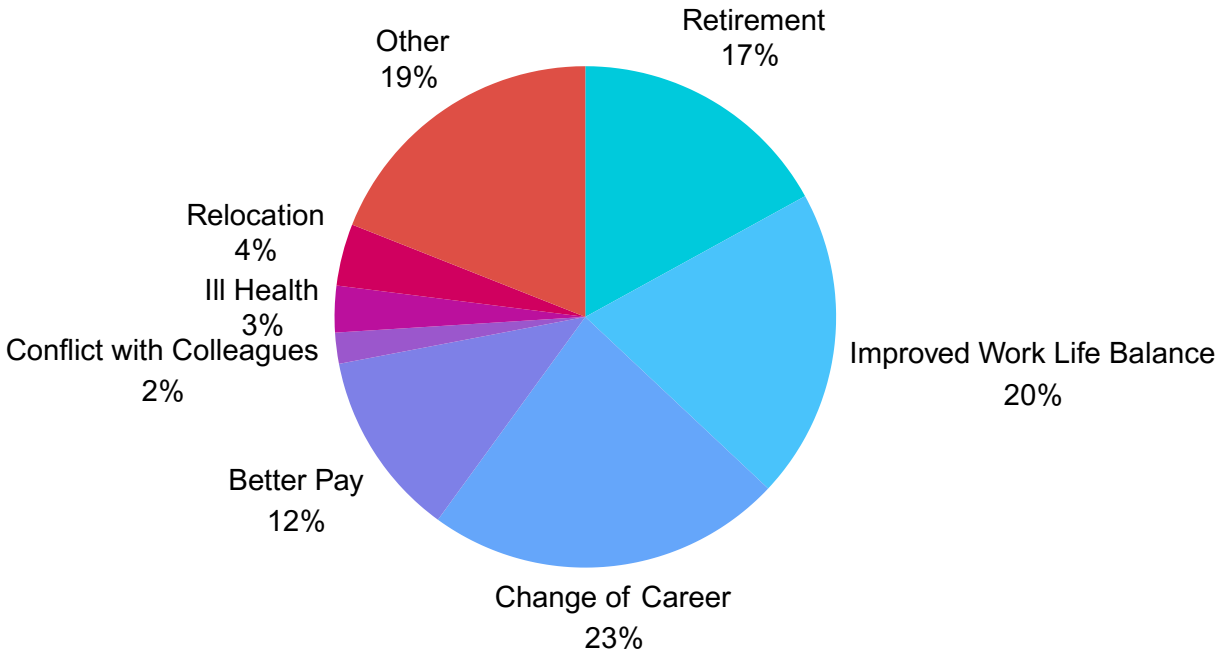
November 24 **1274.3**

HUTH 712.3 NLAG 562

October 24 **1228.1**

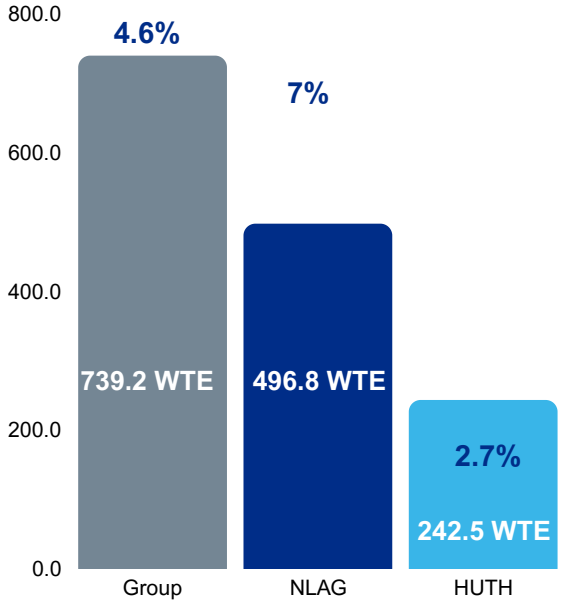
HUTH 668.1 NLAG 560

Humber Health Partnership Exit Questionnaire Data

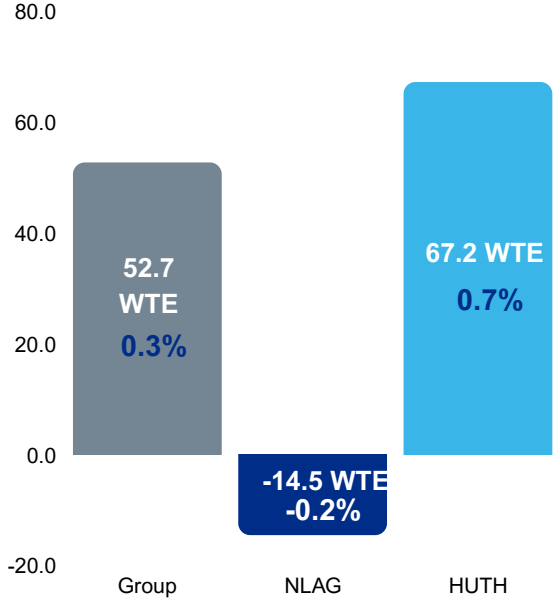


The next two slides represents the vacancy and recruitment activity of the NHS Humber Health Partnership Group. It includes details related to specific staff groups and pipeline information

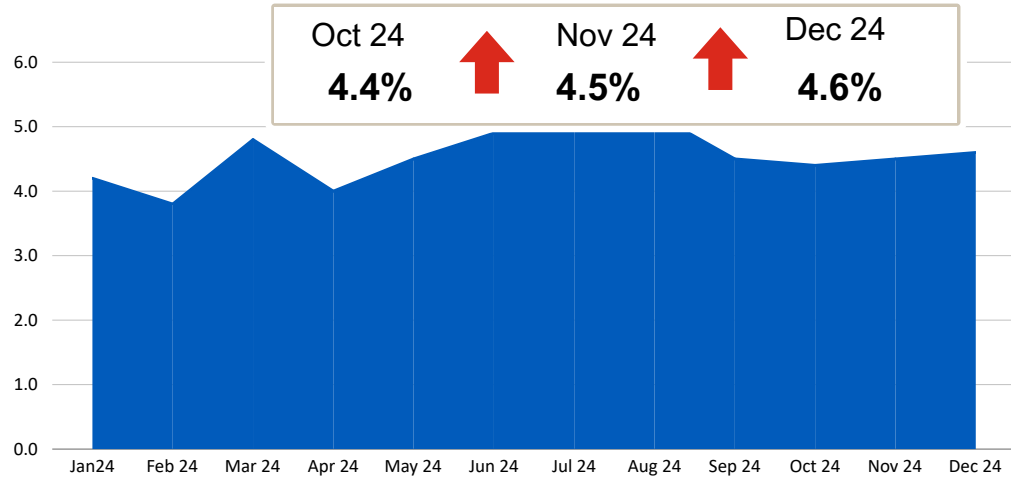
December Group Overall Vacancy Position



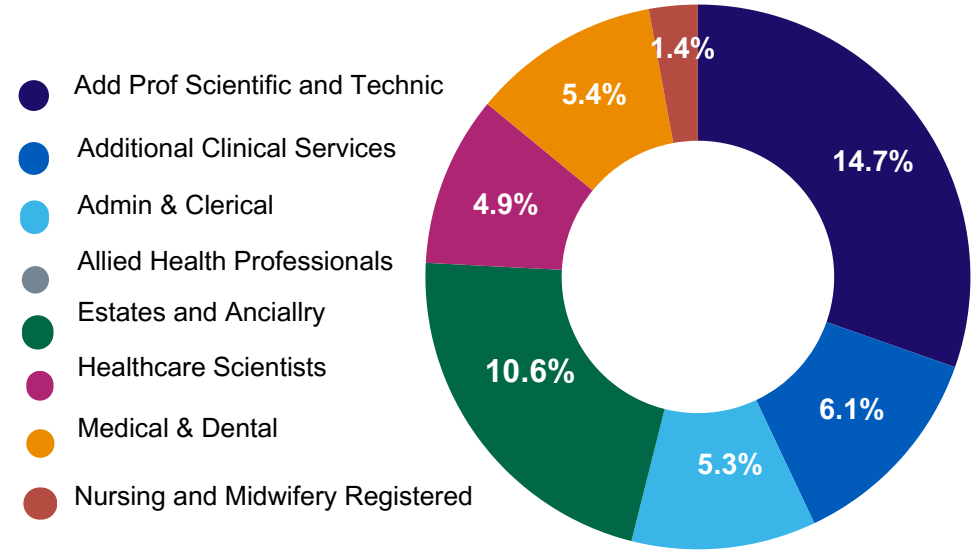
December Group Overall Adjusted Vacancy Position



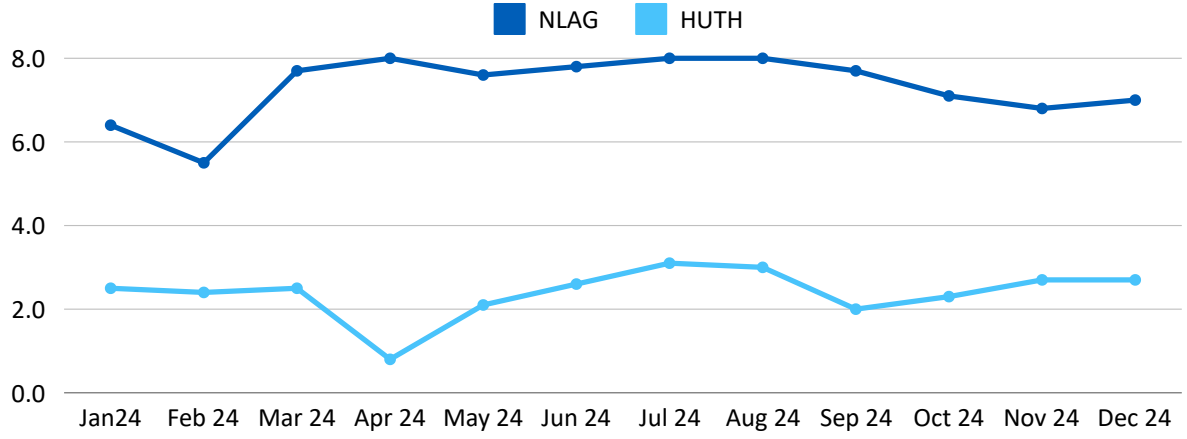
Group Overall Vacancy Trend



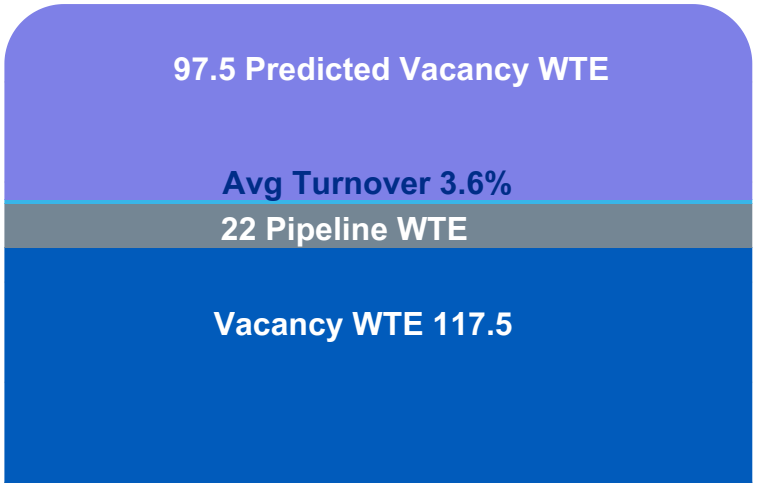
December Group Overall Vacancy by Staff Group



Group Overall Vacancy Trend by Trust



Group Consultant Vacancy 3 Month Predication



Vacancy Rate 13.6%

Predicted Vacancy Rate 11.2%

HUTH Dec Overall Position

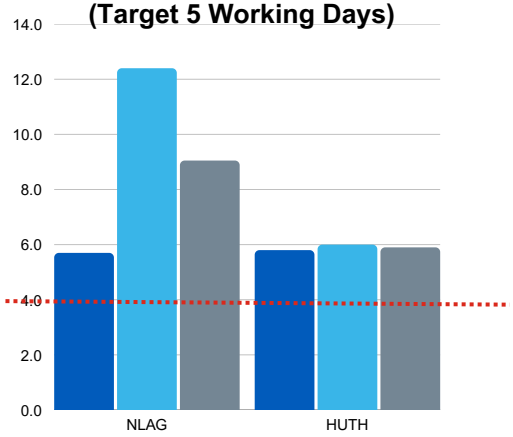
Staff Group	Headcount	Est FTE	SiP FTE	Vacancies FTE	% Vacancies	Agency FTE	Bank FTE	Adjusted Vacancies FTE	% Adjusted Vacancies
Add Prof Scientific and Technic	333	327.5	269.2	58.3	17.8%	0.0	3.1	55.2	16.9%
Additional Clinical Services	1,969	1444.9	1376.8	68.1	4.7%	0.0	66.7	1.5	0.1%
Administrative and Clerical	2,135	1771.5	1696.5	75.0	4.2%	0.6	20.2	54.2	3.1%
Allied Health Professionals	788	666.5	680.5	-13.9	-2.1%	0.8	0.0	-14.7	-2.2%
Estates and Ancillary	697	627.1	563.5	63.6	10.1%	0.0	2.1	61.5	9.8%
Healthcare Scientists	188	173.4	172.6	0.8	0.4%	0.0	0.0	0.8	0.4%
Medical and Dental	1,473	1356.8	1325.5	31.3	2.3%	23.3	16.8	-8.7	-0.6%
Nursing and Midwifery Registered	3,170	2628.2	2668.9	-40.7	-1.5%	10.1	31.7	-82.5	-3.1%
Students	41	41.0	41.0	0.0	0.0%	0.0	0.0	0.0	0.0%
Total	**10,794**	**9037.0**	**8794.5**	**242.5**	**2.7%**	**34.7**	**140.6**	**67.2**	**0.7%**

NLAG Dec Overall Position

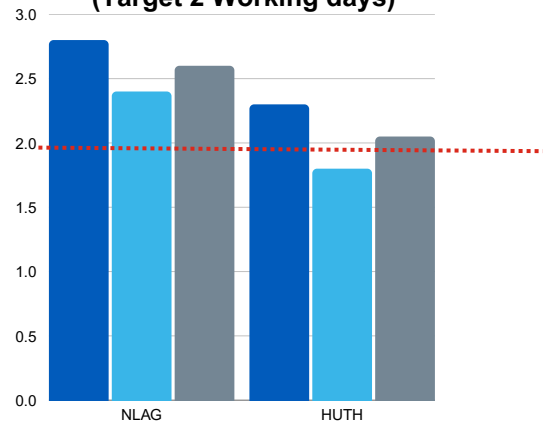
Staff Group	Headcount	Est FTE	SiP FTE	Vacancies FTE	% Vacancies	Agency FTE	Bank FTE	Adjusted Vacancies FTE	% Adjusted Vacancies
Add Prof Scientific and Technic	137	103.3	98.4	4.9	4.8%	1.9	2.6	0.5	0.5%
Additional Clinical Services	2,104	1593.5	1476.2	117.3	7.4%	1.3	110.7	5.3	0.3%
Administrative and Clerical	1,686	1396.0	1303.2	92.8	6.6%	15.6	41.7	35.5	2.5%
Allied Health Professionals	543	486.9	477.7	9.2	1.9%	3.6	7.1	-1.5	-0.3%
Estates and Ancillary	832	569.5	506.5	62.9	11.0%	0.0	63.8	-0.9	-0.2%
Healthcare Scientists	248	186.0	169.1	17.0	9.1%	0.9	8.5	7.6	4.1%
Medical and Dental	790	869.7	781.5	88.2	10.1%	54.4	62.5	-28.8	-3.3%
Nursing and Midwifery Registered	2,421	1922.5	1816.9	105.5	5.5%	41.0	95.7	-31.2	-1.6%
Students	7	0.0	1.0	-1.0		0.0	0.0	-1.0	
Total	**8,768**	**7127.3**	**6630.6**	**496.8**	**7.0%**	**118.7**	**392.5**	**-14.5**	**-0.2%**

Dec Appointing Manager Metrics

Time Taken to Shortlist (Target 5 Working Days)

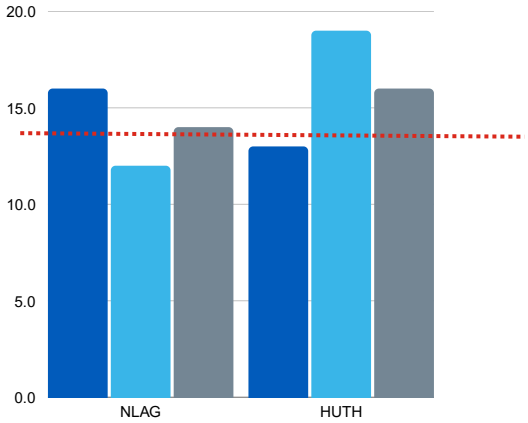


Time taken to provide interview outcome (Target 2 Working days)



Dec Recruitment Team Metrics

Time to Hire (Target 20 working days)



Recruitment KPI Overview	HUTH	NLAG	Total
Number of Active Vacancies	146	88	234
Number of Applications recived	4916	2462	7378
Number of Conditional Offers Issued	149	165	314
Number of New Starters	120	139	259

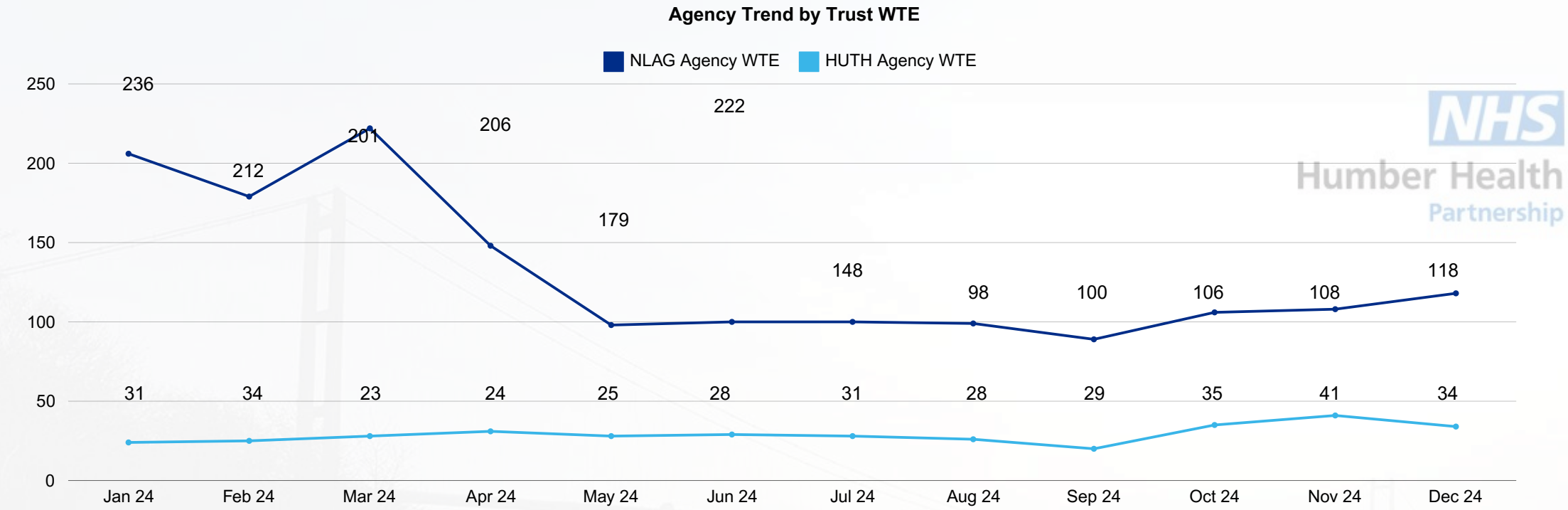
*New Starters are demonstrated as headcount and will include Bank Staff that are represented as 0WTE

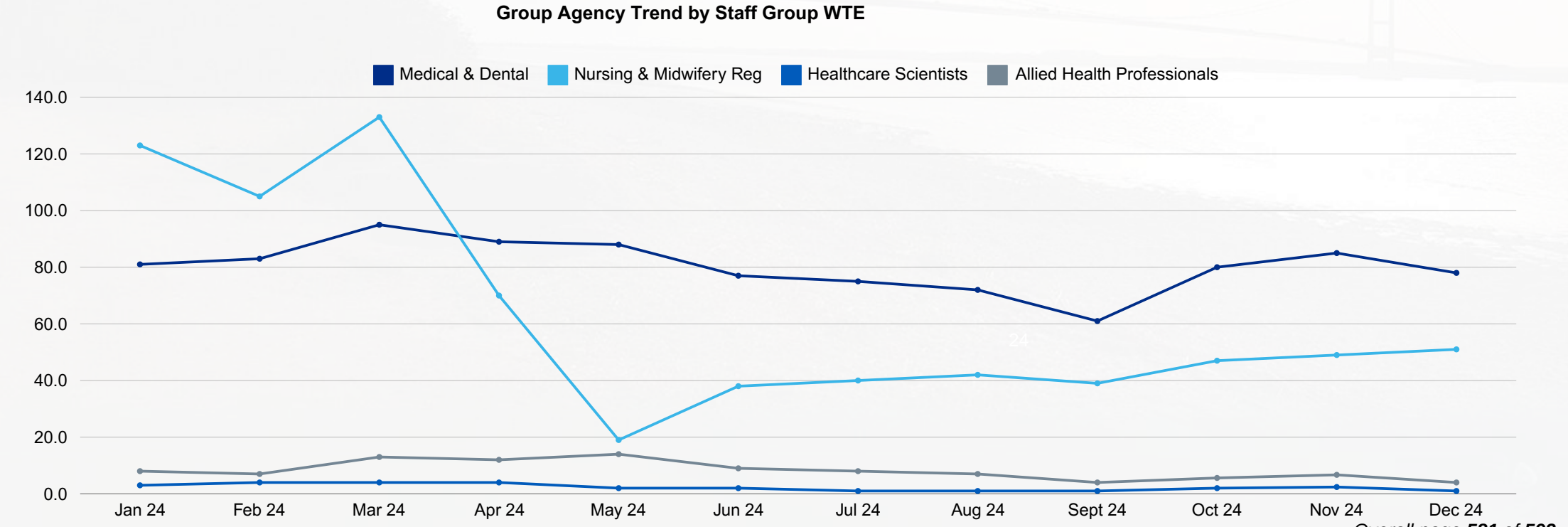
General Staffing

Medical Staffing

All Staffing

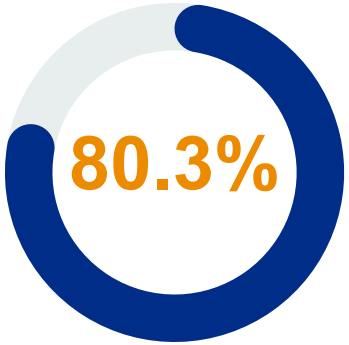
The next slide represents the Agency performance of the NHS Humber Health Partnership Group.





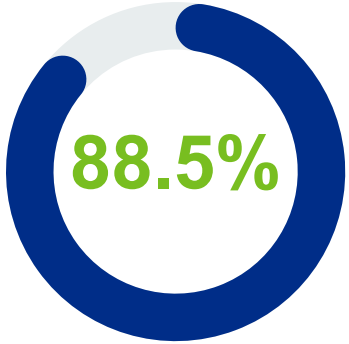
The next slide represents the performance management activity of the NHS Humber Health Partnership Group. It includes details related to appraisals, training and Job Planning.

AfC Appraisals

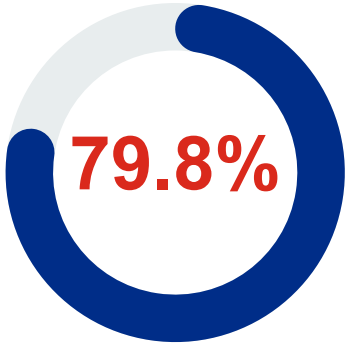


Medical & Dental Appraisals

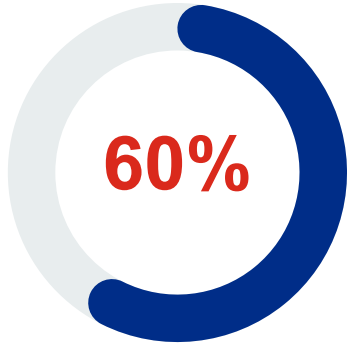
Core Mandatory Training



Role Specific Training



Job Planning



NLAG AfC Appraisals

1,193 overdue appraisals

80.5%

HUTH AfC Appraisals

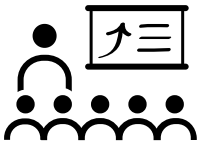
1,548 overdue appraisals

80.2%

0%

November 24

80.3%



NLAG Role Specific Training

15,936 overdue courses

80.8%

HUTH Role Specific Training

29,786 overdue courses

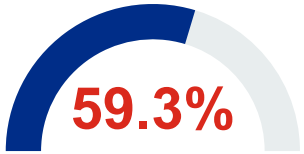
79.2%

0%

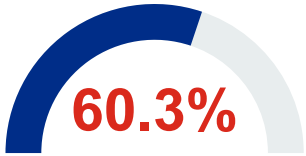
November 24

79.8%

NLAG Job Planning



HUTH Job Planning



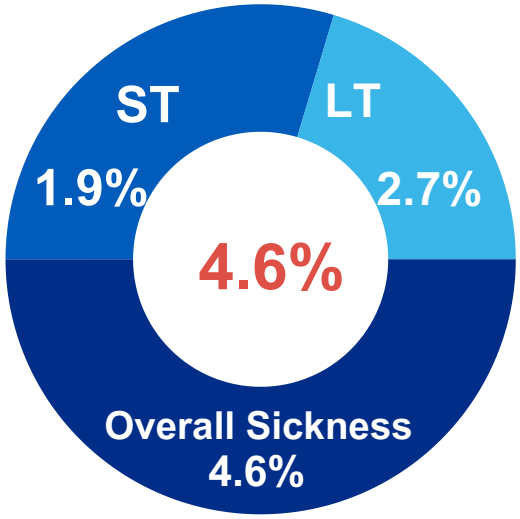
5.1%

November 24

54.9%

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.

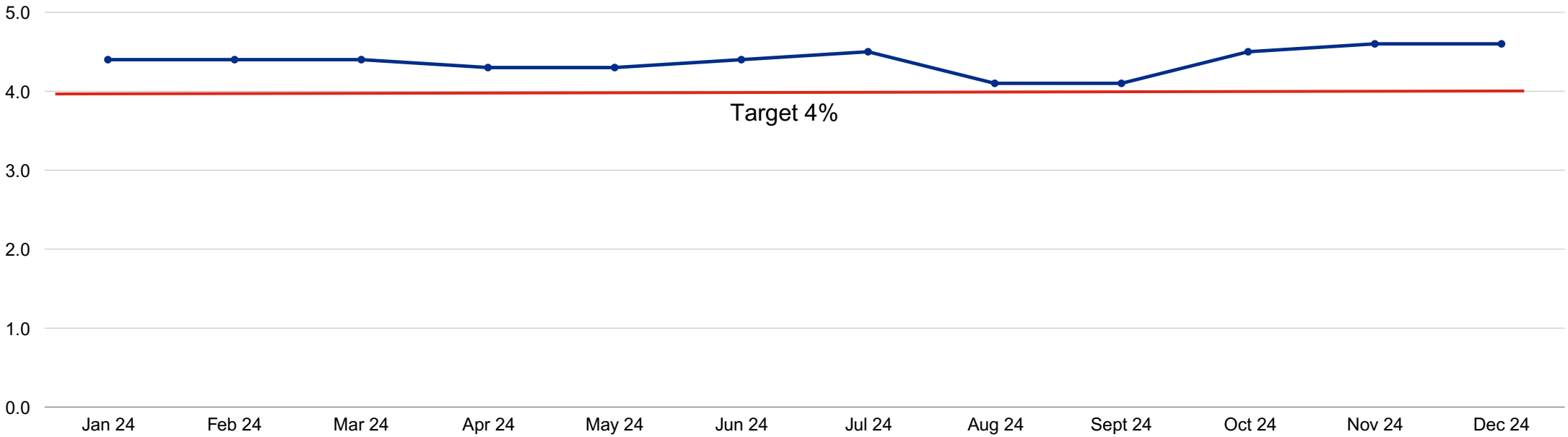
Group December Sickness Position



Group Top 5 Reasons for Sickness

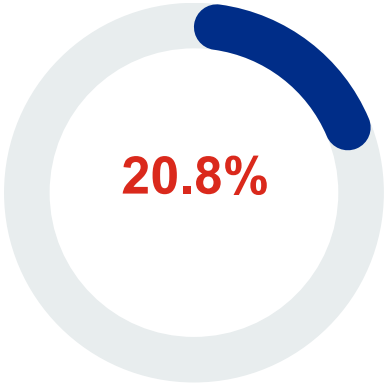
Monthly Absence Reason	FTE Days Lost
S13 Cold, Cough, Flu - Influenza	3,339.43
S10 Anxiety/stress/depression/other psychiatric illnesses	1,477.43
S25 Gastrointestinal problems	1,262.52
S98 Other known causes - not elsewhere classified	1,155.81
S12 Other musculoskeletal problems	545.07

Group Sickness Trend

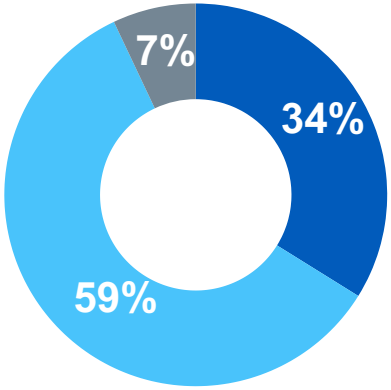


Group December Turnover Position

% First Year Leavers



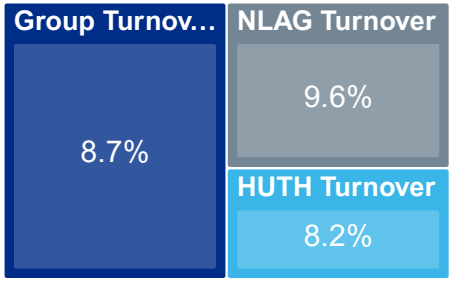
12month Avg Retention



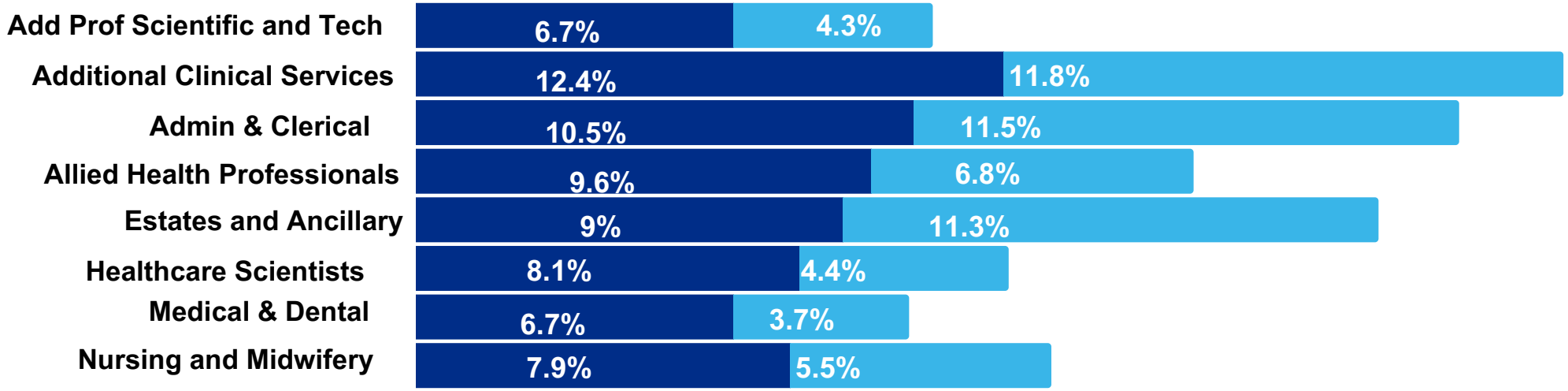
Group Top 5 Reasons for Leaving

Total Instances

Leave Reasons	Instances
Voluntary Resignation - Work Life Balance	1,607
Voluntary Resignation - Other/Not Known	1,259
Retirement Age	1,221
Voluntary Resignation - To undertake further education or training	502
Voluntary Resignation - Child Dependants	463



Group Retention Rates by Staff Group



Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)031

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	13 February 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer / Author	As Above
Title of Report	Documents Signed Under Seal
Executive Summary	The report below provides details of documents signed under Seal since the date of the last report provided in October 2024. The report includes documents sealed by Northern Lincolnshire & Goole (NLaG) NHS Foundation Trust and Hull University Teaching Hospital (HUTH) NHS Trust
Background Information and/or Supporting Document(s) (if applicable)	This is a routine report in the agreed format
Prior Approval Process	N/A
Financial Implication(s) (if applicable)	Not directly
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Use of Trust Seal – February 2025

Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal at NLaG and HUTH has been used on the following occasions:

Seal Register Ref No.	Description of Document Sealed	Seal Signed by	Date of Sealing
NLaG Documents Sealed			
288	Scunthorpe Community Diagnostic Centre (CDC) Shell & Core	Jonathan Lofthouse & Lee Bond	19.10.2024
289	Lease between NLaG & Energy Assets Network Ltd Electricity Substation at Scunthorpe CDC	Jonathan Lofthouse & David Sharif	13.01.2025
290	Schedule 1 Electricity Asset Adoption Agreement – Scunthorpe CDC – Northern Powergrid (Yorkshire) Plc – Integrated Utility Services Ltd	Jonathan Lofthouse & David Sharif	13.01.2025
HUTH Documents Sealed			
2024/12	Hull University Teaching Hospitals NHS Trust and EE Limited and Hutchinson 3G Uk Limited – ECC Rooftop Lease relating to the communications site situated at roof installation at HRI	Jonathan Lofthouse – Group CEO and Emma Sayner – Group CFO	16.12.2024
2025/01	Hull University Teaching Hospitals NHS Trust and Ward Hadaway – variation works in relation to the Castle Hill Hospital Cancer Assessment Unit 2 x CEO Letter 2 x Variation Agreement 2 x Notice of Assignment	Jonathan Lofthouse – Group CEO, Emma Sayner, Group CFO and David Sharif, Group Director of Assurance	28.01.2025

Action Required

The Trust Boards-in-Common are asked to note the report.

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(25)032

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	13 February 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 - V12

	Quarter 4 (24/25)			Quarter 1 (25/26)			Quarter 2 (25/26)			Quarter 3 (25/26)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Trust Board												
Public & Private (Thursdays - 9.00 am - 5.00 pm)		13.02.25 **Boardroom, HRI**		10.04.25 **Boardroom, DPOW**		12.06.25 **Boardroom, HRI**		14.08.25 **Boardroom, DPOW**	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 **Boardroom, HRI**		18.06.25 **Boardroom, DPOW**		20.08.25 **Nightingale, SGH**		22.10.25 **Boardroom, HRI**		16.12.25 **Boardroom, HRI**
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)		27.02.25 **Nightingale, SGH**	27.03.25 **Boardroom, DPOW**	29.04.25 **Boardroom, HRI** (Tuesday)	29.05.25 **TBC, CHH**	26.06.25 **Nightingale, SGH**	24.07.25 **Boardroom, HRI**	28.08.25 **Boardroom, DPOW**	25.09.25 **TBC, CHH**	30.10.25 **Nightingale, SGH**	27.11.25 **Boardroom, HRI**	18.12.25 **Boardroom, DPOW**
Remuneration - (Virtual Meeting) (9.00 am - 11.30 am)		05.02.25			27.05.25			06.08.25			20.11.25	
Workforce, Education & Culture (Wednesdays - 9.00 am - 12.30 pm)	29.01.25 **Boardroom, DPOW**	26.02.25 **Boardroom, HRI**	26.03.25 **Nightingale, SGH**	30.04.25 **Boardroom, CHH**	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 **Boardroom, 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			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	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 - V4

	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		19.06.26 HUTH & NLaG **Annual Accounts** Friday - 9.00 am - 12.00 pm **Boardroom, HRI**	30.07.26				11.11.26 (Wednesday)	
Charitable Funds												
NLAG (9.00 am - 12.00 pm)	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	

7 - ANY OTHER URGENT BUSINESS

Sean Lyons, Group Chair

8 - QUESTIONS FROM THE PUBLIC & GOVERNORS

Sean Lyons, Group Chair

9 - MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON

Sean Lyons, Group Chair

10 - DATE OF THE NEXT MEETING

Sean Lyons, Group Chair

Thursday, 10 April 2025 at 9.00 am