Northern Lincolnshire and Goole NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 6 December 2022, by MS Teams
Time – 9.00 am – 12.45 pm
(Lunch – 12.45 pm – 1.15 pm)
For the purpose of transacting the business set out below

		Note / Approve	Time	Ref
1.	**Introduction**			
1.1	**Chair's Opening Remarks** Sean Lyons, Chair	Note	09:00 hrs	Verbal
1.2	**Apologies for Absence** Sean Lyons, Chair	Note		Verbal
1.3	**Patients' Story and Reflection** Jo Loughborough, Senior Nurse – Patient Experience and Kay Fillingham, Lead Mental Health Professional	Note		Verbal
2.	**Business Items**			
2.1	**Declarations of Interest** Sean Lyons, Chair	Note	09:15 hrs	Verbal
2.2	**To approve the minutes of the Public meeting held on Tuesday, 4 October 2022** Sean Lyons, Chair	Approve		NLG(22)208 Attached
2.3	**To approve the minutes of the Public meeting held on Monday, 14 November 2022** Sean Lyons, Chair	Approve		NLG(22)249 Attached
2.4	**Urgent Matters Arising** Sean Lyons, Chair	Note		Verbal
2.5	**Trust Board Action Log – Public** Sean Lyons, Chair	Note		NLG(22)209 Attached
2.6	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note	09:25 hrs	NLG(22)210 Attached
2.7	**Integrated Performance Report (IPR)**	Note		NLG(22)211 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Key Issues – Quality & Safety** Dr Kate Wood, Medical Director & Ellie Monkhouse, Chief Nurse	Note	09:35 hrs	NLG(22)211 Attached

3.2	**Quality & Safety Committee Highlight Report and Board Challenge** Fiona Osborne, Non-Executive Director & Chair of the Quality & Safety Committee	Note	09:45 hrs	NLG(22)212 Attached
3.3	**Safeguarding Annual Report** Lynn Benefer, Deputy Head of Safeguarding	Note	09:50 hrs	NLG(22)213 Attached
3.4	**Maternity / Ockenden Update** Jane Warner, Associate Chief Nurse Midwifery	Note	10:00 hrs	NLG(22)214 Attached
3.5	**Key Issues – Performance** Shaun Stacey, Chief Operating Officer	Note	10:10 hrs	NLG(22)211 Attached
3.6	**Data Quality Assurance** Shauna McMahon, Chief Information Officer	Note	10:20 hrs	NLG(22)257 Attached
3.7	**Finance & Performance Committee Highlight Report and Board Challenge – Performance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	10:25 hrs	NLG(22)216 Attached
4.	**Strategic Objective 2 – To Be a Good Employer**			
4.1	**Key Issues – Workforce** Christine Brereton, Director of People	Note	10:30 hrs	NLG(22)211 Attached
4.2	**Freedom to Speak Up Self Assessment** Christine Brereton, Director of People	Note	10:40 hrs	NLG(22)217 Attached
4.3	**Freedom to Speak Up Guardian – Quarter Two Report** Liz Houchin, FTSUG	Note	10:45 hrs	NLG(22)218 Attached
4.4	**Workforce Committee Highlight Report and Board Challenge** Sue Liburd, Chair of the Workforce Committee and Non-Executive Director	Note	10:55 hrs	NLG(22)219 Attached
4.4.1	**Workforce Committee Terms of Reference** Sue Liburd, Chair of the Workforce Committee and Non-Executive Director	Approve		
BREAK – 11:00 hrs – 11:10 hrs				
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Key Issues – Finance – Month 07** Lee Bond, Chief Financial Officer	Note	11:10 hrs	NLG(22)220 Attached
5.2	**Green & Travel Plan** Simon Tighe, Deputy Director of Estates & Facilities and Keith Fowler, Associate Director Facilities and Sustainability	Note	11:20 hrs	NLG(22)221 Attached
5.3	**Finance & Performance Committee Highlight Report & Board Challenge – Finance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:30 hrs	NLG(22)223 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Key Issues – Strategic & Transformation** Ivan McConnell, Director of Strategic Development	Note	11:35 hrs	NLG(22)224 Attached
6.2	**Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge** Gill Ponder, Non-Executive Director	Note	11:45 hrs	NLG(22)225 Attached
6.3	**Strategic Development Committee Highlight Report & Board Challenge** Linda Jackson, Non-Executive Director & Chair of the Strategic Development Committee	Note	11:50 hrs	NLG(22)226 Attached

6.4	**Humber Acute Services Development Committee Highlight Report & Board Challenge (Committees in Common)** Sean Lyons, Chair	Note	11:55 hrs	NLG(22)227 Attached
7.	**Strategic Objective 5 – To Provide Good Leadership**			
7.1	None			
8.	**Governance**			
8.1	**Audit, Risk & Governance Committee Highlight Report & Board Challenge** Simon Parkes, Non-Executive Director and Chair of the Audit, Risk & Governance Committee	Note	12:00 hrs	NLG(22)228 Attached
8.2	**Board Assurance Framework (BAF) – Quarter Two** Helen Harris, Director of Corporate Governance	Note	12:05 hrs	NLG(22)229 Attached
8.3	**Provider Licence Consultation** Helen Harris, Director of Corporate Governance	Note	12:10 hrs	NLG(22)230 Attached
8.4	**Enforcement Guidance Consultation** Helen Harris, Director of Corporate Governance	Note	12:20 hrs	NLG(22)231 Attached
8.5	**New Code of Governance** Helen Harris, Director of Corporate Governance	Note	12:25 hrs	NLG(22)232 Attached
9.	**Approval (Other)**			
9.1	**Equality, Diversity and Inclusion Strategy** Christine Brereton, Director of People	Approve	12:30 hrs	NLG(22)233 Attached
9.2	**NHS Smoke-Free Pledge** Dr Kate Wood, Medical Director	Approve	12:35	NLG(22)215 Attached
10.	**Items for Information / To Note (please refer to Appendix A)** Sean Lyons, Chair	Note	12:35 hrs	
11.	**Any Other Urgent Business** Sean Lyons, Chair	Note		Verbal
12.	**Questions from the Public**	Note		Verbal
13.	**Date and Time of Next meeting** **Extra-ordinary Private Trust Board** Thursday, 5 January 2023, 9.00 am **Public & Private Meeting** Tuesday, 7 February 2023, 9.00 am **Board Development** Tuesday, 7 March 2023, 9.00 am	Note		Verbal

- In accordance with Standing Order 14.2 (2007), any Director wishing to propose an agenda item should send it with 8 clear days' notice before the meeting to the Chairman, 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 Chairman. Divisional Directors and Managers may also submit agenda items in this way.
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APPENDIX A

Listed below is a schedule of documents circulated to all Board members for information.

The Board has previously agreed that these items will be included within the Board papers for information. They do not routinely need to feature for discussion on Board agendas but any questions arising from these papers should be raised with the responsible Director. If after having done so any Director believes there are matters arising from these documents that warrant discussion within the Board setting, they should contact the Chairman, Chief Executive or Board Administrator, who will include the issue on a future agenda.

10.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
10.1	**Finance & Performance Committee Minutes – September & October 2022** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(22)234 Attached
	Quality & Safety Committee	
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10.3	**Nursing Assurance Report** Ellie Monkhouse, Chief Nurse	NLG(22)236 Attached
	Workforce Committee	
10.4	**Workforce Committee Minutes – September 2022** Sue Liburd, Non-Executive Director & Chair of the Workforce Committee	NLG(22)238 Attached
10.5	**Guardian of Safe Working Hours Quarter Two Report** Dr Liz Evans, Guardian of Safe Working Hourse	NLG(22)239 Attached
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10.6	**Audit, Risk & Governance Committee Minutes – July 2022** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(22)240 Attached
	Health Tree Foundation Trustees' Committee	
10.7	**Health Tree Foundation Trustees' Committee Minutes – September 2022** Neil Gammon, Chair of the Health Tree Foundation Trustees' Committee	NLG(22)241 Attached
	Other	
10.8	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(22)242 Attached
10.9	**Documents Signed Under Seal** Dr Peter Reading, Chief Executive	NLG(22)243 Attached
10.10	**Covid 19 Inquiry Update** Helen Harris, Director of Corporate Governance	NLG(22)244 Attached

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NLG(22)208

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 4 October 2022 at 9.00 am, In the Newton Suite, Forest Pines, Ermine Street, Broughton, DN20 0AQ

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Chair
Linda Jackson	Vice Chair
Dr Peter Reading	Chief Executive
Lee Bond	Chief Financial Officer
Ellie Monkhouse	Chief Nurse (for item 3.4 – 13)
Shaun Stacey	Chief Operating Officer
Dr Kate Wood	Medical Director
Sue Liburd	Non-Executive Director
Fiona Osborne	Non-Executive Director
Gillian Ponder	Non-Executive Director

In Attendance:

Mr S A Aftab	Consultant Ophthalmologist
Linda Barker	Head of Infection, Prevention & Control (for item 3.3)
Adrian Beddow	Associate Director of Communications
Christine Brereton	Director of People
Dr Liz Evans	Guardian of Safe Working Hours (for item 4.3)
Stuart Hall	Associate Non-Executive Director (for item 1 – 3.6)
Helen Harris	Director of Corporate Governance
Jug Johal	Director of Estates & Facilities
Steve Leggett	Alcidion (Member of the Public)
Jo Loughborough	Senior Nurse – Patient Experience (for item 1.3)
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Ian Reekie	Lead Governor
Kate Truscott	Associate Non-Executive Director
Jane Warner	Associate Chief Nurse Midwifery (for item 3.4)
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Director of Corporate Governance (note taker)

1. Introduction

1.1 Chair's Opening Remarks

Sean Lyons welcomed everyone to the meeting and declared it open at 9.00 am.

Sean Lyons introduced Sue Liburd who had been appointed as Non-Executive Director (NED) and Kate Truscott, Associate NED. Sean Lyons wanted to note thanks to Michael Whitworth, Mike Proctor and Maneesh Singh for all the hard work and commitment to the Trust during their time as NEDs.

1.2 Apologies for Absence

Apologies for absence was received by Simon Parkes.

1.3 Patients' Story and Reflection

Jo Loughborough shared a video from a family member Paula whose mother had been cared for by the Trust as a palliative care patient. Due to some concerns that were raised regarding the patient care Paula had worked with the team to look at the complaints process from ward level to see what had been put in place. Due to some issues with previous care Paula's mother had been too scared to come into hospital. One of the themes that were highlighted related to poor communication with the patient and family. As work had been undertaken with the ward area in question this had now provided Paula with closure on what had been a difficult experience.

Shaun Stacey felt it was important for the board to recognise the message around communication for patients and families but also between professionals too. Under the current pressures it needed to be recognised staff within acute care settings are under huge pressures at the moment. In some situations an acute hospital environment was not always the correct place for a palliative care patients, this was something that needed to be reviewed going forward.

Dr Kate Wood thanked Jo Loughborough and Paula for sharing the story. There was a need to have better understanding of patient care needs to ensure the patient had the right balance. The system was working together with different multi-disciplinary teams which included various roles to provide a better understanding of what care can be provided going forward.

Linda Jackson referred to relatives that were seen as carers for patients as they were often more aware of the care needed for family members and that this should be respected. Jo Loughborough agreed with this, but unfortunately on this occasion the relative had not been listened to. However, the video had referred to certain individuals that had made a difference to care, Linda Jackson queried whether the positive feedback was shared with staff members. It was confirmed when staff members are mentioned this was the case. As some junior staff had been the ones that had made a difference Gill Ponder queried whether training had changed to how it had been delivered previously, if this was the case would it be an option for the training to be offered to longer standing staff. Dr Kate Wood advised current training was more centred on the delivery of care to the patient,

however, it was felt this would be difficult to train existing staff in this way after many years of undertaking roles in a different way.

Sean Lyons thanked Jo Loughborough for the video shared.

2. Business Items

2.1 Declarations of Interest

No declarations of interests were received.

2.2 To approve the minutes of the Public Meeting held on Tuesday, 2 August 2022 – NLG(22)163

The minutes of the meeting held on the 2 August 2022 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made.

- Dr Kate Wood referred to page four, section 3.2 in respect of how Serious Incidents (SIs) were reviewed. It was noted the Quality & Safety Committee (Q&SC) reviewed clusters of SIs or those with a similar theme which were then reviewed through the SI Review Group. It was agreed to put this as a post meeting amendment on the minutes.

2.3 Urgent Matters Arising

Sean Lyons invited Board members to raise any urgent matters that required discussion which were not captured on the agenda. No items were raised.

2.4 Trust Board Action Log – Public by exception NLG(22)164

Sean Lyons invited Board members to raise any further updates by exception in relation to the Trust Board Action Log.

- Item 2.7 – Dr Peter Reading advised this related to the emerging governance structures across the Integrated Care System (ICS) and other collaboratives. It was hoped at this point the ICS structures would be confirmed, however, this was not the case. This continued to be developed with a full board session due to be held that week and that other events would be held to put this in place. This area had one of the most complicated systems in place which had impacted on timescales. It was agreed an update would be provided at a future meeting.

  Linda Jackson highlighted this issue had been discussed in the Strategic Development Committee (SDC) as it was recognised delays were putting pressures on the Executives due to the number of meetings requiring attendance. A request was made to hold a board development session to review the current requests and how to manage them in order of prioritisation. It was agreed a session would be held once requirements were clear.

Action: Trust Board development session to be arranged

- Item 3.2 - Dr Kate Wood advised this point related to future board visits being both productive and constructive in order to support areas. Fiona Osborne advised this would be discussed outside the meeting with Ellie Monkhouse.

- Item 4.1 – Christine Brereton advised this issue was to be raised at the Humber Workforce Group chaired by Simon Nearney it would then be discussed at the Workforce Committee. It was agreed to close this item.

- Item 10 – Christine Brereton advised this item would be resolved outside the meeting and could be closed.

- Item 3.6 - Fiona Osborne advised an update would be provided at the next meeting.

2.5 Chief Executive's Briefing – NLG(22)165

Dr Peter Reading referred to the report and drew the boards attention to particular key points. One highlight was the current pressures on staff which continued, thanks and gratitude were noted for the work being undertaken. The board were reminded of the Emergency Department (ED) opening at the Grimsby site the following day being Wednesday, 5 October. The Care Quality Commission (CQC) report had been delayed from the original expected date. It was noted that Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) had received notification from the Royal College of Nursing (RCN) Union that members would be balloted for possible industrial action.

Sean Lyons was pleased to see there had been national recognition through the Health Service Journal (HSJ) Awards.

It was noted a video tour of the new ED would be available on the Trust website.

2.6 Integrated Performance Report (IPR) – NLG(22)166

Sean Lyons advised the IPR was for noting.

3. Strategic Objective 1 – To Give Great Care

3.1 Key Issues – Quality & Safety - NLG(22)166

Dr Kate Wood advised the IPR was discussed at the Q&SC and was now shared at the Trust Management Board (TMB). Items were also discussed at the divisional Performance Review Improvement Meeting (PRIMs) on a monthly basis.

Dr Kate Wood reminded colleagues of the amazing work in relation to the management of venous thromboembolism (VTE) and thanked everyone for allowing the team to work through previous challenges. The work had now improved with a compliance of 90%. One of the low lights related to Out of Hospital Summary Hospital-Level Mortality Indicator (SHMI), work would be

undertaken with patient pathways, in particular the consideration of alternative pathway for those patients who may not need to be admitted 30 days prior to death. The recording of sepsis management remained a concern, a different process was required in terms of reporting to ensure this reflected accurate data and it was noted that sepsis was not an area of concern for the organisation.

The weighing of patients was a Quality Priority for this year to ensure the board was sighted on issues around this. As medication was at times delivered based on patient weight errors could be fatal in some circumstances. Changes were being put in place on ward areas and links had been included through the Electronic Prescribing and Medicines Administration (EPMA) for weight-based medication, however, more work was required to provide assurance. The Q&SC would continue to monitor this issue and highlight any progress and concerns to the board. Linda Jackson queried what solutions could be put in place to resolve issues and what timeframe this would take. Dr Kate Wood advised this was a multi-factorial issue, one issue was that some patients did not want to be weighed and the risk of this was not always understood by the individual. Once the electronic patient record was in place it was hoped all patient related information would flow better. It was hoped this may be introduced as a Quality Initiative across the organisation. The board were advised the new ED had scales within the floor at the ambulance entrance which would take an estimated weight, although this was not ideal from a clinical perspective it would help.

Sean Lyons noted there had been a dip in complaint response times and queried if this had been reviewed. Dr Peter Reading confirmed this had been raised at TMB on 3 October 2022 and was being worked through with relevant teams.

Kate Truscott queried whether there were any particular wards that had more of a challenge in respect of patient falls. Dr Kate Wood advised through the 15 Step process and Ward Assurance Dashboard, matrons reviewed this regularly and any issues would be challenged by Ellie Monkhouse. Due to the late apologies of Ellie Monkhouse, Dr Kate Wood advised there was a process within the nursing hierarchy to ensure falls were monitored with support in place when required, this was also reported in the Nursing Assurance Report on a monthly basis.

3.2 Quality & Safety Committee Highlight Report and Board Challenge – NLG(22)167

Fiona Osborne highlighted that the committee had received a referral from the Finance & Performance Committee (F&PC) to seek assurance on cancer services. A referral had been sent to the Workforce Committee in respect of recruitment, in particular the ageing profile of nursing staff and the need to address how this would be reviewed.

Sean Lyons referred to the SI detailed in the report and queried why the fetal pillow was not used at all sites. Jane Warner advised this was not mandated by National Institute for Health and Care Excellence (NICE) to be used, at the moment it was being used as a clinician preference. It was used more at Grimsby than Scunthorpe General Hospital (SGH). Dr Kate Wood advised new items to the market took a period of time to understand if they were appropriate to use. The SI had not gone through the review process at the moment so it had not been

determined if this would have made a difference. There was a need to look at consistency across areas to ensure this was not due to the equipment not being used. When incidents occurred questions could also be asked as to why equipment was being used if it had not been approved through NICE Guidance.

3.3 Infection Control Annual Report – NLG(22)168

Linda Barker referred to the report and drew the boards attention to highlights. It was noted the year had again been a challenge due to Covid-19.

Shaun Stacey thanked Linda Barker and the team for work undertaken and the positive report for the Trust. The elective and emergency care had been sustained throughout the year due to the support from the team. Fiona Osborne noted the very thorough report which was most encouraging due to the contribution from various parts of the organisation. The Q&SC had requested an addition to the annual report going forward on the long-term estates strategy to support the collaborative working with the team. Jug Johal referred to the recommendations section that detailed oxygen and isolation requirements, this had been put in place with the new ED building works and would be included in all new builds. In respect of the oxygen, two phases had been completed in respect of refurbishment, the final phase would cost £80,000 which would be funded to ensure this was put in place.

Dr Peter Reading raised the issue regarding the shortage of Consultant Microbiologists across the country which had impacted on the organisation in respect of on-site presence, it was noted this was a major concern. Dr Kate Wood advised the organisation was in an excellent position as there was a number of microbiologists available on the telephone to support, this was not the case in other areas. Shaun Stacey advised NLAG was in the process of recruiting one consultant, however, due to regulatory requirements this was not confirmed. There had been some interest in remote working, however, this would not resolve the risk of on-site cover.

Gill Ponder referred to the joint equipment storage not being fit for purpose and whether the Q&SC had gained assurance in respect of this. Linda Barker advised work was being undertaken with support put in place and some improvements had been made. It was agreed the Q&SC would review this to ensure it would be fit for purpose. Sean Lyons noted from the IPR that NLAG were doing well in respect of infection control.

3.4 Maternity / Ockenden Update – NLG(22)169

Jane Warner provided a brief overview on previous reports. Following an assurance visit in May by the Regional Chief Midwife, Tracey Cooper, the formal report had now been received and positive feedback was included within this report. The East Kent Report was expected during the month and there was an expectation of compliance requirements on receipt of the report. Jane Warner briefed the board on highlights from the report shared.

Linda Jackson referred to the 24 actions completed from the 92 in place and queried how NLAG compared to peer Trusts. A further query was in relation to

staffing as to whether anything was to be put in place, as this had been raised on a number of occasions during a recent 15 steps visit. Jane Warner advised the 24 actions completed was due to a personal baseline set, during discussion with other Heads of Midwifery, baselines had not formally been put in place. It was felt other Trusts were meeting similar actions. Staffing did continue to be a challenge, the SGH unit had been closed due to safety reasons. On occasions patients were diverted to other sites due to staffing and acuity. The Trust currently had around 42 whole time equivalent (wte) vacancies for midwives, the number of vacancies were higher at the SGH site. The Trust had recently recruited 14 student midwives which would support improvements, however, those members of staff would also need support. The student midwives would have the support of a pastoral support midwife.

Gill Ponder referred to the Clinical Negligence Scheme for Trusts (CNST) as to whether non-achievement would have a financial implication. Jane Warner confirmed NLAG were provided with a rebate if the standards were met. In previous years NLAG had not met CNST and there had been an option to state why the standards would not be met, particularly if this related to the need for specific equipment or training. Funding would then be provided to enable this to be put in place. The issue on this occasion related more to the number of vacancies. Lee Bond confirmed the funding had not been withdrawn for the last two years, however, pre-pandemic those Trusts not meeting the standards were invited to put forward business cases for a specific request. In response to a query regarding the compliance of mandatory training being met, Jane Warner was confident this would be the case.

Ellie Monkhouse joined the meeting.

Shaun Stacey confirmed considerable efforts were being made to achieve the mandatory training, however, this was a challenge due to the increased demands on staff. Sue Liburd queried whether assurance could be provided as to whether there were some innovation and creativity in place for the shortfall. Jane Warner explained in respect of high cost agency NLAG had requested support which was out of Trust processes, although this had been undertaken with permission to ensure wards were covered due to wards being inadequately staffed. Although the birth to midwife ratios were still safe this remained a concern. The option of having registered nurses in some maternity areas was also being put in place when safe to do so, those nurses would not undertake any midwifery tasks. Other options were national Facebook recruitment. Support was being offered to staff when it became aware of those that may wish to leave, individuals had been asked if there was anything that could be introduced to enable staff to stay.

Dr Kate Wood thanked Jane Warner for the work completed. One issue not in the report was the review of services across the Humber. It was noted the area did have low birth rates each year. It was felt the board needed to be reminded of this due to there being a need for a review on how to deliver maternity care across the organisation which was ongoing.

Linda Jackson advised staff referred to several staff working bank shifts elsewhere due to the enhancements being paid, with this in mind would enhancements be introduced for NLAG staff working bank shifts going forward. Dr Peter Reading

advised it was helpful to be made aware of this issue, however, when incentives had been offered previously it had not made a difference. It was agreed to review this again with the Executive Team in light of the comments made.

Action: Dr Peter Reading

Sean Lyons thanked Jane Warner for the report provided.

3.5 Key Issues – Performance – NLG(22)166

Shaun Stacey referred to the report and highlighted key points. Apologies were offered for patients that had had a planned procedure cancelled the previous week, all would be rescheduled as soon as possible. The Trust continued to perform well through the Same Day Emergency Care (SDEC) and Urgent Care Service with over 98% of patients being seen within one and a half hours. The SDEC performance of 48% of patients being seen was a national record as other Trusts had not performed in this way. The Trust continued to see continual flow of admissions set against difficulties to discharge. Diagnostic services remained challenged directly linked to the demand through the Urgent Emergency Care Service and the need to maintain cancer and elective flows.

Linda Jackson queried what action was being taken in respect of 62-day cancer performance as it was currently on a downward trend. Shaun Stacey advised NLAG were looking at other pathways to ensure it was being operated correctly, one other challenge was to ensure patients were referred to specialist centres as near to the 28 days as possible. A further challenge was the validation and ensuring this was carried out correctly. Patients that did not have a cancer diagnosis were yet to be reported on the system, which was creating a data anomaly showing this as a deterioration. The cancer team were trying to resolve those issues as soon as possible. Linda Jackson queried when this would be resolved. Shaun Stacey felt a more improved figure of 65-70% would be shown by the end of March 2023 with further improvement to 80% in the first quarter of next year, although this would be dependent on treating patients within the specified pathway.

Kate Truscott referred to the number of patients that had waited 104 days to be treated on the cancer pathway was quite high and queried why this was the case. Shaun Stacey advised this was a combination of issues, one issue was around the patient having the primary tumour diagnostic shown as negative, the patient would then be put on a diagnostic pathway to exclude other cancers. The second cohort of patients were those that NLAG would not treat due to not being within the treatment pathways, those patients would be treated at tertiary services where there may be a delayed treatment. The third cohort was those patients that had personally chosen to delay treatment.

Sean Lyons queried what the expectation would be for ambulance handover delays when the new ED opened at Diana, Princess of Wales Hospital (DPOWH). Shaun Stacey felt the additional space would help this, however, if the work around flow was not sustained and the department became full this would cause issues. It was hoped the new ED would help to manage flow.

Dr Peter Reading wanted to pass on personal congratulations from Sir David Sloman, Chief Operating Officer at NHS England to staff for how the new ED had been developed.

Stuart Hall referenced the increase in energy costs as it was felt this would have a deterioration on the health of the population which would increase pressures on the Trust, and whether this had been factored into planning. Shaun Stacey agreed NLAG were already seeing the impact of this, as patients with long term conditions could have been better managed outside the hospital environment by clinicians. The winter plans had accommodated for this but there could be other implications. The bed flow was being reviewed along with increasing the access to the urgent care service particularly around SDEC flow. Dr Kate Wood explained there was a need to look at this as a system, due to patients being at potential risk. As an organisation this was impacting on the NLAG front door. There would be a need to discuss what could be undertaken differently to change the current practice with system partners.

3.6 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(22)170

Gill Ponder referred to the highlight report and drew the boards attention to key points. It was noted the Trust Green and Travel Plan were recommended to be presented to the board for approval in due course.

Stuart Hall left the meeting at this point.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Key Issues - Workforce – NLG(22)166

Christine Brereton advised robust plans had been put in place earlier in the year for registered nurses and Health Care Support Workers (HCSW). Due to a recruitment event in September 2022, 142 HCSW were now going through the recruitment process. A further recruitment event was due to take place in December this year. The IPR included the turnover figure which was higher than it should be, although this was now levelling up. In respect of registered nurses, 89 would be recruited directly from local universities between September 2022 and February next year which would also be supported by international recruitment. In addition there will be the development of the apprenticeship model for direct registered nursing and it was anticipated 40 staff would be recruited to the programme.

A piece of work on retention was been undertaken as it had shown the first year for registered nurses and HCSWs was crucial in terms of support required. Further discussion would take place with Lee Bond and Ellie Monkhouse to see how this could be strengthened. The retention work would feed into the development of the culture and board development work and a presentation on the work being undertaken with culture would be provided at the board development session in November.

The mandatory training position was now more positive, there were some areas that would require increased monitoring. Sickness absence had levelled up but due to operational pressures there were some areas with high levels.

Dr Peter Reading felt the work on recruitment was excellent in multiple areas at the Trust. A query was raised as to whether additional work was needed in supporting staff and if this needed more discussion in terms of finances. Christine Brereton felt this would be required to support newly appointed staff.. Once staff commenced in workplaces it normally became clear what support would be required.

Linda Jackson was pleased to learn of the great news in respect recruitment as this had not been clear within the IPR. It was requested this was included in future reports. During a recent visit it had been recognised flexibility was one of the key issues for staff when continuing to work for the Trust so this would need to be followed through. Dr Kate Wood agreed further discussion would need to take place in respect of the support offered for overseas staff working at NLAG. It was noted, however, that clinicians were not being supported as well as nurses that arrived in the organisation. Contact had also been received by the national workforce team as NLAG had been chosen as a pilot site to provide detail and in-depth data for the national team to help understand how recruitment challenges were being managed. Although the issue was recognised nothing was being put in place. Ellie Monkhouse highlighted the issues would not be resolved in the near future, funding had been received in the past to provide support, however, more substantive support was required as this was currently being undertaken by staff seconded for other areas. More investment was required to support education and training to maintain requirements. Sean Lyons had had conversations with some of the Trust international nurses and the feedback had been positive in respect of the support received.

Lee Bond referred to the sickness absence on page 41 as this appeared to be short term sickness, it was felt this may need to be reviewed in light of current pressures. Christine Brereton confirmed work was being undertaken in hot spot areas at the moment. It was noted Occupational Health staff were also under pressure due to support being required by staff.

4.2 Workforce Committee Highlight Report and Board Challenge – NLG(22)171

Fiona Osborne referred to the highlight report and noted key points. The committee had received a Key Performance Indicator (KPI) dashboard that referred to workforce. A report was received on flexible working arrangements and forward planning which included a pilot in clinical areas for self-managed rotas.

4.3 Guardian of Safe Working Hours Annual Report – NLG(22)172

Dr Liz Evans shared the report and referred to themes highlighted. It was noted there had been an increased rate of exceptional reporting in the last year, it was felt this was due to the engagement work undertaken over the past year.

Sean Lyons thanked Dr Liz Evans for a well presented and easy to understand report. Shaun Stacey queried whether there was a theme in the Medicine Division

due to the high level of concerns raised.. Dr Liz Evans advised this was thought to be due to there not being enough junior doctors in those areas to cover the work required. Gill Ponder queried whether the reporting was proportionate to the number of junior doctors within medicine or if there were really issues in that area. Dr Liz Evans did not feel this was the sole issue and that it related more to doctors in those areas reporting concerns. It was advised this would be reviewed further and the reasons would be noted in future reports.

Kate Truscott referred to training numbers and queried whether the Trust were able to have an increased number of junior doctors. Dr Kate Wood explained the previous junior doctor fill rate had been 67% from the Deanery, this had now increased to 80% - 90% due to conversations taking place. The Trust were now an organisation of choice due to the fantastic work undertaken by the undergraduate team. It was important the work continued which included the medical student and junior doctor experience.

Sean Lyons queried whether accommodation was part of the attraction to junior doctors to a particular site at NLAG. Dr Liz Evans advised feedback had been good in respect of the Roost, feedback had not been received in respect of the SGH site. Dr Kate Wood advised this issue had been highlighted previously. It was noted refurbishment of those areas continued.

5. Strategic Objective 3 – To Live Within our Means

5.1 Key Issues - Finance – Month 05 - NLG(22)173

Lee Bond referred to the report and noted key highlights.

Gill Ponder referred to the CNST rebate and queried whether this was included within the budget. Lee Bond understood this was not included but would confirm this. This would mean there would not be an additional risk if this was not received. Ellie Monkhouse highlighted the Trust would continue to operate with a risk over the winter period along with the anticipated increase in Covid patients and respiratory illness.

5.2 Executive Report – Estates & Facilities – NLG(22)174

Jug Johal informed the Board that the National Standard of Healthcare Cleaning related to areas that were linked to the ward including staff rooms. In addition, the assessment related to the hospital environment which could impact on the organisation due to the number of wards that required refurbishment. The increase in Covid patients would mean a challenging time for those teams. The back-log maintenance had increased by around 10% every year, the trajectory for the next ten years would mean an amount of a quarter of a billion pounds. There was concern there may be another major infrastructure failing which would continue to be mitigated against. Jug Johal noted concerns due to external contractors and it was agreed this would be discussed outside the meeting.

Gill Ponder referred to commercial services and the potential opportunity for private work and queried how the Trust may capitalise on this and whether private

work could be allocated to the independent sector with an appropriate tariff. Jug Johal agreed to explore this further with the team.

Linda Jackson wanted to note thanks to Jug Johal and the team due to recent increased pressures.

5.3 Fire Alarm Replacement – Scunthorpe General Hospital – NLG(22)175

Jug Johal referred to the paper and advised this was for noting as it had been approved virtually in September by Trust Board members.

5.4 Business Planning Timetable

Lee Bond advised the work for next year had commenced. The capacity work would be completed by Christmas and would include a robust assessment for bed capacity. The planning process from the previous year would be reflected on to highlight any improvements. The Trust had not yet received the plan from Place on how this would interact with the Trust. Progress on the plans would be progressed through the F&PC.

5.5 Major Capital / Overarching Capital – NLG(22)176

Lee Bond referred to the slides shared and noted the five areas that were being reviewed. Ivan McConnell referred to the strategic capital as the board needed to be aware this would still be an operational capital risk.

5.6 Finance & Performance Committee Highlight Report and Board Challenge – Finance - NLG(22)177

Gill Ponder referred to the report and highlighted key points in particular the programme for Ward 25 and ED being behind as this would impact onto the Integrated Acute Assessment Unit (IAAU) plan being completed within this year.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Key Issues – Strategic & Transformation – NLG(22)178

Ivan McConnell referred to the report and noted key highlights.

6.2 Health Tree Foundation Trustees' Committee (HTFTC) Highlight Report & Board Challenge – May 2022 – NLG(22)179

Gill Ponder drew the boards attention to key points within the report.

6.3 Strategic Development Committee (SDC) Highlight Report & Board Challenge – NLG(22)181

Linda Jackson referred to the report and highlighted key points. In respect of discussions that had taken place regarding requests received from external stakeholders it was noted a Trust Board Time Out session would be arranged to work this through.

Action: **Trust Board Development Session to be arranged**

7. Strategic Objective 5 – To Provide Good Leadership.

7.1 There were no items to discuss under this section.

8. Governance

8.1 Audit, Risk & Governance Committee (AR&GC) Highlight Report & Board Challenge – NLG(22)182

Gill Ponder referred to the report and shared key points.

8.2 Emergency Preparedness Resilience & Response Annual Report - NLG(22)183

Shaun Stacey referred to key highlights from the report and confirmed the Trust continued to maintain compliance as required. The board were asked to recognise staff that were on the Gold On Call Rota would undertake Strategic Health Commander training.

Thanks were noted to staff that worked so rapidly in response to the sad death of Queen Elizabeth II.

9. Approval (Other)

There were no items for approval.

10. Items for Information

The following items were shared at the October 2022 meeting:

- F&PC Minutes – June, July & August 2022
- Q&SC Minutes – July & August 2022
- Nursing Assurance Report
- 15 Steps Annual Report
- Workforce Committee Minutes – July 2022
- AR&GC Minutes – June 2022
- HTFTC Minutes – July 2022
- Communications Round-Up

11. Any Other Urgent Business

There were no items of any other business raised.

12. Questions from the Public

Sean Lyons asked for questions from the public. No questions were received.

13. Date and Time of the next meeting

Formal Trust Board Meeting

Tuesday, 6 December, Time: 9.00 am

Board Development

Tuesday, 1 November 2022, Time: 9.00 am

The Private Trust Board meeting was due to follow at 13:30 hours.

Sean Lyons closed the meeting at 12:30 hours.

Cumulative Record of Board Director's Attendance (2022/23)

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	4	4	Ellie Monkhouse	4	4
Dr Peter Reading	4	4	Fiona Osborne	4	4
Lee Bond	4	4	Simon Parkes	4	2
Christine Brereton	4	3	Gillian Ponder	4	4
Stuart Hall	4	4	Michael Proctor	3	3
Helen Harris	4	2	Maneesh Singh	3	3
Linda Jackson	4	3	Shaun Stacey	4	4
Jug Johal	4	2	Kate Truscott	1	1
Sue Liburd	1	1	Michael Whitworth	3	3
Ivan McConnell	4	3	Dr Kate Wood	4	2
Shauna McMahon	4	3			

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Monday, 14 November 2022 at 11.30 am, By MS Teams

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Chair
Linda Jackson	Vice Chair
Dr Peter Reading	Chief Executive
Shaun Stacey	Chief Operating Officer
Dr Kate Wood	Medical Director
Fiona Osborne	Non-Executive Director
Sue Liburd	Non-Executive Director
Gillian Ponder	Non-Executive Director (for item 1 – 2.2)

In Attendance:

Adrian Beddow	Associate Director of Communications
Christine Brereton	Director of People
Stuart Hall	Associate Non-Executive Director
Helen Harris	Director of Corporate Governance
Jug Johal	Director of Estates & Facilities
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Kate Truscott	Associate Non-Executive Director
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Director of Corporate Governance (note taker)

1. Welcome and Introduction

Sean Lyons welcomed everyone to the meeting and declared it open at 11.30 am.

It was noted apologies for absence were received from Lee Bond, Simon Parkes and Ellie Monkhouse.

Sean Lyons went through what the consultation period had included following the Private Extra-ordinary Trust Board Meetings held on the 18 October 2022 at Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospital (HUTH). Both Boards had agreed the direction of travel at the meetings and a three week engagement period with wider stakeholders had been

agreed. Sean Lyons drew the Board's attention to feedback within the paper which would be discussed during the meeting along with a letter of concerns received by NLAG senior consultants.

2. Proposal to Develop A Group Leadership Model: Final Case for Change – NLG(22)205

2.1 Appendix A: Stakeholder Engagement & Feedback

2.2 Appendix B: Risks & Mitigations

Sean Lyons advised stakeholder and staff sessions had been well attended at both Trusts and the feedback received had been positive.

Sean Lyons sought comments from the Board. Dr Kate Wood referred to the concerns raised by NLAG consultants which was what impact this would have on patients in terms of outcomes; the delivery of care for the hospital closest to where patients' lived and the impact on staff. It was felt the Board should be fully sighted on why this may not be the best way forward. Fiona Osborne felt the comments were valid and it would need to be recognised this would continue to be built on. A query was raised as to whether those staff should be included in any engagement to ensure comments were noted.

Dr Peter Reading advised a meeting had been held with the relevant consultants following the receipt of the letter. Sean Lyons, Dr Kate Wood and Linda Jackson had also attended the meeting. It had been recognised the engagement with consultants would need to continue and further discussions would take place with Chris Long, HUTH Chief Executive to reinforce confidence with the Interim Clinical Plan. Dr Peter Reading felt there had been a general feeling of support for the Group Model apart from the concerns raised by NLAG consultants that had wanted safeguards in place for patients on the South Bank. The joint Executive roles would need to ensure the best care was delivered equally for patients on the North and South Bank. The close connections NLAG had with the three Places would also need to be continued. It was felt once that was in place there would be support for the direction of travel. It was noted the safeguards would be in place and there would be a continuation of monitoring them.

Sean Lyons agreed there would be a need to continue with challenge where relevant. Feedback from stakeholders was for inclusion in the recruitment process of the Group Chief Executive. Sean Lyons highlighted it was important to show both Trusts would enter into the process as equals.

Sue Liburd queried whether there had been confusion as to what a Group Model was during the engagement sessions. If this was the case it would need to be emphasised this was not a merger of the two Trusts but instead a partnership. Sean Lyons advised detailed messages would be shared throughout the process to show a merger would not be considered to ensure confidence was embedded. It was felt this would become obvious as the process commenced. Dr Peter Reading felt the majority of people did understand the difference between the two processes. Minimal comments from some staff had been that this was a HUTH take over.

Linda Jackson felt staff had expected a move would take place due to previous joint roles being put in place. The general feeling from staff had been what this would mean for them and various teams. The protection of NLAGs identity had been raised and it was again noted safeguards would be put in place. Linda Jackson had attended the recent consultants meeting which had been well attended. The meeting had been constructive with four key themes emerging. One was in respect of the NLAG journey as it was felt the organisation had moved a long way in the last five years and the momentum should not be lost. There was a feeling that if the Medical Director and Chief Executive were no longer in post from NLAG this would reduce the ability of the NLAG clinicians to raise concerns and have influence. It was felt the Group Model would be populated by HUTH employees meaning the NLAG voice would be diminished, reassurance of this not happening was sought. One other issue was that some areas of NLAG were more innovative and this should not be lost. To move forward the Interim Clinical Plan needed to be refocussed with further consolidation required in the operationalisation of agreed pathways.

Kate Truscott felt it was important to continue with the engagement of staff and stakeholders to ensure risks were mitigated. Sue Liburd queried whether the work around values had been raised as the Trusts both had different values in place. Sean Lyons advised this had not been raised although there had been agreement both Trusts may work better together due to the resources across both organisations. Although the values were both different the intentions were the same.

Gill Ponder queried how the message would be shared with members of the public as there was a need to ensure this was done correctly to show there would not be a loss of local services but that it was an organisational change. Sean Lyons confirmed the engagement with the public would include this whilst ensuring concerns were understood. Dr Peter Reading agreed and felt this should also be noted when advertising the Group Chief Executive role. Engagement events had been very open over recent weeks. There may be a need to reinforce that a Group Model would provide additional safeguards for local patients.

At this point Gill Ponder left the meeting.

Dr Kate Wood felt one of the safeguards was as two organisations there would be a constant reflection of continued learning. As a Group Model there needed to be assurance this would be in place to ensure patients received the best care with the resources available. Sean Lyons agreed and advised Dr Peter Reading and Chris Long would work through this to ensure it was in place.

Sean Lyons confirmed the Governors comments had been included in the paper along with the responses. It was explained there would be no change to the role of the Council of Governors (CoGs) as NLAG was a Foundation Trust. It was hoped the move to a Group Model would attract more staff which would alleviate agency costs. There was no expectation for management costs to increase. It was noted Executive appointments would be ring fenced to those currently in those roles.

Sean Lyons referred to the risk and mitigation within the paper and sought comments. It was noted this would be a live document as the Group Model progressed. Fiona Osborne asked if a statement could be included within the document to advise of this. It was agreed this would be included and both Trust Boards would continue to be sighted on this.

Sean Lyons advised the Programme Oversight Board would consider what additional representatives would be required at meetings going forward.

Dr Kate Wood felt the main risk would be culture and organisational development, there would be a need to ensure there was appropriate two-way engagement between staff at both Trusts. It was important to emphasise more effort would be required for the system to work with other providers when caring for patients. Although this was noted within the paper it was felt it may not have been identified by everyone due to the large paper provided. Sean Lyons noted the comment made and asked for this to be considered. Ivan McConnell felt there would be a need to build this in to ensure it did not become a risk. Sean Lyons agreed there would be a need to reflect on this moving forward.

Sean Lyons sought agreement to move forward with the Group Model. It was noted this would be with the consideration of noted mitigations and risks taken into account. The Trust Board were in agreement to continue with the process. It was noted regular reports and updates would be received at both Trust Board meetings.

3. Trust Constitution – NLG(22)206

Helen Harris referred to the Trust Constitution and advised amendments were required in line with the Group Model proposal. The Board were asked to approve the updated paper and agreed to the recommendation for this to be approved by the CoG by virtual correspondence. The Board were advised of the changes in the Trust Constitution.

Dr Kate Wood queried whether there was any further information available in respect of Section 15 as this did not provide much understanding. Helen Harris explained the Remuneration and Terms of Service Committee had approved the Principles Framework for Determining the Remuneration & Terms of Service for the Chief Executive and Executive Directors at a meeting earlier this year. Christine Brereton agreed to share the document with Executive Directors.

Action: Christine Brereton

The Trust Board agreed to the changes in the Trust Constitution and recommend the approval to the CoGs.

4. Next Steps

Sean Lyons advised the next step in the process was for HUTH Trust Board to reach agreement for the same proposal, this meeting was due to be held the same day. Both Remuneration Committees would then meet that week to consider the Group Chief Executive appointment and recruitment process.

Further consideration would take place as to how the Programme Oversight Board may widen its membership. Updates on the progress of the Group Model would continue to be reported through both Trust Boards. It was noted there would be a need to ensure safeguards were in place along with resolving any mitigations that were currently in place or further risks that may arise.

5. Any Other Urgent Business

Sean Lyons invited Board members to raise any urgent matters that required discussion. No items were raised.

6. Questions from the Public

Sean Lyons asked for questions from the public. No questions were received.

Sean Lyons thanked everyone for the work undertaken so far with the Group Model. The way forward would be to secure patient services for the future with the resources already in place at both Trusts.

7. Date and Time of the next meeting

Public
Tuesday, 6 December 2022, 9.00 am
Main Boardroom, DPOWH

Sean Lyons closed the meeting at 12.25 hours.

Cumulative Record of Board Director's Attendance (2022/23)

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	5	5	Ellie Monkhouse	5	4
Dr Peter Reading	5	5	Fiona Osborne	5	5
Lee Bond	5	4	Simon Parkes	5	2
Christine Brereton	5	4	Gillian Ponder	5	5
Stuart Hall	5	5	Michael Proctor	3	3
Helen Harris	5	3	Maneesh Singh	3	3
Linda Jackson	5	4	Shaun Stacey	5	5
Jug Johal	5	3	Kate Truscott	2	2
Sue Liburd	2	2	Michael Whitworth	3	3
Ivan McConnell	5	4	Dr Kate Wood	5	3
Shauna McMahon	5	4			

NLG(22)209

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2022/2023

Kindness · Courage · Respect

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Public Meeting
2022/23

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
3.6	02.08.2022	Key Issues - Performance		Quality & Safety Committee to review what areas patient initiative follow ups mapped	Quality & Safety Committee	06.12.2022	Update to be provided at the December Trust Board meeting.			
3.4	04.10.2022	Bank Incentives (raised in Maternity / Ockenden Update item)		It was agreed the Executive Team would review staff pay incentives when working bank shifts.	Dr Peter Reading	06.12.2022	Update to be provided at the December Trust Board meeting.			
3	14.11.2022	Trust Constitution		It was agreed Christine Brereton would circulate the Principles Framework for Determining the Remuneration & Terms of Service for the Chief Executive and Executive Directors to the Executive Team.	Christine Brereton	06.12.2022	Document was circulated to Exec Team.			

Key:

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

Trust Board Public Meeting

2022/23

Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
3.5	07.06.2022	Volunteer Strategy		Volunteer Strategy to be updated following proof reading	Ellie Monkhouse	02.08.2022	Update to be provided at the August Trust Board meeting. Amendments had been made to the report			
3.6	07.06.2022	Key Issues - Performance		Update to be provided on whether the IPR could include exact timings patients had waited over a 12 hr breach.	Shauna McMahon	02.08.2022	Update to be provided at the August Trust Board meeting. At decision was made as to what would be included in the report going forward along with a deep dive at the F&PC meeting.			
3.7	07.06.2022	Finance & Performance Committee Highlight Report & Board Challenge		Deep Dive on ventilation and air conditioning to be shared with Ellie Monkhouse.	Gill Ponder	02.08.2022	Update to be provided at the August Trust Board meeting. This action could be closed as the report had been shared.			
6.2	07.06.2022	HTFTC Highlight Report & Board Challenge		Communication to be sent to staff on the process for accessing Health Tree funds.	Ade Beddow	02.08.2022	Update to be provided at the August Trust Board meeting. The Charity Manager was attending meetings to update colleagues on the progress. An update was also to be provided at the SLC on the current process			
8.1	07.06.2022	ARG Highlight Report & Board Challenge		BAF Session to be added to the Trust Board Development Session timetable	Dr Peter Reading / Helen Harris	02.08.2022	Update to be provided at the August Trust Board meeting. It was advised the board development programme was being updated to reflect accommodating this session			
2.7	07.06.2022	CEO Briefing		Update to be provided on how collaboratives would fit within NLAGs Assurance Frameworks.	Sean Lyons & Dr Peter Reading	04.10.2022	A board development session would be held on this item.			
3.2	07.06.2022	Quality & Safety Committee Highlight Report & Board Challenge		Update to be provided from the Q&SC regarding board visits.	Mike Proctor, Dr Kate Wood, Ellie Monkhouse	02.08.2022	It was agreed this item would be discussed outside the meeting between Fiona Osborne and Ellie Monkhouse.			
4.1	07.06.2022	Key Issues - Workforce		Christine Brereton to look at opportunites with Universities in terms of recruiting family members of overseas students. Joint discussion to take place with Simon Nearney	Christine Brereton	02.08.2022	This item would be monitored through the Workforce Committee.			
10	07.06.2022	Items for Information		Christine Brereton to advise of factual accuracies in specific ARG Minutes	Christine Brereton	04.10.2022	It was agreed this item would be resolved outside of the meeting with the relevant Chair.			

Key:

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

NE&Y Revised NHS Oversight Arrangements 2022/23

July 2022

NHS England and NHS Improvement

NHS Oversight Framework 2022-23: Introduction

1. Integrated care systems (ICSs) **are partnerships of health and care organisations that together plan and deliver joined up services** to improve the health of people who live and work in their area.

2. From 1 July 2022 integrated care boards **(ICBs) have the general statutory function of arranging health services for their population and will be responsible for performance and oversight of NHS services within their ICS**.

3. 2022/23 will be a **year of transition** as new collaborative arrangements are developed.

4. The 2022/23 framework reinforces system-led delivery, taking account of the **establishment of statutory ICBs with commensurate responsibilities, and NHS England's duty to undertake an annual performance assessment** of ICBs.

5. The framework will support ICBs and NHS England to **work together and develop proportionate and locally tailored approaches** to oversight that reflect a shared understanding of:

    - the ambitions, accountabilities and roles between NHS England, ICBs, individual trusts and local partnerships
    - how performance will be monitored
    - the unique local delivery and governance arrangements specifically tailored to the needs of different communities
    - the importance of delivery against both shared system priorities agreed between local partners and national NHS priorities.

NHS Oversight Framework 2022-23: Purpose & Approach

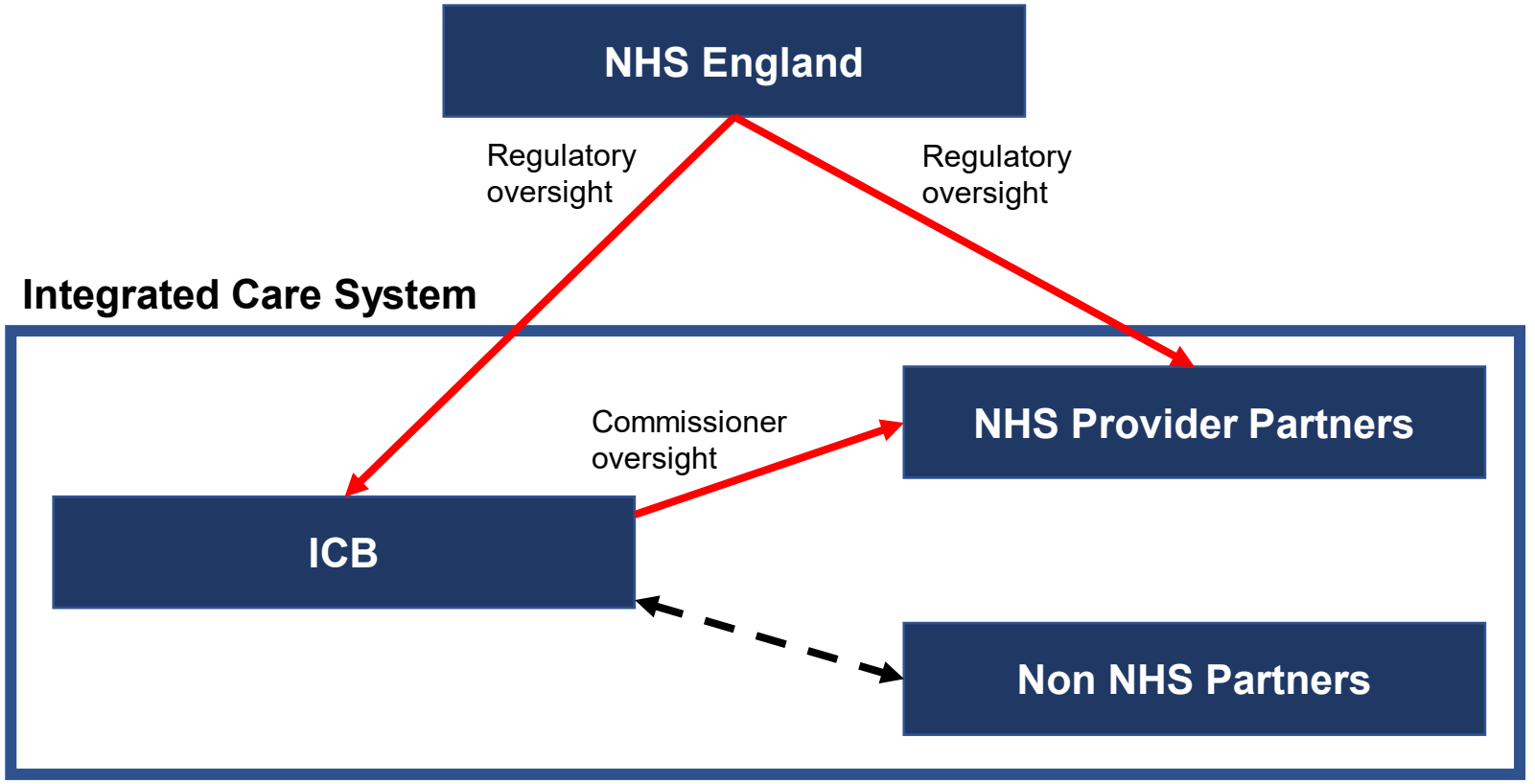
The **purpose** of the NHS Oversight Framework is to:

- ensure the alignment of priorities across the NHS and with wider system partners
- identify where ICBs and/or NHS providers may benefit from, or require, support
- provide an objective basis for decisions about when and how NHS England will intervene.

The overarching **approach** to oversight is characterised by the following key principles:

- working **with and through ICBs**, wherever possible, to tackle problems
- a greater emphasis on **system performance and quality of care outcomes**, alongside the contributions of individual healthcare providers and commissioners to system goals
- matching **accountability for results** with improvement support, as appropriate
- **autonomy** for ICBs and NHS providers as a default position
- **compassionate leadership behaviours** that underpin all oversight interactions

2022-23 Oversight & Assurance Model – Accountable Organisations



NHS England Oversight of ICBs 2022-23

1. The "What" - Operating Model

Oversight of ICBs	NHS England
Statutory Accountability for Oversight & Regulation	✓
Responsible for Performance, Quality & Financial Oversight	✓
Responsible for Co-ordinating Support Interventions	✓

2. The "How" (Process)

NHS England will:	ICBs will
i. Lead the oversight of ICBs on delivery against NHS Oversight Framework domains. ii. Through this, gain assurance of place-based systems and individual organisations. iii. Where necessary, lead and co-ordinate support requirements identified for the ICB. iv. Chair quarterly ICB Focus Meetings covering six themes of NHS Oversight in accordance with the framework. i. Lead the SOF segmentation of ICBs in accordance with the NHS Oversight Framework.	i. Establish delivery & governance arrangements with partners to include: • The role of place-based partnerships and provider collaboratives in delivering NHS priorities set out in operational planning guidance. • Quality governance processes that enable the proactive identification, monitoring and escalation of quality issues and concerns as set out in NQB guidance. ii. Share actual or prospective changes in performance with NHS England in a timely manner. iii. Manage and escalate quality risks in line with the National Quality Board quality risk response and escalation guidance.

ICB Oversight of Providers 2022-23

1. The "What" - Operating Model

Oversight of Providers	ICBs	NHS England
Statutory Accountability for Oversight & Regulation		✓
Lead responsibility for Performance, Quality & Financial Oversight	✓	
Lead responsibility for Co-ordinating Support Interventions	✓ (SOF 1&2)	✓ (SOF 3*&4)

* SOF3 – Although during 2022-23 NHS England will retain the lead responsibility for SOF3&4 support interventions. This will be delivered in partnership with the ICB.

2. The "How" (Process)

NHS England will:	ICBs will
i. Work with ICBs to ensure that oversight arrangements at ICB, place and organisation level incorporate regular review meetings informed by a shared set of information	i. Ensure delegations to place-based partnerships are discharged effectively.
ii. Draw on regional, national & other expertise as necessary	ii. Lead the oversight of individual providers within their ICS.
iii. Establish focused engagement with the ICB and the relevant organisations where specific issues emerge.	iii. Oversee and seek to resolve local issues before escalation.
iv. Retain statutory accountability for oversight of both ICBs and NHS providers but in general discharge duties in collaboration with ICBs	i. Share actual or prospective changes in performance with NHS England in a timely manner.
v. In exceptional circumstances, intervene directly with providers with the full awareness of the ICB.	ii. Manage and escalate quality risks in line with the National Quality Board quality risk response and escalation guidance.
vi. Lead the SOF segmentation of providers in accordance with the NHS Oversight Framework.	iii. Co-ordinate NHS support interventions within their system where appropriate, working in partnership with NHS England.

The “How” – 4 + 1 Behaviours & Expectations

The following behaviours and expectations underpin our shared approach to oversight.

1. The principle of subsidiarity applies – we will always seek to resolve issues as close the patient as we possibly can.
2. Our decision making in relation to oversight will be evidence based. We will be transparent in sharing data and evidence.
3. We operate as a four + one to deliver provider oversight, with commitment to “no surprises”, high trust, co-production and high ambition.
4. We share an understanding that we are working together through a period of transition – where we are now is not the end of the journey. The SOF for 2022-23 is an interim model.
5. We will confirm and clarify roles and accountabilities in order to deliver an effective oversight model during this complex period of change.
6. We will ensure that our interventions are part of the solution, and that they add value rather than complexity.
7. We are willing to learn, to shape our approach to oversight as we move through the year and use this to inform national thinking on the best approach.
8. We are able to be honest when things have not worked well and operate with mutual accountability.
9. We will respect the different perspectives, responsibilities and accountabilities of individuals and organisations.

Identification of Support Needs

	Segment description		Scale and nature of support needs
	ICB	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver on the statutory and wider responsibilities of an ICB are well developed	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective ICB Plans that have the support of system partners are in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in the capability and capacity required to deliver on the statutory and wider responsibilities of an ICB	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

- To provide an overview across systems, inform oversight and target support, NHSE NE&Y have allocated ICBs & trusts to one of four ‘segments’ for 2022/23.
- Segmentation decisions are determined by assessing the level of support required based on a combination of objective criteria and judgement.
- For individual trusts, NHS England and relevant ICB will together discuss segmentation and any support required.
- NHS England will be responsible for making the final segmentation decision and taking any necessary formal enforcement action.

Mandatory Support

- ICBs and trusts allocated to segment 1 will benefit from the lightest oversight arrangements.
- Autonomy will be the default position with the expectation that ICBs and trusts will be allocated to segment 2.
- ICBs and trusts with significant support needs that may require formal intervention, will be placed into segment 3 or 4.
- They will be subject to enhanced direct oversight by NHS England (in the case of individual trusts in partnership with the ICB).

SOF Segment	NHS England will:	ICBs will
SOF 1 & 2	• Retains statutory accountability, but oversight delegated to ICB.	• Share actual or prospective changes in performance with NHS England in a timely manner.
SOF 3	• Lead and co-ordinate mandated support via regional team (SOF3) in partnership with ICB. • Work with an ICB or trust triggering a specific concern, involving system leaders and subject matter experts to identify factors behind issues and determine whether local support is available and appropriate. • Assess the seriousness, scale and complexity of the issues that the ICB, or trust is facing • Potentially re-evaluate the current allocated support needs segment.	• Play their role in addressing system-related causes or supporting system solutions identified in mandatory support packages. • Work in partnership with NHS England to co-ordinate and support interventions.
SOF 4	• Lead and co-ordinate mandated support via national Recovery Support Programme. (SOF4). • Work with an ICB or trust triggering a specific concern, involving system leaders and subject matter experts to identify factors behind issues and determine whether local support is available and appropriate. • Assess the seriousness, scale and complexity of the issues that the ICB, or trust is facing • Potentially re-evaluate the current allocated support needs segment.	• Play their role in addressing system-related causes or supporting system solutions identified in mandatory support packages. • Work in partnership with NHS England to co-ordinate and support interventions.

References

NHS England » NHS Oversight Framework 2022/23.

NHS England: A Shared Commitment To Quality
https://www.england.nhs.uk/wp-content/uploads/2021/04/nqb-refreshed-shared-commitment-to-quality.pdf

National Quality Board Guidance.
https://www.england.nhs.uk/ourwork/part-rel/nqb/nqb-publications-for-integrated-care-systems/

Our-Leadership-Way-Long.pdf (leadershipacademy.nhs.uk)

NHS England » Our shared ambition for compassionate, inclusive leadership

Humber and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

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Peter Reading
Chief Executive
Northern Lincolnshire and Goole
Hospital Trust

Peter.reading@nhs.net

16 November 2022

Re: Oversight of NHS Providers

Dear Peter

This letter outlines the roles and responsibilities of the Humber and North Yorkshire Integrated Care Board (HNY ICB) in relation to the oversight of NHS providers across Humber and North Yorkshire and how we plan to take forward the arrangements for the ICB.

You will be aware that the statutory establishment of ICBs, from 1 July 2022, placed clear responsibilities on ICBs for both the oversight and delivery of NHS priorities across its geography and that appropriate arrangements are in place to ensure the effective oversight of the work of providers in its area.

We attach the recently published *NHS England Operating Framework* and a slide deck that summarises the key elements of the NHSE Oversight Framework for 2022/23. We would like to draw your particular attention to the following areas:

- **NHS England Operating Framework – Page 15**
  This outlines the respective roles of NHSE, ICBs and individual providers.

- **Slide Deck – Slide 6**
  This highlights the lead role of the ICB in ensuring the oversight of the work of providers and working with NHS England for providers in SOF 3 and 4.

The HNY ICB System Oversight and Assurance Group (SOAG) will have oversight of this work, with overlap to the work of the Finance, Performance and Delivery Executive Committee and the Quality Committee of the ICB.

Humber and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

The terms of reference for SOAG have recently been strengthened in the light of recent experiences and feedback from NHS England, with a core group established to ensure that the ICB effectively discharges this role.

We will work closely with you to ensure that any arrangements are not burdensome and add value, with an emphasis on mutual accountability and supporting sustained improvement while ensuring we drive efficiencies as much as possible.

This is an important area of work for HNY ICB and, whilst this year is a transitional year in terms of these arrangements, we are keen to put appropriate arrangements in place for HNY ICB as soon as possible, learning from our recent experiences with both NHSE and CQC.

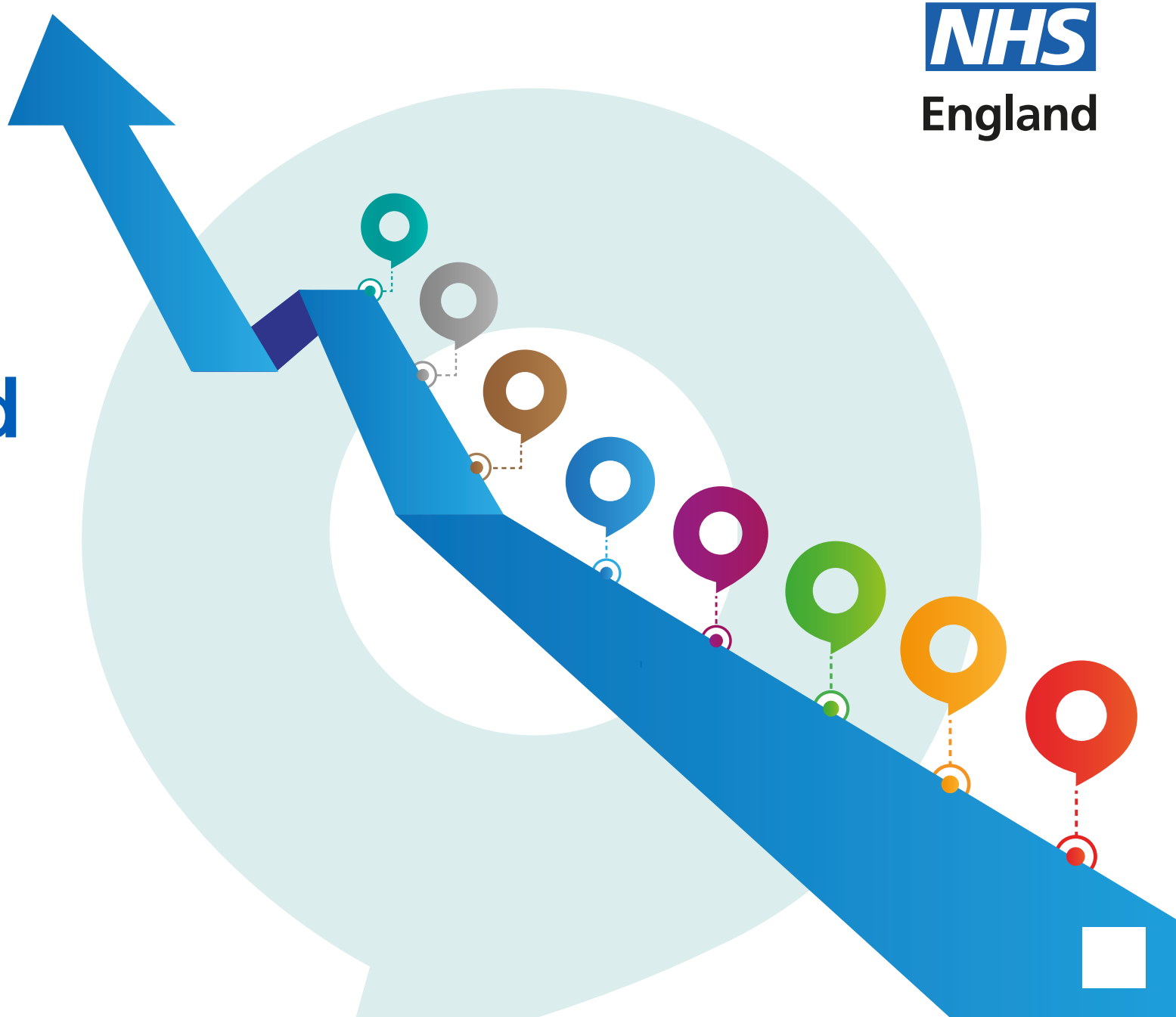
Yours sincerely

Amanda Bloor
Deputy Chief Executive and Chief Operating Officer
Humber and North Yorkshire Health and Care Partnership

Shaun Jones
Humber and North Yorkshire Interim Locality Director
NHS England– (NE and Yorkshire)

Operating framework

for NHS England



Contents

Introduction

- **On 1 July 2022, Integrated Care Systems (ICSs) were placed on a statutory footing.** This brought together the different partner organisations within an ICS – across the NHS and local government, working with the Voluntary, Community and Social Enterprise sector and other partners – to better integrate services and take a more collaborative approach to agreeing and delivering ambitions for the health and wellbeing of their local population.
- The establishment of ICSs and the new statutory framework, means that **NHS England is changing the way that we work (our operating framework) to best empower and support local system partners to deliver on their responsibilities.** This requires a cultural and behavioural shift towards partnership-based working; creating NHS policy, strategy, priorities and delivery solutions with national partners and with system stakeholders; and giving system leaders the agency and autonomy to identify the best way to deliver agreed priorities in their local context.
- As NHS England, **we will focus on what we are uniquely placed to do as a national organisation, increasingly using our resources to provide practical support to colleagues within systems**, in order to deliver on the commitments outlined in the NHS Long Term Plan annual planning guidance, the mandate from government and our statutory responsibilities. We will continue to agree the mandate with government, with input from Integrated Care Boards (ICBs), and then support systems to deliver their part of this. Whilst many of the formal powers and accountabilities that we (or our predecessor national bodies) have held historically will remain broadly the same, it is how we deliver these – the behavioural change - that will be the fundamental difference in future.
- **This document sets out in more detail how we will work as NHS England and with systems.** It outlines our purpose and behaviours, how we will add value, our medium-term priorities and the accountabilities and responsibilities of the different organisations in the NHS, as well as how we will work with our partners across the health and care system. It will inform how we develop as an organisation in order to become more agile and reduce duplication and help the NHS to deliver the priorities identified within the NHS Long Term Plan alongside the actions needed to respond to the pandemic and wider pressures. Regions have been working with their systems to develop ways of working with and in each system to align with the overarching principles of our operating framework and it is intended that this document should further support this. We will continue to evaluate and refine our framework as we implement it.
- **The operating framework will be a key input into the design of the new NHS England.** This will be further developed alongside the operating models and statutory responsibilities of our new partners, Health Education England and NHS Digital, as part of the new NHS England change programme.

What is an operating framework

What is our NHS England operating framework?

- Our operating framework sets out "**how we do things around here**" – the ways of working that will enable us to deliver our purpose. We previously referred to this as our 'operating model' but have changed to 'framework' as it sets out the parameters for how we will work in NHS England.

- There are four core foundations to our new operating framework, these include our:
  Purpose – why we are here
  Areas of value – how we deliver value
  Leadership behaviours and accountabilities – how we work
  Medium-term priorities and long-term aims – what we are working to achieve.

- These foundations in turn underpin how our organisation will be designed and how decisions will be made.

- **The focus of this document is on the core foundations of our operating framework and their influence on the structures and our approach to change.**

Why do we need to change?

- **The changes to our operating framework are part of a cultural reset for the NHS, to reflect the change to system-based approaches to improvement and stronger partnership working.**

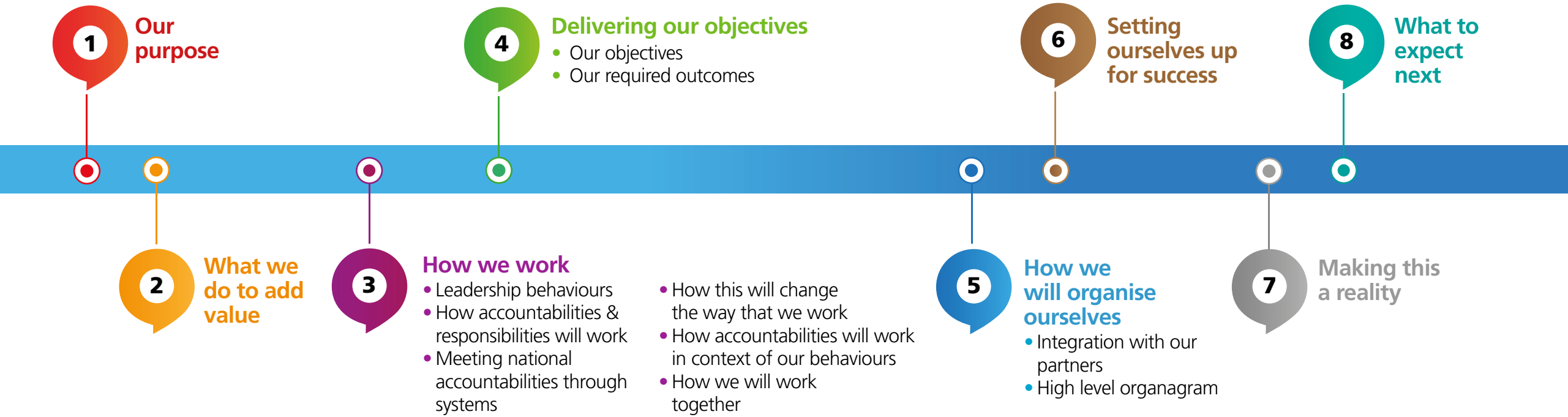
- There are two main reasons for the change:
  1. The need to work and behave differently following the establishment of ICSs and the new statutory framework.

  2. The proposals to create a new organisation by bringing together NHS England, Health Education England and NHS Digital. This will require us to develop a new culture and structural design. We have established a new NHS England change programme to deliver this, with the operating framework a key part of that programme, alongside the operating models and statutory responsibilities of Health Education England and NHS Digital.

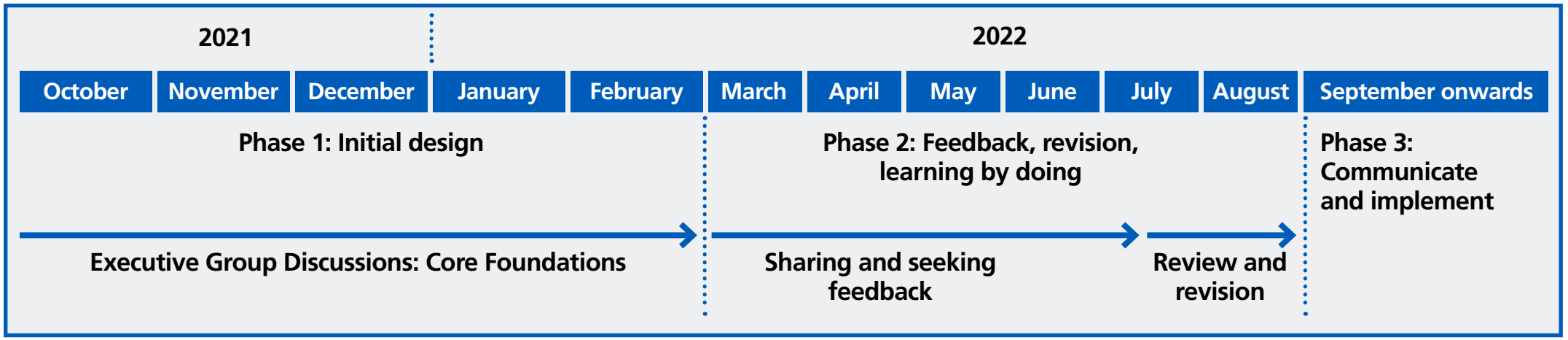
An update on our progress towards developing an operating framework for the new NHS England

To support the changes made in legislation on 1 July 2022, we have been working together as an organisation and with our partners to clarify our role in the new system and how we best deliver our objectives. This document aims to share what we have described to date and work that is yet to be done. Some of these elements, for example, our purpose, have been agreed alongside our new partners Health Education England and NHS Digital, whilst other elements need to continue to be developed together as part of the new NHS England change programme, for example, our behaviours.

The illustration below shows how many elements of our high level operating framework have developed and what we need to do next. **Further detail on each element can be accessed by clicking on the topic of interest.**



Our work to date



- The development of the core foundations of the NHS England operating framework began in 2021, through a series of NHS England and NHS Improvement Executive Group sessions as well as discussions with NHS England and NHS Improvement, Health Education England and NHS Digital Board members.
- In March 2022, we began to seek wider input and have run engagement sessions with almost 300 colleagues both within our organisation and with ICB leaders, provider leaders, local government colleagues and other partners, to capture feedback and refine the operating framework for the new NHS England, supporting the principles of co-creation, inclusivity and collaboration.
- We are now entering the implementation phase, which will focus on embedding these ways of working in all our activities, learning as we are doing this and refining our operating framework further as is needed.
- The operating framework core foundations will be a key input into the design of the new organisation, through the integration of NHS England, Health Education England and NHS Digital.

1. Our purpose

To lead the NHS in England to deliver high-quality services for all.

We will achieve this purpose by:

- **enabling local systems and providers** to improve the health of their people and patients and reduce health inequalities;
- **making the NHS a great place to work**, where our people can make a difference and achieve their potential;
- **working collaboratively** to ensure our healthcare workforce has the right knowledge, skills, values and behaviours to deliver accessible, compassionate care;
- **optimising the use of digital technology, research and innovation**; and
- **delivering value for money.**

Our purpose statement, provides clarity on **what NHS England is seeking to achieve**, this drives both 'what' we do (how we add value and what our priorities are) as well as 'how' we operate (our values, behaviours and accountabilities, and structures). The purpose statement is agreed between NHS England, Health Education England and NHS Digital and will continue to drive our organisation as part of the new NHS England change programme.

2. What we do to add value

To achieve our purpose, we need to be clear on how we, as NHS England, can deliver value to support the wider health and care system. At NHS England, we will focus our activities on eight key ways that we are uniquely placed to add value. Our organisation; **(1) Sets direction; (2) Allocates resources; (3) Ensures accountability; (4) Supports and develops people; (5) Mobilises expert networks; (6) Enables improvement; (7) Delivers services;** and **(8) Drives transformation.**

1: Set direction

- Develop and set national policy and strategy
- Manage relationship with government
- Agree the mandate with government, coordinating input from ICBs
- Determine NHS priorities, subject to the mandate
- Provide thought leadership and subject matter expertise for national priorities
- Provide leadership on NHS contribution to reducing health inequalities

2: Allocate resources

- Work with partners to develop strategy and plans to ensure we have the right workforce capacity across the NHS
- Lead on national workforce innovation
- Set financial structures and incentives
- Be responsible for financial stewardship of the NHS
- Contribute to the UK economy

3: Ensure accountability

- Define accountability structures
- Set standards for performance
- Monitor, assure and hold to account for performance on quality, finance and access
- Assure direct commissioning
- Provide support, guidance and oversight in relation to information processing
- Perform health protection functions

4: Support and develop people

- Establish our leadership culture
- Role model our culture and behaviours
- Create the conditions for a fully inclusive and diverse NHS
- Deliver workforce, training and education functions of Health Education England
- Ensure we have a structured approach to identify leadership talent and support their development

5: Mobilise expert networks

- Bring together expert knowledge to support service improvement
- Support delivery of improved outcomes and provide benchmarks for services
- Enable the spread of best practice
- Secure access to new tests, products and treatments
- Manage relationships across national and professional bodies
- Enable and support the development of systems and ICBs

6: Enable improvement

- Support delivery of quality and operational performance improvement
- Deploy resources to support challenged organisations and systems where required
- Perform regulatory intervention when required and run the Recovery Support Programme
- Provide national services to improve quality or reduce cost

7: Deliver services

- Drive the digital agenda
- Provide specific data and analytics services
- Offer centralised commercial and procurement support
- Commission a number of services directly

8: Drive transformation

- Support delivery of medium-term priorities (e.g. secondary prevention and earlier diagnosis)
- Drive development of key enablers of transformation (for example, digital; diagnostic infrastructure)
- Create the environment for innovation and transformation, including partnership with life sciences industry
- Lead the NHS's contribution to population health and prevention

How each of the component parts of NHS England support Integrated Care Systems and providers in their roles

Regions

- Set direction
- Allocate resources
- Ensure accountability
- Support and develop people
- Enable expert networks
- Enable improvement
- Deliver services
- Drive transformation

- Act as the main voice to ICSs and the primary interaction between NHS England and systems
- Translate national strategy and policy to fit local circumstances, ensuring local health inequalities and priorities are addressed
- Agree 'local strategic priorities' with individual ICSs
- Provide oversight to ICBs and agree oversight arrangements for place-based systems and organisations
- Develop leadership within ICBs and providers
- Within national frameworks, determine the 'how' of delivery to achieve outcomes and expectations to reflect local populations, workforce, service structures and digital capabilities
- Develop mechanisms for systematically collating and sharing good practice and lessons learnt
- Manage regional level relationships including, regional government
- Provide support to ICSs to enable delivery

Integrated Care Systems and Providers

National Programmes

- Set direction
- Allocate resources
- Ensure accountability
- Support and develop people
- Enable expert networks
- Enable improvement
- Deliver services
- Drive transformation

- Create the evidence based strategy for transformation
- Act as a central hub of subject matter expertise that can be drawn down
- Articulate the value of change and suggest the most appropriate approach to implementation
- Help ensure national funding is aligned with agreed goals and develop a national approach to resource deployment
- Set expectations and guidance on data standards so that we can measure progress consistently and coordinate a national view
- Ensure people implications are considered
- Manage the programme specific relationships with external stakeholders, e.g. professional bodies, arms length bodies and national charities
- With regions, facilitate supportive interventions to improve performance and outcomes
- Embed digital and data in our programmes
- Develop guidance to support front line services in transforming services

Integrated Care Systems and Providers

Corporate functions

- Set national strategy, priorities and incentives to improve standards of care and reduce unwarranted variation and create the conditions for a fully inclusive and diverse NHS
- Lead and represent the NHS with Government, and nationally with partners and the public
- Work with government to ensure the NHS has the resources it needs, and allocate resources
- Set national frameworks including the Financial Framework; System Oversight Framework; People Plan; Digital maturity expectations etc.
- Account to HM Treasury and Department of Health and Social Care for delivery, performance and mandate progress
- Foster strategic relationships across national arms length bodies, royal colleges and professional bodies
- Foster productive relationships with trade unions and professional bodies, and lead contract negotiations for primary care providers
- Trigger regulatory intervention when required and run the Recovery Support Programme
- Provide technology architecture and policies, operate backbone systems, set minimum standards (for example, in cyber security and privacy) and promote interoperability and reuse
- Directly commission certain services

Set direction

Allocate resources

Ensure accountability

Support and develop people

Enable expert networks

Enable improvement

Deliver services

Drive transformation

Integrated Care Systems and Providers

3. How we work

Leadership behaviours

To deliver our purpose in the context of system-working will require a new approach not just to 'what' we do but in 'how' we do it. We have set out on the right **12 leadership behaviours** aligned to six key values linked to the NHS Constitution, which can act as a guide for our interactions. **As part of the new NHS England change programme between NHS England, Health Education England and NHS Digital, we will work to develop a shared set of behaviours for the new organisation.**

By consistently living these behaviours we aim in the new NHS England to:

- **Work as 'one team' across the NHS (ICBs, providers and NHS England) with our partners, being collaborative and empowering each other** – but also being clear about who is accountable for what.
- **Seek co-creation and co-ownership** of our strategy, priorities and support offers – both within the NHS team and with partners - and demonstrate collaborative leadership.
- **Be inclusive and value diversity** – make sure that no one feels excluded and listen to all perspectives.
- **Work at pace when appropriate and be agile** – streamlining how we make decisions, avoiding duplication and multiple layers where we can.
- **Learn by doing** – acting, evaluating and continuously improving.
- **Be transparent and honest** – in all our interactions and activities.

Working to improve lives

1. **Driven by the people and communities we serve**
2. **Focussed on clear outcomes**

We are inclusive - everyone counts

3. **Inclusive and diverse**
4. **Collaborating, co-producing, co-owning, being a great partner**

Working as one team

5. **Accountability to role and team**
6. **Trusting and empowering each other**

Getting things done

7. **Working at pace when appropriate, with agility and courage**
8. **Being ambitious and can-do**

Learning and improving

9. **Learning by doing, cycles of change**
10. **Data-driven and evidence-based**

Compassion and respect

11. **Hard on problems and supportive of people**
12. **Transparent, honest and authentic**

How accountabilities and responsibilities will work

The tables below set out the **accountabilities and responsibilities for NHS England, ICBs and providers given the changes to legislation and shift to system based working*.** Whilst this sets out a form of hierarchy, we expect ways of working to be agreed locally so that collaboration is at the fore of transformation in systems.

	NHS Providers	Integrated Care Boards	NHS England
Accountability (What do they need to deliver?)	• Statutory responsibilities for safe, effective, efficient, high-quality services • Effective system working and delivery of their contribution to ICS strategies and plans • Financial performance and requirements set out in NHS planning guidance, including quality and access • Compliance with provider licence, Care Quality Commission standards • Reducing unwarranted variation, especially through collaboratives (collaboratives can support and enable the delivery of some of these accountabilities and responsibilities).	• Effective system leadership which balances immediate and longer term priorities • Overseeing NHS delivery of these strategies and plans, ensuring progress toward and achievement of objectives for annual planning and Long Term Plan priorities. • Overseeing the budget for NHS services in their system. • Ensuring delivery of the ICB core statutory function of arranging health services for its population and compliance with other statutory duties • Work with local authorities to act as the stewards of local population health outcomes and equity.	• Use input from ICBs, providers and their partners to agree the mandate for the NHS with government and secure required resources • National NHS performance and transformation as set out in NHS mandate and constitution • National and regional NHS contribution to effective system working and delivery • Foster relationship and alignment with government • Stewards of the NHS • Set strategy for the future • Foster productive relationships with partners and major stakeholders.
	Joint plans/contracts		Memorandum of understanding

*This does not capture the full accountability framework for ICSs. The purpose of this document is to set out the operating framework for NHS England and therefore accountabilities and responsibilities are focused on NHS partners.

NHS Providers	Integrated Care Boards	NHS England
Accountability (Who do they 'account'/provide assurance to?)		
Operationally within the NHS: • ICBs for 'business as usual' delivery of services and performance and their agreed contribution to the system strategy & plan • NHS England national commissioners of specialised services • NHS England as regulator (with associated statutory powers) - by escalation/ exception or agreement with ICB • Care Quality Commission for leadership, quality and safety of services. **Locally:** • People, communities and service users; all ICS partners; Foundation Trusts to Board of Governors (and members).	**Operationally within the NHS:** • NHS England, via Regional Directors – including for delivery of the outcomes and priorities expressed in the Joint Forward Plans • NHS England, as regulator (with associated statutory powers) • Care Quality Commision as part of ICS (not as individual organisations) for leadership, quality, safety and integration of services. **Locally:** • People, communities and service users.	• Parliament, via the Secretary of State • People, communities and service users.

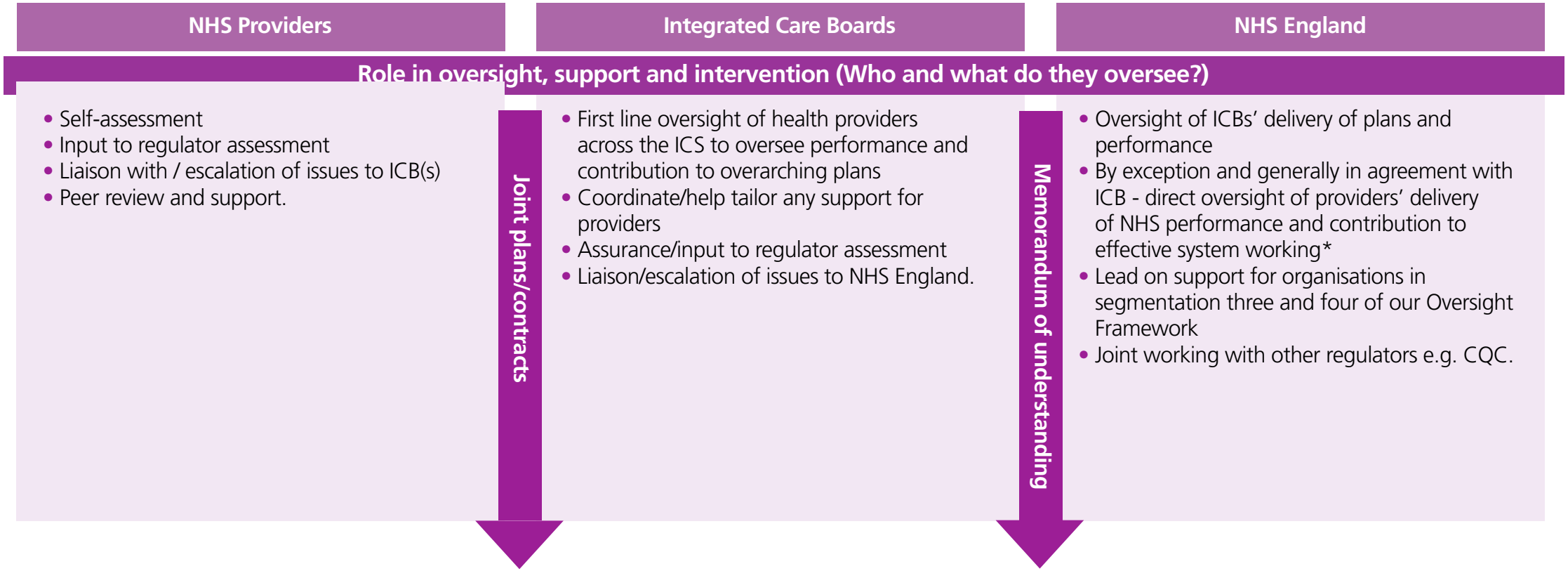
Joint plans/contracts

Memorandum of understanding

NHS Providers	Integrated Care Boards	NHS England
Roles (What is done day-to-day?)		
• Delivering services • Setting organisational strategy and plans • Education and training • Monitoring and improving service performance and finance • Working with system partners to deliver wider ICS strategies, plans and shared functions • Research and innovation.	• Working with partners to set system-level strategy and plans • Working with partners to ensure effective arrangements in place across system for joint working to deliver plans, performance, outcomes and transformation • Commissioning, agreeing and managing contracts, delegation and partnership agreements with providers and primary care • Contribute to long term workforce planning • Help inform national goals and mandate • Delivery of Integrated Care Partnership strategies and joint 5 year forward plan.	• Shaping and setting national policy, strategy, plans and priorities for the NHS in England, including in collaboration with ICBs • Providing support for systems and providers to achieve those priorities, including statutory intervention if required • Delivering 'shared services' to the NHS • Providing national oversight and assurance of NHS delivery and performance • Ensuring NHS organisations work effectively with partners at system and place base level.

Joint plans/contracts

Memorandum of understanding



*Detailed agreement on working arrangements between ICBs and NHS England to be set out in Memorandums of Understanding.

NHS Providers	Integrated Care Boards	NHS England
Specific legal powers in relation to other bodies (Formal or statutory functions)		
• In relation to other providers and partners, as per contracts, delegation and joint working agreements • Agree joint 5 year forward plan and joint capital plan with partner ICB.	• In relation to providers and partners, as per contracts, delegation and joint working agreements • Agree joint 5 year forward plan and joint capital plan with partner trusts.	• Appoint ICB and trust (not Foundation Trust) chairs and Chief Executive Officers • Establish and annually assess each ICB, agree its constitution and any changes to this and determine its allocations • Set financial objectives for systems • Conduct annual assessment of each ICB • Determine the need for enforcement action with respect to ICBs and providers aligned with Oversight Framework and Enforcement Guidance. Interventions with providers will happen with the awareness of the relevant ICB.

Joint plans/contracts

Memorandum of understanding

Meeting national accountabilities through systems

How will we meet national accountabilities?

- **ICBs are responsible for developing and overseeing the implementation of joint strategies and plans with their partners to meet national commitments**, as well as any additional local priorities for health service, social care and public health improvement that are agreed within each ICS strategy and ICB/provider joint forward plan.
- **Individual providers are responsible for delivering safe, effective, efficient, high quality services in line with universal required standards and commitments, their statutory duties and their contracts and agreements with ICBs and NHS England**, and for delivering any agreed wider contribution to implementing the Integrated Care Partnership strategy and joint-forward plan.
- **NHS England is responsible for supporting ICBs, NHS providers and their local partners** to deliver their plans and make their full contribution to the ICS strategy, and for intervening if the NHS's national commitments are at risk or are not being met. NHS England's approach to supporting performance improvement and delivery (for the purposes of improved health of local populations) will be to set clear objectives, ask system and provider leaders to identify how they will best achieve them in their local context and provide or facilitate access to support where needed to address particular challenges. Solutions and support will draw on evidence of best practice and root-cause analysis, with NHS England contributing as a system partner alongside other local stakeholders.
- **NHS England is also responsible to Parliament for NHS performance and has regulatory powers supporting this**. Therefore, while we will not determine the day-to-day working relationships between leaders, it is important to be clear on the formal accountability lines between NHS organisations under the new arrangements. These regulatory powers include the ability to intervene and direct both ICBs and NHS providers that are failing or at risk of failing to meet required standards or perform their functions and duties.

NHS Oversight Framework

- Our national approach to ongoing monitoring of progress and performance against universal NHS standards and commitments and agreed local priorities, for identifying support needs and intervening to secure improvement when required is set out in the **NHS Oversight Framework**.
- The arrangements for applying this within each ICS area will be agreed and set out in a **Memorandum of Understanding** between each ICB and the relevant NHS England regional team, alongside other details of their agreed ways of working. This will provide clarity of oversight arrangements for each provider, avoiding duplication.

How this will change the way that we work

Many of the formal powers and accountabilities that NHS England (or our predecessor national bodies) have held historically remain broadly the same. It is how we deliver these that will be different – some examples of how we will work are outlined on the right, with specific illustrations of the change on the next page.

- **Proportionate and streamlined:** ICBs and NHS England will ensure oversight and performance management arrangements within their ICS area are proportionate and streamlined, and do not create duplication or unnecessary bureaucracy and reporting requirements for providers.
  - NHS England will describe a single set of national priorities, and metrics to track performance against them, in the Oversight Framework and will oversee this through a single mechanism.
- **Devolved:** For both ICBs and their partner NHS providers the primary relationship with NHS England will be through the relevant regional team.
  - Where national teams need to interact directly with ICBs and NHS providers, this will be done in conjunction with the relevant regional team, to ensure interactions are coordinated.
  - The arrangements between regional teams, ICBs and providers will be agreed locally, and set out in the Memorandum of Understanding. This will be discussed and agreed by all partners in the ICB and will be clearly communicated to partners in the system.
- **No surprises:** relationships between NHS England, ICBs and providers will be mature, respectful and collegiate, underpinned with effective lines of communication and a 'one team' philosophy, so there are 'no surprises' regarding the actions of each party.
- **ICB annual assessments:** NHS England has a duty to annually assess ICBs across a number of domains. The first annual assessment of ICBs will be completed in Q1 23/24 and will use a variety of evidence, but a key part of the process will be ICB self-reflection and dialogue between the ICB and NHS England over the course of the year.

How accountabilities will work in context of our behaviours

Below are examples to illustrate how activities might change as part of the new approach. They show how many of the formal powers and accountabilities remain the same, but how we implement them will be different. It is worth noting that how responsibilities and roles are applied will depend on the circumstances and there will need to be some exceptions to the general rule as we implement the new approach and learn as we go.

	From	To
Appointment of Foundation Trust Chair	Accountability and powers: **Trust Governors** Trust Governors have responsibility for appointing the Chair. The appointment process may or may not include external stakeholders.	Accountability and powers: **Trust Governors** Trust Governors continue to have responsibility for the appointment. The appointment processes should consistently seek the views and input of relevant partners, such as ICB leaders (e.g., ICB chair).
Oversight Framework Segmentation (Provider)	Accountability and powers: **NHS England** Oversight of providers carried out by NHS England regional teams and decision on segmentation and support requirements made by NHS England.	Accountability and powers: **NHS England** NHS England will remain accountable for decisions on segmentation and mandated support for providers. NHS England regional teams will oversee ICBs and work with them to advise on provider segmentation decisions. ICBs will lead on oversight of providers and work with NHS England regional teams if support is required at SOF 3. NHS England regional and national teams will lead on support and intervention at SOF 4.

Behaviours

- **Collaborating, co-producing, co-owning, being a great partner.**
- **Accountability to role and team.**
- **Trusting and empowering each other.**
- **Hard on problems and supportive of people.**

How we will work together

Within NHS England, some roles will increasingly focus on providing practical support to colleagues within systems.
The table below outlines at a high-level how different parts of our organisation will function.

Regions	National programme teams	NHS England corporate functions
Focus and ways of working		
Regions will act as the coordinating point between NHS England and systems and the point of access to tailored support and advice. • The central focus of regional teams will be to support local system partners to implement their plans. • Regions will bring together multi-disciplinary teams to inform and co-develop national strategy and policy, working with systems to reflect local realities. They will translate national strategy and policy to fit local circumstances and ensure this addresses local health inequalities and priorities. • Regions will need to work with their systems to develop the ways of working within their region to align with the overarching principles of this operating framework.	**NHS England programme teams will work with and through regional teams to:** • Co-create the evidence based strategy for transformation and improvement for their programme; • Agree expectations on outcomes with and through regions; and • Provide the subject matter expertise that systems can use to support implementation and provide intensive improvement support if needed. We are currently reviewing the national programmes that will form part of the new NHS England in order to streamline activities to ensure more effective coordination and interaction both across NHSE and with systems.	**Regions and programme teams will in turn be supported by NHS England corporate functions.** • These teams will set the overarching strategy, standards and incentives which enable the whole NHS to focus on its core priorities, ensuring support and guidance offered to the system is coherent. There will continue to be things that are best done 'once', such as ensuring the NHS has the staff it needs, modernising how we use technology and data to improve population health and access and NHS-wide campaigns. • Internal corporate support will provide a range of internal advice and support services for the new NHS England, for example, communications and engagement, finance, commercial, governance and legal, HR, estates, corporate social responsibility, corporate IT and internal strategy.

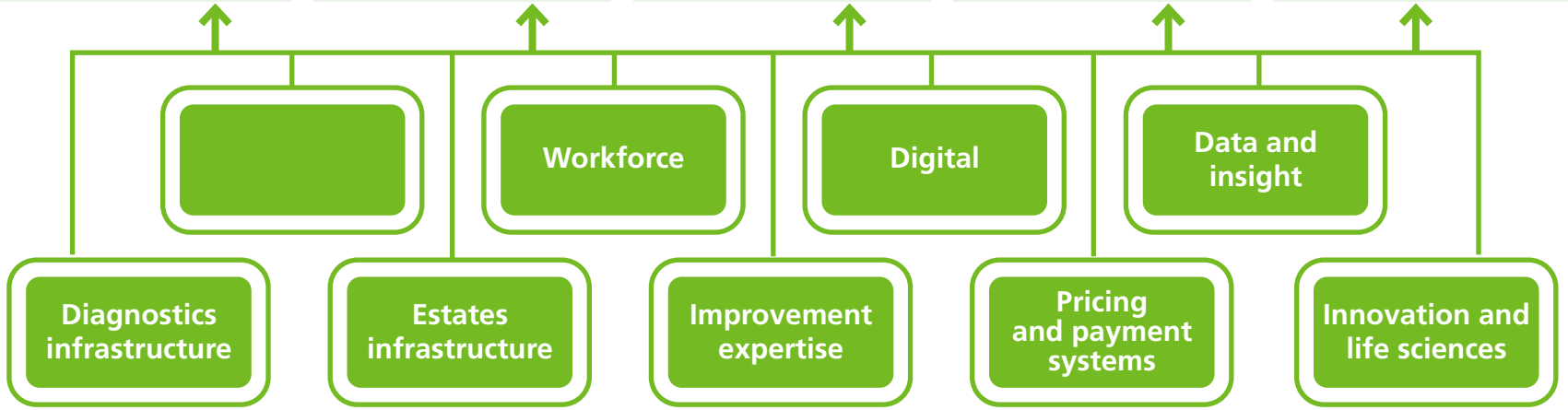
For both ICBs and their partner NHS providers, the primary relationship with NHS England will be through the relevant regional team. National teams will only work directly with ICBs and individual providers to request information or plans, or to offer or mandate support, by agreement with the relevant regional team (other than in exceptional circumstances).

4. Delivering our objectives

Our objectives

In order to deliver our purpose and value-add for the health and care system, **we have set out on the right five transformational priorities for the medium-term (next 3-5 years).** Agreeing medium-term transformational priorities represents a shift in how we operate and will enable us to focus on interim objectives to help frame and achieve our long-term goals. This will also enable us to more effectively address the challenges we face today.

1. STOP avoidable illness & intervene early	2. SHIFT to digital and community	3. SHARE the best	4. STRENGTHEN the hands of the people we serve	5. SUPPORT our local partners
I take responsibility for my own health and I am supported to stop myself becoming unwell whenever possible.	When I need it, I get the right care in the right place and I don't have to wait too long.	I always get the best of the NHS wherever I am cared for – and I get good value for my money as a taxpayer.	I am involved in all decisions about my treatment and care and am more in charge of my own health.	Everyone works together in my local community to make things better, with me in mind.



The medium-term priorities are underpinned by nine key enablers, which support delivery of each priority.

Each of the five medium-term, transformational priorities contribute to delivery of our urgent priorities and our long-term aims, as illustrated below. As part of embedding these priorities in our activities, measurable outcomes will be aligned to each so that we can monitor delivery over time.

1. **STOP** avoidable illness & intervene early	2. **SHIFT** to digital and community	3. **SHARE** the best	4. **STRENGTHEN** the hands of the people we serve	5. **SUPPORT** our local partners
I take responsibility for my own health and I am supported to stop myself becoming unwell whenever possible.	When I need it, I get the right care in the right place and I don't have to wait too long.	I always get the best of the NHS wherever I am cared for - and I get good value for my money as a taxpayer.	I am involved in all decisions about my treatment and care and am more in charge of my own health.	Everyone works together in my local community to make things better, with me in mind.

Examples of actions we take to support urgent priorities

- Take action to avoid unnecessary illness and stop conditions escalating now. This should improve access to Urgent and Emergency Care services and outcomes for patients.
- Take action to decompress the acute system now, which should help release acute capacity to support improvements to patient flow.
- Take action to adapt and adopt best practice to improve consistency of care now.
- Take action to provide patients with the information they need to choose the right care in the right place.
- Take action to ensure the successful establishment of new ICSs now.

Examples of actions we take to ensure we keep building towards the long-term

- Work with partners to build expertise & capability in delivering prevention and early intervention, using personalised approaches focused on inequalities.
- Work to build out of hospital capacity and different models for the longer-term.
- Work to build greater standardisation by embedding best practice and separation of urgent and elective care at scale.
- Work to create a fundamental shift in the balance of power to give people more control in shaping their own health and care, enabled by technology and data.
- Work to build strong and sustainable local systems and partnerships.

Our required outcomes

Our six longer-term aims

- **Longer healthy life expectancy**
- **Excellent quality, safety and outcomes**
- **Excellent access and experience**
- **Equity of healthy life expectancy, quality, safety, outcomes, access and experience**
- **Value for taxpayers' money**
- **Support to society, economy and environment**

5. How we will organise ourselves

Integration with our partners

- **The proposed merger of NHS England, Health Education England and NHS Digital on 1 April 2023, provides a unique opportunity to create a 'new' NHS England,** putting workforce, data, digital and technology at the heart of our plans to transform the NHS.

- This operating framework will be a key input into the design of the new combined organisation. **The new NHS England change programme will seek to use the principles of the operating framework to ensure the new organisation maximises the potential of our move to system working; streamlining what we do nationally to give systems the space to lead and ensuring we focus our efforts on what we are uniquely placed to do at a national level.** This will include being clear on interdependencies between regional and national functions in order to deliver our accountabilities.

- Part of our commitment in the creation of a new NHS England is to develop a new culture for the organisation, supported by a set of behaviours which we will co-develop and refine as part of the integration process.

High level organogram

At the top level, the proposed design for the new NHS England will integrate Health Education England and NHS Digital with the NHS England structure, with clear national, regional and internal accountabilities. The top level structure is shown below. Our regions will continue to hold the primary relationship with systems, supporting delivery of priorities locally as well as influencing national policy development by providing local context input.

You can find our latest organogram here.

NHS Chief Executive - Amanda Pritchard

National Directorates

National teams from across the organisations will come together to deliver the core functions of the new NHS England through 10 Directorates.

Commercial | Delivery | Finance | Medical | Nursing | Operations | Strategy | Transformation | Vaccinations | Workforce, Training and Education

Programmes

Programmes will be consolidated and operate through more streamlined delivery models, facilitated through greater central coordination

Internal Corporate Support

Internal corporate services (for example, Finance, HR, Estates) will be integrated across the three organisations. Support will be delivered through a blend of shared and directorate-aligned functional teams.

Regional Teams

Regional teams from NHS England and Health Education England will be integrated and seven regions will remain. Regions will look for opportunities to transfer more accountabilities to ICB level.

East of England | London | Midlands | North East & Yorkshire | North West | South East | South West

6. Setting ourselves up for success

We have developed a common framework and discipline for how we approach change programmes in NHS England. As part of our development of the operating framework our Executive identified five components to ensure that these change programmes are successful. We engaged with stakeholders to refine this as part of the operating framework conversations. The output of this is outlined below. The impact of this approach is multiplicative, if one of the five components is zero then the net effect is zero. **We will aim to consistently embed these into our change approaches in future.**

1. Clear direction, priorities and measures of success

- An inspiring goal that puts mission first
- Short-term, medium-term and long-term ambitions, goals and strategy
- Sharp prioritisation and focus ("if everything is a priority then nothing is")
- Clarity in advance on measures of success and expected benefits

.

2. The right leadership and people

- Excellent system leaders
- Co-development with residents, partners and key stakeholders
- Visible clinical leaders with ownership
- Diversity of perspectives
- Design by those who will deliver
- Clear accountabilities
- The right supporting talent
- The right ethos and behaviours

.

3. The right tools, support and resources

- Hyper-local/highly granular data and analytics
- An enabling structure/ subsidiarity/ local ability to act (and authority at level of accountability)
- Improvement skills and resources
- Deliberative engagement with service users
- Digital enablers
- The right culture and tone
- Adequate financial resources

4. Aligned incentives and consequences

- Aligned payment systems/ clear consequences for resources
- Aligned "soft" incentives (e.g., what the culture values)
- Mutually supporting agendas with non NHS partners
- Courage to confront issues of both performance and behaviour

.

5. Effective monitoring, learning & course correction

- Excellent data on progress
- Excellent monitoring processes
- Effective feedback mechanisms and transparency of data to enable sharing of best practice
- Limited "performance management overhead"
- Use of real time learning to course correct and adapt
- Intensive expert support available if required.

7. Making this a reality

We have set out the foundations of our ways of working for the new NHS England; **we now need to consistently embed these ways of working in all our activities and interactions.**

There are a number of objectives that we will implement through the new NHS England change programme:

1. **Doing what only we can do and focusing on how we deliver value**
2. **Adding value at the right place**
3. **Providing a single voice and clearer interactions with the system**
4. **Adapting ourselves to support the development of ICSs**
5. **A simpler and better coordinated organisation**
6. **Integrating the wisdom of frontline services in everything we do**

It will take time to implement these changes and there will be a programme of work to support this over the coming years.

8. What to expect next

- **We have started a programme of work to enable us to deliver our immediate next steps and objectives as part of the new NHS England change programme.** These actions will take place over the coming year ahead of the organisations coming together on 1 April 2023 to form the new NHS England, subject to Parliament's approval of the necessary regulations.
- Whilst the formal merger will take place on 1 April 2023, further work will continue into 2023/24 as we implement an organisation design programme to transform our ways of working.
- This will enable us to add further detail to this document and to develop the operating framework for the new NHS England with Health Education England and NHS Digital, some of which we will start to put into practice before the merger date as we work closely together with our partners. Key amongst these will be in the development of the four high impact areas of cross-cutting design and a revised Executive governance meeting structure.
- An Organisational Development and Transformation programme will be established to support this beyond the merger date, recognising these changes will take time.
- We will evaluate this over time, collaboratively and in partnership with system leaders and stakeholders.

The NHS England operating framework: the foundations

NHS England

1 Why we are here — To lead the NHS in England to deliver high-quality services for all

2 What we do to add value

Set direction	Allocate resources	Ensure accountability	Support and develop people	Mobilise expert networks	Enable improvement	Deliver services	Drive transformation
• Policy and strategy • Relationship with government • Agree mandate • Set annual planning guidance and priorities • Provide leadership.	• Plan workforce strategy with partners • Workforce innovation • Financial structures and incentives • Financial stewardship of NHS • Financial allocation.	• Accountability • Standards • Goals and expectations • Monitoring and assurance • Regulation • Health protection.	• Leadership culture and development • Culture and behaviours • Inclusion and diversity • Training and education.	• Expert knowledge and consensus • Outcomes • Benchmarks • Best practices • New products and services • National stakeholders • System development.	• Support improvement • Deploy improvement support • Intensive support • Regulatory intervention.	• Digital • Data and analytics • Commercial & procurement support • Direct commissioning.	• Medium-term priorities • Transformation enablers • Partner with life sciences • Population health and prevention.

3 How we do it

Leadership behaviours ▶ We are inclusive - everyone counts | Working as one team | Getting things done | Learning and improving | Compassion and respect

Accountabilities and responsibilities

Providers	ICBs	NHS England
• Statutory responsibilities for safe, effective, efficient, high-quality services • Effective system working and delivery of their contribution to ICS strategies and plans • Financial performance and requirements set out in NHS planning guidance, including quality and access • Compliance with provider licence, Care Quality Commission standards • Reducing unwarranted variation, especially through Provider Collaboratives.	• Effective system leadership which balances immediate and longer term priorities • Overseeing NHS delivery of strategies and plans, ensuring progress toward and achievement of objectives for annual planning and Long Term Plan priorities. • Overseeing the budget for NHS services in their system • Ensuring delivery of the ICB core statutory function of arranging health services for its population and compliance with other statutory duties • Work with local authorities to act as the stewards of local population health outcomes and equity.	• Use input from ICBs, providers and their partners to agree the mandate for the NHS with government and secure required resources • National NHS performance and transformation as set out in NHS mandate and constitution • Contribution to effective system working and delivery, including statutory intervention if required • Foster relationship and alignment with government • Stewards of the NHS • Set strategy for the future • Foster productive relationships with partners and major stakeholders.

4 What we need to achieve

Medium term objectives ▶ **STOP** avoidable illness and intervene early | **SHIFT** to digital and community | **SHARE** the best | **STRENGTHEN** the hands of the people we serve | **SUPPORT** our local partners

Outcomes

- **Longer healthy life expectancy**
- **Excellent quality, safety and outcomes**
- **Excellent access and experience**
- **Equity of healthy life expectancy, quality, safety, outcomes, access and experience**
- **Value for taxpayers' money**
- **Support to society, economy and environment**

* Partnerships between ICBs, NHS providers, local authorities and other partner agencies are now a core component of the NHS's operating framework and ways of working. NHS England will support NHS leaders to embed partnership working locally, and we will work with partners to support wider ICS development.

NLG(22)210

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	Tuesday, 6 December 2022	
Director Lead	Peter Reading, Chief Executive	
Contact Officer/Author	Peter Reading, Chief Executive	
Title of the Report	**Chief Executive's Briefing**	
Purpose of the Report and Executive Summary (to include recommendations)	To brief Board members on certain items of interest not covered elsewhere on the Board agenda.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

1. CQC inspection report

The Care Quality Commission (CQC) inspected the Trust (most but not all hospital services, and not community services) in June and July 2022. The report of this inspection is expected to be published on Friday, 2 December.

2. Industrial action

Following ballots by the two largest NHS trades unions (Royal College of Nursing (RCN) and UNISON), both have now confirmed that they did not achieve the legal threshold in NLaG in terms of votes in favour as a percentage of those entitled to vote, for them to call industrial action.

Two other organisations (Royal College of Midwives and Chartered Society of Physiotherapists) are currently balloting their members with respect to industrial action and the results of their ballots are expected in the next few weeks.

3. Oversight of NHS providers – new NHS England and ICB guidance

Humber and North Yorkshire Integrated Care ICB (HNY ICB) has issued new guidance summarising its proposed arrangements with respect to the oversight of providers, following the publication of the new NHS England Operating Framework.

Please see embedded documents below – covering letter from the Deputy Chief Executive of the ICB, the ICB guidance and the NHS England Operating Framework.

HNY.022 Letter to P Reading v2.pdf

20220722 -ENC C NHS Oversight 2022

B2068-NHS-Englan d-Operating-Framev

Peter Reading
Chief Executive
30 November 2022

NLG (22)211

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 6th December
Director Lead	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Medical Director Christine Brereton, Director of People
Contact Officer/Author	Shauna McMahon, Chief Information Officer
Title of the Report	**Integrated Performance Report (IPR)**
Purpose of the Report and Executive Summary (to include recommendations)	**1. Introduction** The IPR aims to provide the Board with a detailed assessment of the performance against the agreed indicators and measures and describes the specific actions that are under way to deliver the required standards. **2. Access and Flow** The executive summary of the Access and Flow section is provided over on page 4. **3. Quality and Safety** The executive summary of the Quality and Safety section is provided over on page 6. **4. Workforce** The executive summary of the Workforce section is provided over on page 8. **5. Appendix** a) Appendix A National Benchmarked Centiles b) Appendix B Extended Scorecards as presented to each respective Sub-Committee **6. The Trust Board is requested to:** a) Receive the IPR for assurance. b) Note the performance against the agreed indicators and measures. c) Note the report describes the specific actions which are under way to deliver the required standards.
Background Information and/or Supporting Document(s) (if applicable)	Access and Flow Quality and Safety Workforce
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable

Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Improving quality care and access.	
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

IPR EXECUTIVE SUMMARY	Date: November 2022

1. ACCESS & FLOW – Shaun Stacey

Highlights: (share 3 positive areas of progress/achievement)

- Cancer – Two Week Wait
- Percentage of Patients Discharged Same Day As Admission (excluding daycase)
- Inpatient Non-Elective Average Length of Stay

Lowlights: (share 3 areas of challenge/struggle)

- Number of Incomplete RTT Pathways
- Outpatient Did Not Attend (DNA) Rate
- Outpatient Overdue Follow Up (Non RTT)

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Number of Weeks Incomplete RTT Pathways	HIT Theatre commenced in October and planned throughout November.	HIT lists should mean more treatments and therefore more clock stops and hence a reduction in the number of patients on the RTT waiting list.
Outpatient Did Not Attend (DNA) Rate	Deep dive into DNA - Information reports in development to identify patients who persistently DNA/Cancel their appointment, adjustments to provide appointment window for nonf2f, identified clear links to DNA rate and depravation.	Decrease in DNA's should occur with further understanding of the reasons people DNA and the adjustments which can be made for these patients.
Outpatient Overdue Follow Up (Non RTT)	Working with Clinical Lead to meet with speciality clinical leads to agree a PIFU plan.	Increasing PIFU take up should reduce the overall waiting list size and therefore reduce the outpatient overdue follow ups.

2. QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

Highlights: (share 6 positive areas of progress/achievement)

- SHMI continues to be low and within expected range.
- Duty of candour remains achieved.
- There has been no hospital acquired MRSA bacteraemia for 2 years. To date there have been no lapses in care identified with C.diff cases.
- The number of reported falls per 1000 bed days has reduced for the second consecutive month.
- Hospital Acquired Pressure Ulcers - the number of reported pressure ulcers per 1000 bed days has reduced in September.
- 1 mix sex breach was declared at DPOW which involved 3 patients The theme was the Trust had declared OPEL 4 on all occasions and there was a lack of capacity in step down beds.

Lowlights: (share 6 areas of challenge/struggle)

- Clinical reassurance has been provided in relation to appropriate sepsis screening being carried out, however documentation evidence using the formal tool to provide assurance remains a challenge with continued low compliance rates in adults and children.
- The number of patients admitted to IAAU with an actual weight recorded on EPMA or WEB V continues to be low with 15% recorded in September compared to 16% in August.
- Pharmacy data collection for the reduction in patients prescribed an antibiotic and evidence of a review within 72 hours has been delayed due to Pharmacy staff capacity.
- The case threshold for Pseudomonas aeriginosa has been exceeded, however the performance is good in comparison to peer trusts with no further national recommendations that can be considered.
- Notable decline in Complaint responses within timescale - Key themes identified and action plans in place with weekly reporting to divisions as well as divisional meetings with PALs and Complaint Manager

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Sepsis screening	Education to all clinical areas continues and follow up discussions with staff to check staffs understanding of sepsis has demonstrated improvements in staff understanding. Targeted approach for DPoW wards IAAU, C2, B6,B7 and for SGH wards 22,24,29 and 28. Funding for Education Lead to support DP/Sepsis project continues to March 2023.	Improvement in compliance through targeted support.
Measuring patient weight	New ECC build complete at DPOW with facility to weigh patients in ambulance arrivals area to aid compliance with actual weight being documented. Initial calibration issues with trolleys using new weighing facility in ECC has been overcome and the system is now operating effectively. Agreed to implement additional question to the weekly Walk About Tool (WAT) to capture if patient's actual weight has been measured and recorded in the past 7 days. Matrons will note any non-compliant area and will action for patients to be measured and recorded. Ward areas to check they have appropriate equipment such as slings, scales, and hoists available for use.	Improvement in recording of patient's weight through additional monitoring via weekly WAT.

Pharmacy data collection	The Quality and Audit team have met with Pharmacy to discuss the missing data fields and have agreed that the Quality and Audit team will support with retrospective data collection for the past two quarters to ensure the data is included in the next IPR. Pharmacy to arrange a meeting with the Clinical Services Manager to understand why the data collected was incomplete to ensure steps are taken to prevent this from occurring again in future.	Prescribing data to be available next month to inform progress with the reduction in patients prescribed an antibiotic and evidence of a review within 72 hours.

IPR EXECUTIVE SUMMARY	Date: November 2022

1. WORKFORCE – Christine Brereton

Highlights:

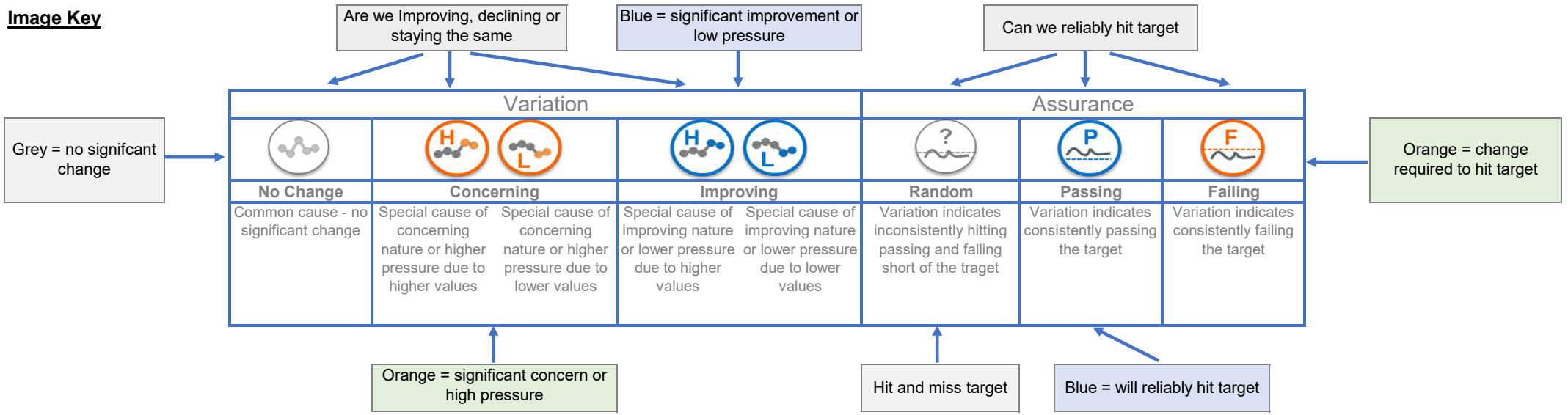
- The Core Mandatory Training position overall currently stands at 90%, Compliance continues to be above the Trust target of 90%
- Turnover has continued to decrease with the latest data showing 12%, this still remains above the trust target of 10%
- Medical Vacancies rate is at 14.7% against a target of 15%

Lowlights:

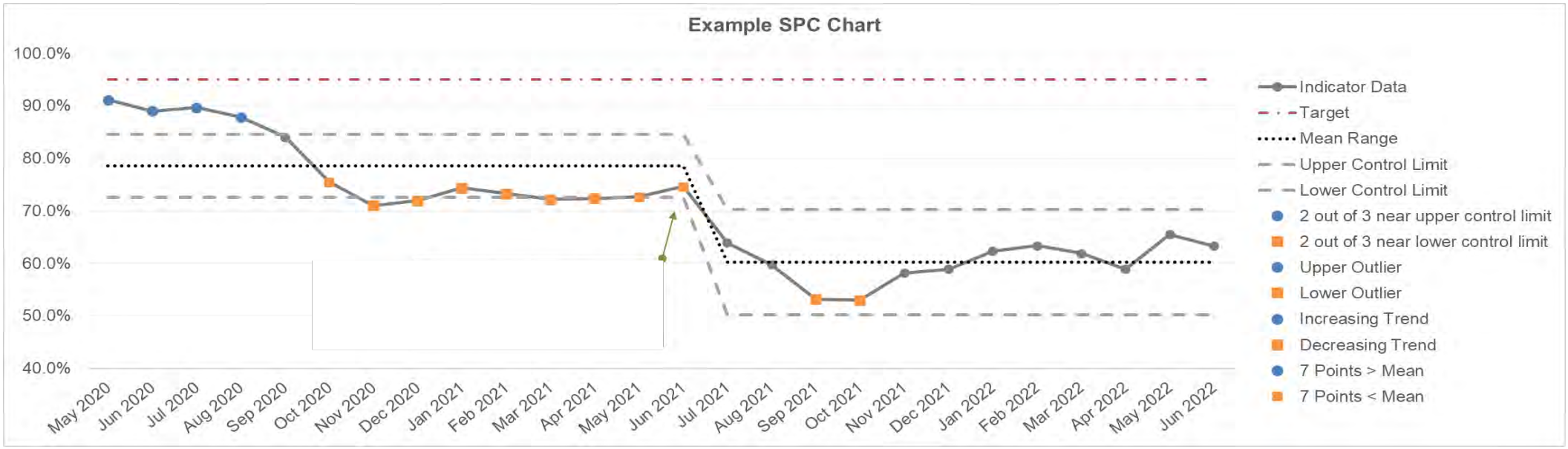
- Hotspot areas of low compliance for Statutory /Mandatory training in medical workforce
- Sickness absence remains above target of 4.1% with sickness rate at 5.5%
- Registered Nursing vacancy positions continues to be above target of 8% with the current vacancy rate at 15.0%

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Registered Nursing Vacancies The target to of 120 international nurses by December is on track. A local/regional/national registered nursing campaign will launch in November aimed at increasing the appointment of domestically trained registered nurses. **Role Specific Training –** Accommodation and capacity of resource to deliver role specific training is being address through the Education and Estate and Facilities team exploring additional classroom space to increase classroom capacity. **Sickness Absence** – A focus on long term sickness across all divisions with the aim of supporting leaders to manage long term sickness processes to enable return to work where possible or escalation of processes	**Registered Nursing Vacancies** Increased CPD capacity facilitating cohorts of international nurses and engagement with universities increasing NQN recruitment. Nursing recruitment plans implemented and monitored through PRIMs. **Role Specific Training** – Targeted training of areas with lowest compliance for role specific training to increase compliance via the use of Power BI so that teams/areas and individuals of low compliance can be identified and addressed. **Sickness Absence** – All long-term sickness processes are being evaluated with a view to implement time bound actions and support specific to the circumstances. This is a combined piece of work	**Registered Nursing Vacancy** - An improved vacancy position is anticipated to support staff retention alongside Nursing career frameworks and the introduction of nursing apprenticeships will see reliance on international nurse sourcing reduce longer term. **Role Specific Training** – Estate will be available/collaborate with HUTH on shared facilities and training resource. This will lead to greater classroom size and trainer resource. Increase access to training for operational staff. **Sickness Absence** – A reduction in long term sickness is evident already and is expected to continue to reduce with increased focus on management of process and increase levels of support for individuals.

Image Key



Note: 'Action Required' is stated on the Scorecard when either the Variation is showing special cause concern or the Assurance is indicating failing the target (where applicable). This is only applicable where there is sufficient data to present as a Statistical Process Control Chart (SPC).



Orange Squares = significant concern or high pressure	Blue Circles = significant improvement or low pressure	Green Arrow = Process Limits Re-calculation point

Notes on Process Limits Re-Calculation

Process limits will be affected when there has been a change in an operational process or procedure that has resulted in a change to the data, for example a process improvement or impact.

This might be shown as:-

- The data points are consistently on one side of the mean.
- A statistically significant change in the data triggers consistent special cause variation on the same side of the mean.

Re-calculation, when appropriate, allows us to see whether we are likely to consistently achieve any target and will still allow us to see of improvement or deterioration is occurring.

The following principles apply when deciding whether to re-calculate:-

- There should be an identifiable real process change that resulted in the above.
- The change must have been sustained for an appropriate number of data points.

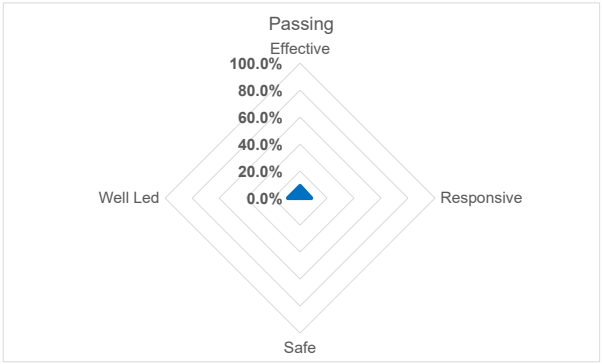
Radar

Note: Only indicators with a target are relevant for this page as it is based on the target assurance element of the indicator.
* Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Consistently Passing

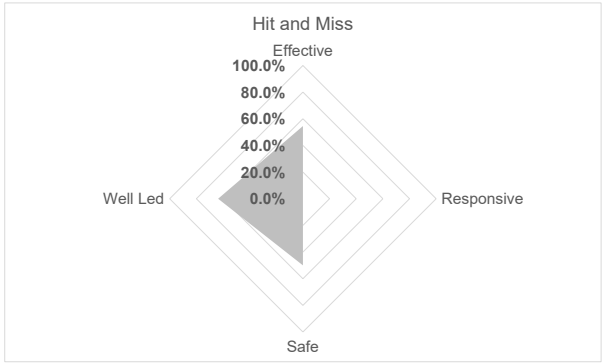
Total: 3



% Outpatient Non Face To Face Attendances
Core Mandatory Training Compliance Rate
Total Inpatient Waiting List Size

Hit and Miss

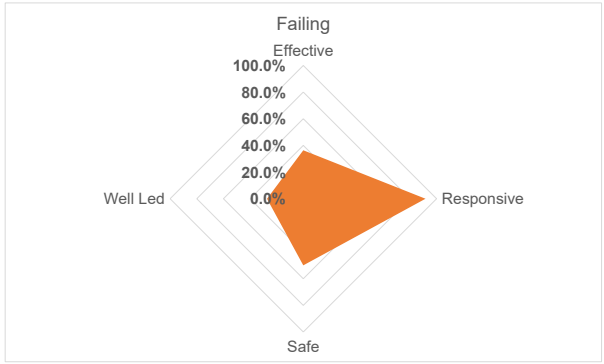
Total: 14



% Discharge Letters Completed Within 24 Hours of Discharge
% Patients Discharged On The Same Day As Admission (excluding daycase)
Bed Occupancy Rate (G&A)
Duty of Candour Rate
Medical Staff PADR Rate
PADR Rate
Role Specific Mandatory Training Compliance Rate
% of Extended Stay Patients 21+ days
Inpatient Elective Average Length Of Stay
Inpatient Non Elective Average Length Of Stay
Unregistered Nurse Vacancy Rate
Registered Nurse Vacancy Rate
Medical Vacancy Rate
Trustwide Vacancy Rate

Consistently Failing

Total: 19



% Inpatient Discharges Before 12:00 (Golden Discharges)
Ambulance Handover Delays - Number 60+ Minutes
Cancer Request To Test In 14 Days*
Cancer Waiting Times - 104+ Days Backlog*
Cancer Waiting Times - 62 Day GP Referral*
Combined AfC and Medical Staff PADR Rate
Emergency Department Waiting Times (% 4 Hour Performance)
Number of Incomplete RTT pathways 52 weeks*
Number of Overdue Follow Up Appointments (Non RTT)
Outpatient Did Not Attend (DNA) Rate
Percentage Under 18 Weeks Incomplete RTT Pathways*
Turnover Rate
Venous Thromboembolism (VTE) Risk Assessment Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
Complaints Responded to on time
Sickness Rate
Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission
Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*
Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge

			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement	H		% Discharge Letters Completed Within 24 Hours of Discharge % Patients Discharged On The Same Day As Admission (excluding daycase)	Outpatient Did Not Attend (DNA) Rate Number of Incomplete RTT pathways 52 weeks*
		L		Inpatient Non Elective Average Length Of Stay Duty of Candour Rate Medical Staff PADR Rate	Venous Thromboembolism (VTE) Risk Assessment Rate
	Common Cause			Bed Occupancy Rate (G&A) % of Extended Stay Patients 21+ days Inpatient Elective Average Length Of Stay	% Inpatient Discharges Before 12:00 (Golden Discharges) Complaints Responded to on time Ambulance Handover Delays - Number 60+ Minutes Cancer Request To Test In 14 Days* Emergency Department Waiting Times (% 4 Hour Performance) Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)* Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38* Sickness Rate
	Special Cause Concern	H	% Outpatient Non Face To Face Attendances Total Inpatient Waiting List Size	PADR Rate Role Specific Mandatory Training Compliance Rate	Number of Overdue Follow Up Appointments (Non RTT) Cancer Waiting Times - 104+ Days Backlog*
		L	Core Mandatory Training Compliance Rate	Unregistered Nurse Vacancy Rate Registered Nurse Vacancy Rate Medical Vacancy Rate Trustwide Vacancy Rate	Cancer Waiting Times - 62 Day GP Referral* Percentage Under 18 Weeks Incomplete RTT Pathways* Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge Turnover Rate Combined AfC and Medical Staff PADR Rate

Scorecard - Access and Flow

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time. * Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR. n/a is stated for Assurance/Variation when the data is not presented as an SPC chart.

Planned	% Under 18 Weeks Incomplete RTT Pathways*	Oct 2022	65.4%	92.0%	**Alert**		
	Number of Incomplete RTT pathways 52 weeks*	Oct 2022	371	0	**Alert**		
	Total Inpatient Waiting List Size	Oct 2022	10,920	11,563	**Alert**		
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Oct 2022	28.6%	1.0%	**Alert**		
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Oct 2022	34,028	9,000	**Alert**		
	Outpatient Did Not Attend (DNA) Rate	Oct 2022	7.0%	5.00%	**Alert**		
	% Outpatient Non Face To Face Attendances	Oct 2022	26.9%	25.00%	**Alert**		
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Oct 2022	44.2%	85.0%	**Alert**		
	Cancer Waiting Times - 104+ Days Backlog*	Oct 2022	56	0	**Alert**		
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Oct 2022	10.0%	75.0%	**Alert**		
	Cancer - Request To Test In 14 Days*	Oct 2022	83.4%	100.0%	**Alert**		
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Oct 2022	61.2%	95.0%	**Alert**		
	Number Of Emergency Department Attendances	Oct 2022	12,897	No Target	**Alert**		n/a
	Ambulance Handover Delays - Number 60+ Minutes	Oct 2022	540	0	**Alert**		
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Oct 2022	708	0	**Alert**		
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Oct 2022	336	0	**Alert**		
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Oct 2022	40.5%	40.0%			
	% of Extended Stay Patients 21+ days	Oct 2022	11.7%	12.0%			
	Inpatient Elective Average Length Of Stay	Oct 2022	2.3	2.5			
	Inpatient Non Elective Average Length Of Stay	Oct 2022	3.5	3.9			
	Number of Medical Patients Occupying Non-Medical Wards	Oct 2022	172	No Target	**Alert**		n/a
	% Discharge Letters Completed Within 24 Hours of Discharge	Oct 2022	90.2%	90.0%			
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Oct 2022	16.1%	30.0%	**Alert**		
	Bed Occupancy Rate (G&A)	Oct 2022	93.9%	92.0%			
COVID	Number of COVID patients in ICU beds (Weekly)	Oct 2022	2	No Target			n/a
	Number of COVID patients in other beds (Weekly)	Oct 2022	30	No Target			n/a
	% COVID staff absences (Weekly)	Oct 2022	9.3%	No Target			n/a

Scorecard - Quality and Safety

Northern Lincolnshire and Goole NHS Foundation Trust

Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

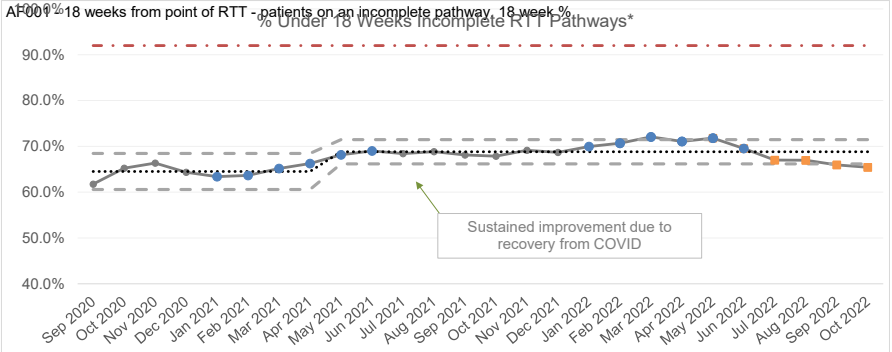
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Sep 2022	0.00	see analysis			n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Sep 2022	0.30	see analysis			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Sep 2022	0.10	see analysis			n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Sep 2022	0.10	see analysis			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Sep 2022	0.47	see analysis			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Aug 2022	99.1	As expected			As expected
	Summary Hospital level Mortality Indicator (SHMI)	May 2022	102.5	As expected		L	As expected
Safe Care	Patient Safety Alerts actioned by specified deadlines	Sep 2022	100%	100%			n/a
	Number of Serious Incidents raised in month	Sep 2022	7	No target			n/a
	Occurrence of 'Never Events' *(Number)*	Sep 2022	0	0		n/a	n/a
	Duty of Candour Rate	Sep 2022	100%	100%		H	?
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Sep 2022	4.8	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Sep 2022	3.2	No target	**Highlight**	L	n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Oct 2022	95.4%	95.0%	**Alert**	H	F
	Care Hours Per Patient Day (CHPPD)	Sep 2022	8.2	No target			n/a
	Mixed Sex Accommodation Breaches	Sep 2022	3	0		n/a	n/a
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Aug 2022	5.0	No target			n/a
	Complaints Responded to on time	Aug 2022	50.0%	85.0%	**Alert**		F
	Friends and Family Test (FFT)						
	Number of Positive Inpatient Scores	Sep 2022	618 out of 668	No target		n/a	n/a
	Number of Positive A&E Scores	Aug 2022	442 out of 648	No target		n/a	n/a
	Number of Positive Community Scores	Sep 2022	108 out of 114	No target		n/a	n/a
	Number of Positive Outpatient Scores	Sep 2022	45 out of 52	No target		n/a	n/a
	Number of Positive Maternity Antenatal Scores	Sep 2022	4 out of 6	No target		n/a	n/a
	Number of Positive Maternity Birth Scores	Sep 2022	54 out of 66	No target		n/a	n/a
	Number of Positive Maternity Post-Natal Scores	Sep 2022	4 out of 4	No target		n/a	n/a
	Number of Positive Maternity Ward Scores	Sep 2022	24 out of 26	No target		n/a	n/a

Scorecard - Workforce

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time. * Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR. n/a is stated for Assurance/Variation when the data is not presented as an SPC chart.

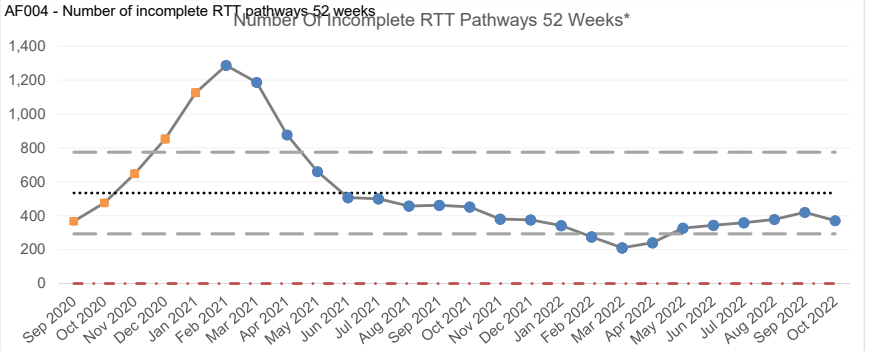
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate	Sep 2022	15.7%	8.0%	Alert		
	Registered Nurse Vacancy Rate	Sep 2022	15.0%	8.0%	Alert		
	Medical Vacancy Rate	Sep 2022	14.7%	15.0%	Alert		
	Trustwide Vacancy Rate	Sep 2022	12.5%	8.0%	Alert		
Staffing Levels	Turnover Rate	Oct 2022	12.0%	10.0%	Alert		
	Sickness Rate	Sep 2022	5.5%	4.1%	Alert		
Staff Development	PADR Rate	Oct 2022	79.0%	85.0%	Alert		
	Medical Staff PADR Rate	Oct 2022	88.0%	85.0%			
	Combined AfC and Medical Staff PADR Rate	Oct 2022	77.9%	85.0%	Alert		
	Core Mandatory Training Compliance Rate	Oct 2022	90.0%	90.0%	Alert		
	Role Specific Mandatory Training Compliance Rate	Oct 2022	76.0%	80.0%	Alert		

AF001 - 18 weeks from point of RTT - patients on an incomplete pathway, 18 week %



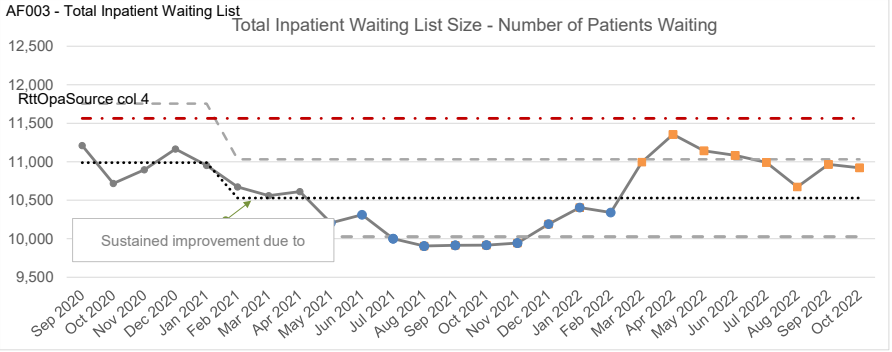
Oct 2022	Target	Variance	Assurance
65.4%	92.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target

AF004 - Number of incomplete RTT pathways 52 weeks



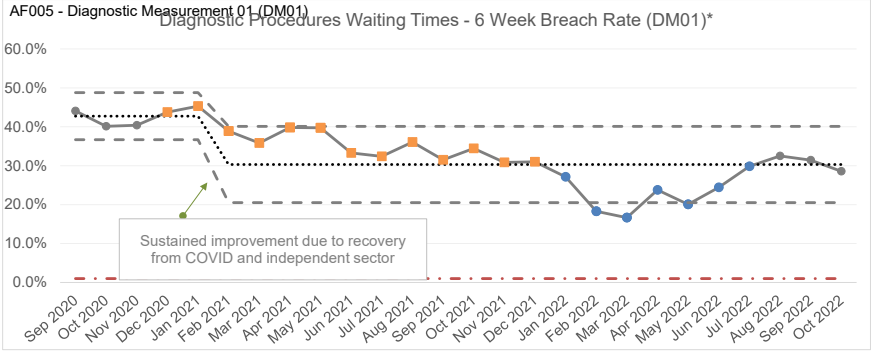
Oct 2022	Target	Variance	Assurance
371	0	Special cause of improving nature or lower pressure due to lower values	Consistently falling short of the target

AF003 - Total Inpatient Waiting List



Oct 2022	Target	Variance	Assurance
10,920	11,563	Special cause of concerning nature or higher pressure due to higher values	Consistently passing the target

AF005 - Diagnostic Measurement 01 (DM01)



Oct 2022	Target	Variance	Assurance
28.6%	1.0%	Common cause - no significant change	Consistently falling short of the target

Data Analysis:
Under 18 weeks incomplete*: Although recent data has been largely stable, the data is now below the lower process limit and is showing special cause concern. Current data indicates that the target will not be met without action, planned actions outlined below.
Incomplete 52 weeks*: The number of 52 week waits has decreased over the past 18 months, and shows overall improvement following the spike in 2020. Current data indicates that the target will not be met without action, planned actions outlined below.
Inpatient waiting list: Note: Process limit re-calculation from Feb 21. The number of patients on the waiting list over the past 7 months has increased and is showing special cause concern. The indicator can reliably be expected to meet the target.
Diagnostics 6 Week Wait (DM01)*: Note: Process limit re-calculation from Feb 21. The performance following the increase seen over this summer appears stable. The data remains within the expected values. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:
• Consultant workforce vacancies • Echo DM01 waiting times have increased - insufficient capacity in core - secured IS provider, need to continue into 2022/23
• The balance of unplanned vs planned care activity • Ongoing performance management of the IS Provider contracts
• Acceptance of Mutual Aid • Theatre capacity affected by short notice sickness • Issues with theatre estates and an influx of acute activity causing elective activity to be converted • Significant pressures in anaesthetic assessment capacity due to Mutual Aid creating a bottle neck in the pathway
• Increasing demand on diagnostic services from all referral routes
• Increased focus on cancer targets and meeting cancer 28 day FDS impacts on DM01 position • Gynaecology - Reduced theatre access DPOW due to ongoing refurbishment works. • Increased medical staff sickness in August and September & October 2022
• Paediatric service SGH increased ward admissions troughout October/November pulling clincians away from planned outpatient activity to cover ward.

Key Risks:
• Mutual aid of patients when trying to reduce long waiters • Potential further COVID waves and staff sickness
• Carry over of annual leave • Unable to mitigate the activity gaps of tenders not being realised - ENT and Ophthalmology
• Ongoing management of high levels of acute activity impacting elective work • Theatre nurse staffing vacancy, retention and high sickness rates
• Contracting agreements and funding for use of Independent Sector not yet agreed for 22/23 • Ageing Diagnostic equipment
• Ability to deliver 120% of 19/20 activity • Radiology reporting times: high vacancy rate internally, limited out-sourcing capacity available

Actions:
• Use of the Independent Sector (ongoing)
• Additional sessions by NLaG clinicians (ongoing)
• Working with various external providers to provide additional clinic capacity (ongoing)
• Continue to push for funding for WLIs to uplift theatre activity to support performance and waiting list position (ongoing)
• Continue to utilise St Hugh's for new patients for Ophthal and ENT (ongoing)
• Robust recruitment plan for theatres with external company, options were presented in July 2022 and with recruitment plan being progressed (ongoing)
• HIT Theatres commenced in October and planned throughout November to improve theatre efficiency (Oct & Nov 2022)
• Internal increase in CT capacity at SGH (ongoing)
• Utilise bank & OT to support admin activity (ongoing)
• Work with regional teams to support and develop CDC models of delivery (ongoing)
• Review of Demand and Capacity across specialties to quantify current context and identify any imbalances and required remedial action (Oct 22)
• Paediatrics (SGH) patient flow review to take place including C&D analysis of elective and non elective pathways, ward attenders (Nov 22)

Mitigations:
• Regularly review waiting lists and focus on long waiting and high risk patients. • Risk stratification programme continues across all specialities
• Use of locums to mitigate vacancies • Additional sessions still being undertaken by NLaG clinicians. • Working with various external providers to provide additional clinic capacity • Process maps for booking of patients to ensure optimum list utilisation

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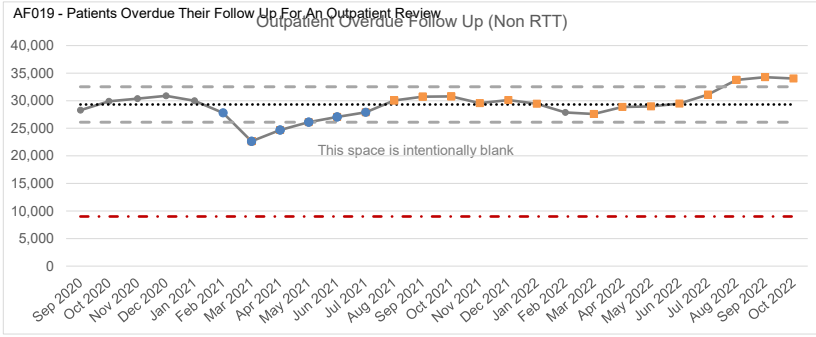
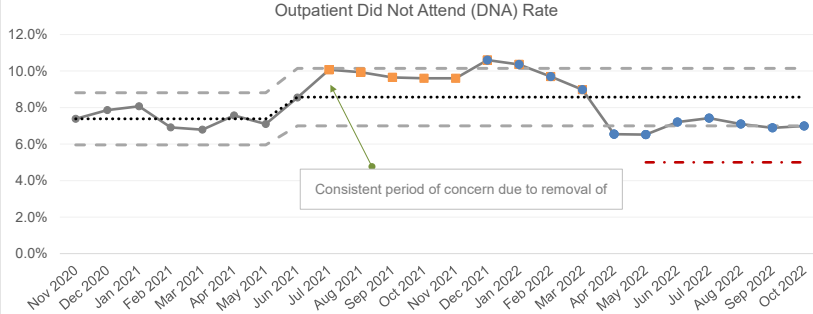
AF019 - Patients Overdue Their Follow Up For An Outpatient Review

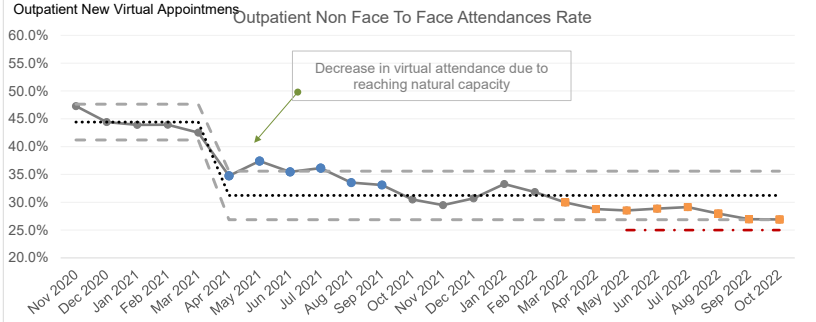


Oct 2022	Target	Variance	Assurance
34,028	9,000	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target



Oct 2022	Target	Variance	Assurance
7.0%	5.0%	Special cause of improving nature or lower pressure due to lower values	Consistently falling short of the target

Outpatient New Virtual Appointmens



Oct 2022	Target	Variance	Assurance
26.9%	25.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently passing the target

Data Analysis:

Outpatient Overdue follow up: Performance has largely recorded concern for the past year. Over this period the indicator has consistently failed the target of 9,000 by some margin. Current data indicates that the target will not be met without action, planned actions outlined below.

Outpatient DNA rate: Process limit recalculation from June 21. Following a period of concern the indicator has recorded improvement for the past 7 months. The target of 5% starts from April 2022. Current data indicates that the target will not be met without action, planned actions outlined below.

Non Face to Face Outpatient: Note: Process limit re-calculation from Apr 21. The figure has consistently fallen below the mean for 8 consecutive months triggering special cause concern. However, performance is reliably achieving the ICS target. Local target is 32% by end March 2023.

Challenges:

- Funding arrangements for the CHN model post 22-23 financial year remains challenging. System financing models are not conducive to system working
- The overdue follow up list is 33,796, just over 3,000 patients higher than the previous year
- A&G requests and response times have improved in month 7, but remains significantly behind target
- Balance between providing overdue follow ups and reducing follow ups by 25%

Key Risks:

- Clinical buy-in across some specialities to embed PIFU as standard clinical practice
- Inability to secure a long-term finance model for CHN when pump prime funding expires from March 2023
- The quality of Advice and guidance needs to improve significantly to ensure primary care clinicians utilise A&G rather than referring pts directly into secondary care
- There is significant risk that the follow up backlog continues to increase unless there is significant focus on changing traditional models of working and embrace PIFU and A&G as a new way of working

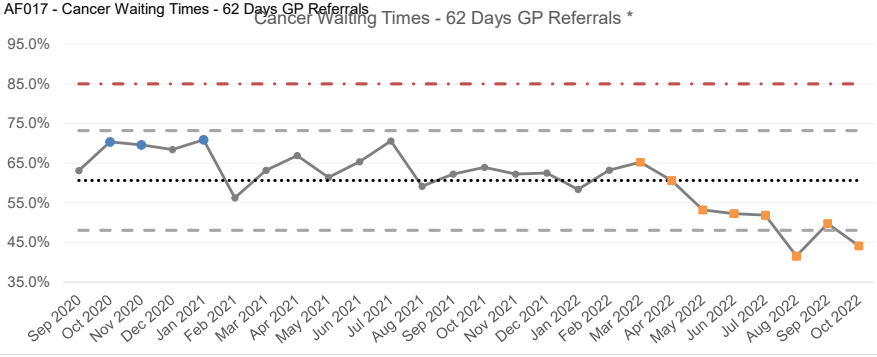
Actions:

- Deep dive into DNA - Information reports in development to identify patients who persistently DNA/Cancel their appointment, adjustments to provide appointment window for nonf2f, idenitfied clear links to DNA rate and depravation. Analysis, report and recommendations (Dec 22)
- Phase 2 for the digital letters project commenced go-live with non-leaflet Inpatient Letters and is on a rolling programme including SMS text messaging (ongoing)
- Director of Place at NL, SRO for OP Transformation to raise with ICS Finance colleagues for plan CHN finance for 23/24 (Mar 23)
- Working with Clinical Lead to meet with speciality clinical leads to agree a PIFU plan. Presentation to MAC to focus on adaptation of PIFU (Nov 22)
- Targeted work with specialties to increase the number of patients on a PIFU pathway in line with expected Trajectory (Mar 23)
- Further collaborative work with Primary Care Networks (ongoing)
- Heart Failure at home being trialled as part of PKB in Cardiology (ongoing)

Mitigations:

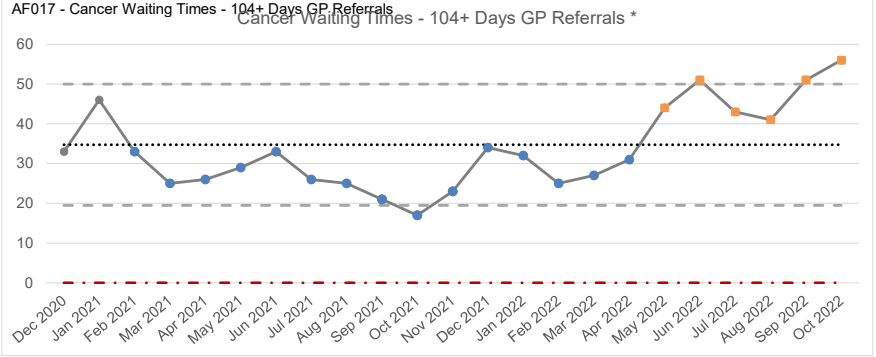
- Director of Place at North LIncs is co-orindating a group to develop a BS to secure funding to support the CHN Model from March 2023 onwards
- Focus on clinical leadership to secure clinical buy-in of PIFU
- Clinicians engaged with following the access policy with regards to DNAs
- Weekly assurance meetings on the activity planning numbers
- Risk Stratification of outpatient waiting lists
- Mutually agree the majority of out-patient appointments, to minimise DNA rates

AF017 - Cancer Waiting Times - 62 Days GP Referrals



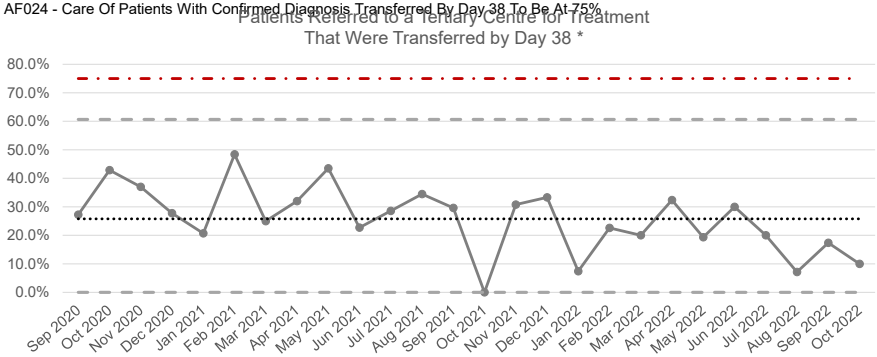
Oct 2022	Target	Variance	Assurance
44.2%	85.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target

AF017 - Cancer Waiting Times - 104+ Days GP Referrals



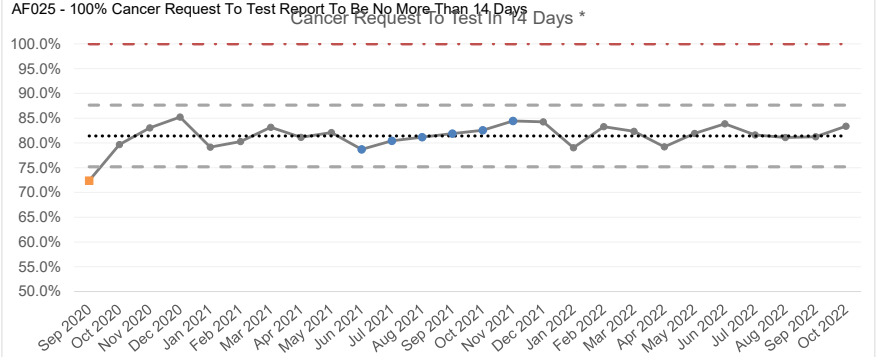
Oct 2022	Target	Variance	Assurance
56	0	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target

AF024 - Care Of Patients With Confirmed Diagnosis Transferred By Day 38 To Be At 75%



Oct 2022	Target	Variance	Assurance
10.0%	75.0%	Common cause - no significant change	Consistently falling short of the target

AF025 - 100% Cancer Request To Test Report To Be No More Than 14 Days



Oct 2022	Target	Variance	Assurance
83.4%	100.0%	Common cause - no significant change	Consistently falling short of the target

Data Analysis:

62 days GP referral*: Performance has deteriorated over the past 7 months and now falls outside the expected range. This target has not been achieved over the last 2 years. Current data indicates that the target will not be met without action, planned actions outlined below.

104+ days GP referrals*: Although performance is largely within the process limits, the last 2 months' data has exceeded the upper process limit. The indicator is consistently failing the target, and current data indicates that the target will not be met without action, planned actions outlined below.

Transferred by day 38*: Wide variation is due to very low numbers. Performance has not changed significantly over the past 2 years, and the target has not been achieved during this time. Current data indicates that the target will not be met without action, planned actions outlined below.

Request to test 14 days*: Performance is stable and as expected based on the data. The target of 100% has not been achieved for more than 2 years. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

- All tumour sites are affected by the increasing waiting times for oncology consultant appointments
- UGI is a challenge but the teams are working to improve referrals in to ensure the right patients receive the diagnostics required
- Medicine UGI and Lung tumour site pathways for 28 day performance continue to be challenged
- Management of complex unfit patients requiring significant work-up are causing delays
- Most tumour sites are unable to achieve 62 day standard due to multiple factors, including diagnostic and pathoogy turnaround times
- Colorectal is a challenge but the teams are working to improve referrals in to ensure the right patients receive the diagnostics required
- Notable increase in Urological Cancer referrals over last 3 months and increase in 62 day breaches due to TURBT no longer being classed nationally as a first treatment.

Key Risks:

- There are a number of issues related to visiting consultant services (e.g urology, oncology), tertiary based staging scans (EUS, PET CT) which affect the ability to transfer (IPT) for treatment by Day 38
- Request to test (14 days) - in order to meet 28 day Faster Diagnosis Standard, this needs to be reduced to 7 calendar days.
- Meeting the 38 day IPT standard is impacted through delays occurring with tertiary diagnostics/staging TAT, and visitng consultant/oncology services (urology - prostate)
- UGI and Head & Neck surgery is carried out in Hull which is currently causing significant delay
- Lack of Oncology Capacity for 1st appointments - now booking 4 weeks from point of referral
- Covid + • One Clinician at SGH running STT UGI service • HUTH have relocated Urology oncologist to Breast, which is causing a significant risk to waiting times. Patient choice • Urology cancer consultant taking extended period of leave from September 2022.

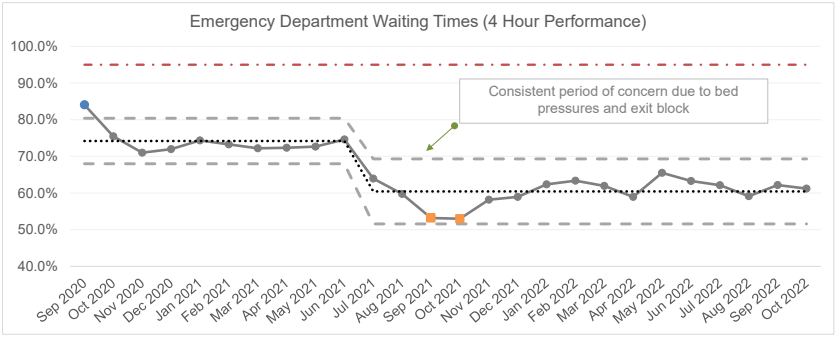
Actions:

- Single Lung MDT with HUTH & NLaG (Jan 23)
- Cancer Improvement Plans developed in Medicine for Lung and UGI cancer (ongoing)
- Timely removal of patients from cancer tracking once non-malignancy confirmed (ongoing)
- Urology service review completed with additional one stop clinics introduced from September 2022 in collaboration with Radiology. CNS activities to be reviewed to improve one stop clincis from end of October with Radiology one stop (Nov 22)

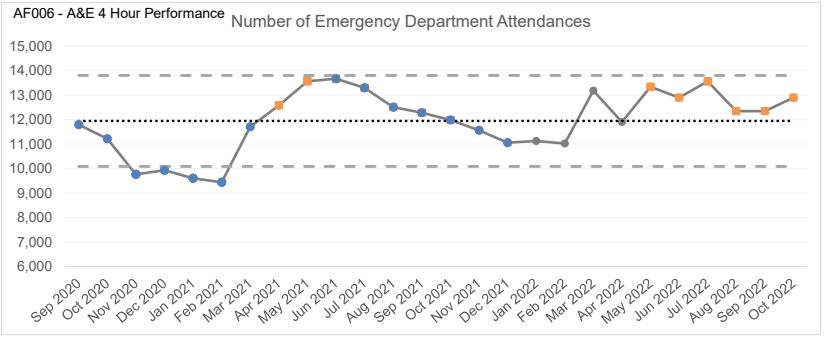
Mitigations:

- The pathway analyser tool that has been developed within NLAG (using the IST tool) and the in depth analysis of pathways will enable teams to identify where improvements in NLAG can be achieved
- The joint transformation pathway work with HUTH will help with the transfer of patients between NLAG/ HUTH and to identify areas where the pathway can be accelerated
- Performance is being reviewed and managed weekly
- RDC pathway in place
- Colorectal - CNS straight to test commenced
- UGI - consultant led straight to test commenced
- Funding approved to recruit to Band 3 and Band 2 admin support
- 62 day performance is being reviewed and managed weekly - along with the 28 day performance
- Urology agency consultant currently in post.

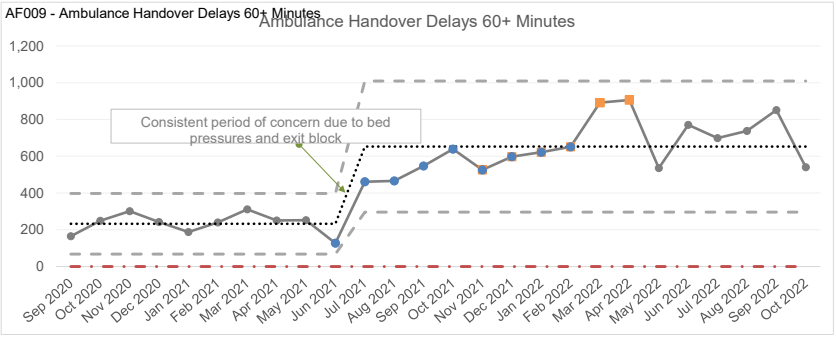
Northern Lincolnshire and Goole NHS Foundation Trust



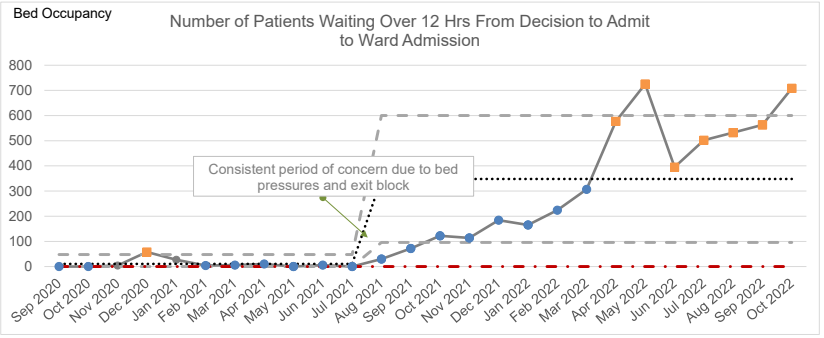
Oct 2022	Target	Variance	Assurance
61.2%	95.0%	Common cause - no significant change	Consistently falling short of the target



Oct 2022	Target	Variance	Assurance
12,897	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target therefore target assurance is not relevant



Oct 2022	Target	Variance	Assurance
540	0	Common cause - no significant change	Consistently falling short of the target



Oct 2022	Target	Variance	Assurance
708	0	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target

Data Analysis:

ED 4 hour waiting: Following the significant deterioration in the summer of last year, performance has been stable and within the recalculated expected range. Current data indicates that the target will not be met without action, planned actions outlined below.

ED Attendances: The number of attendances remains within the expected range. However, performance has moved closer to the upper range of the data over the past several months due to an increased number of attendances.

Ambulance handover 60+ minutes: Process limits re-calculated from July 21. Performance remains elevated but within the expected range of the data since the re-calculation. Current data indicates that the target will not be met without action, planned actions outlined below.

DTA 12 hours: Process limit re-calculation from Aug 21. This indicator continues to record very high, increasing levels triggering concern. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

- Pressure within the community in relation to demand for ambulance attendances
- High level of acuity with pressures within Resus and for walkin patients
- Increased attendances
- SDEC regularly running at full capacity.

Key Risks:

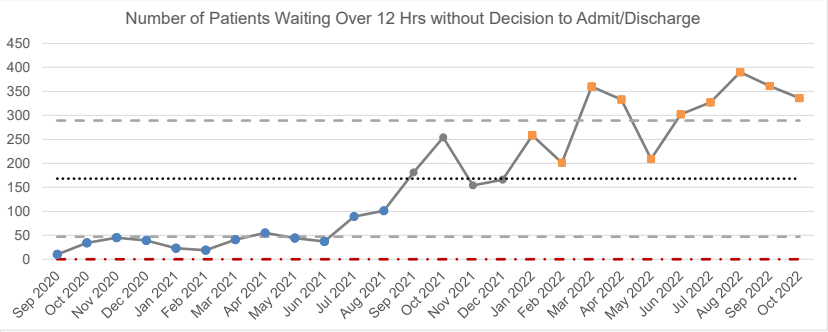
- Staffing gaps in both medical and nursing
- High levels of agency and locum staff
- Inability to achieve Ambulance Handover targets due to patient flow within the hospital
- Inability to meet patient waiting times in ED
- Staff burnout
- Demand on resus area and high acuity walkins
- The current substantive SDEC staffing establishment does not meet the requirement for the increased service hours in place to support operational activity.

Actions:

- Virtual Ward plan phased to go live (Dec 22)
- Plan to increase OPAT capacity (Dec 22)
- Work continues on the new build increase footprint with SGH New Emergency Department going live (Jan 23)
- Paper completed in relation to additional staffing for Medical staffing as part of a Quality Improvement Project (ongoing)
- Work continues on improvement to pathways (ongoing)
- Review of all Urgent Care Services across Northern Lincolnshire has commenced to look at reducing pressure across the system by ensuring that patients are seen at the right place, by the right person, first time (ongoing)
- Delivery of the improvements within the Ambulance Handover Plan (ongoing)
- Working with Single Point of Access to improve direct referrals to SDEC (GP/EMAS). Pilot of electronic referral system (Nov 22)
- Paediatric service patient flow review to take place including C&D analysis of elective and non elective pathways, ward attenders (Nov 22)

Mitigations:

- Home Care Discharge Programme initiated
- Acute and Community joint work group established between Medicine and Community & Therapies
- CRT GP suporting Category 3 & 5 calls
- 2 hour community response is performing at 96% against the 70% target
- Daily review of medical and nursing staffing to ensure appropriate skill mix
- Screen installed in SDEC and SAU to enable "straight to" ambulance handover pathways to be implemented to support ED avoidance
- Patients are triaged on the ambulances if there is a delay to ambulance handover to ensure patient safety
- New structure in place within ED with senior decision makers now identified on a daily basis for EPIC, Resus/Majors, Initial Assessment and Ambulance Triage
- Tier system is in place to ensure that escalation is taking place where appropriate to support patient flow to ensure a swift resolution to issues



Oct 2022
336
Target
0
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently falling short of the target

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Data Analysis:

Discharged same day as admission: Performance continues to record special cause concern with high numbers of 12 hour DTAs exceeding the upper process limit. Current data indicates that the target will not be met without action, planned actions outlined below.

Issues / Risks: ...

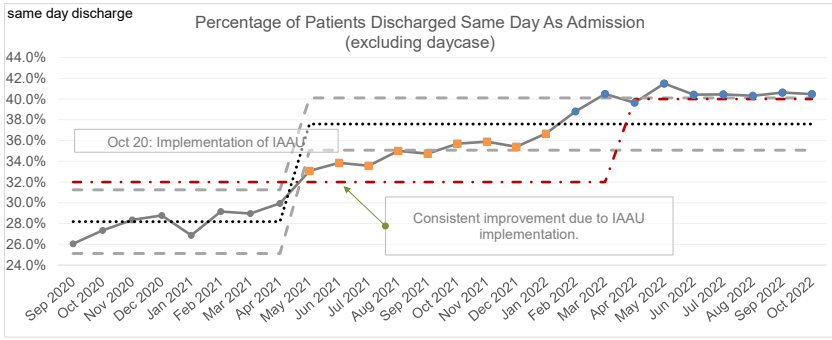
Challenges
- Number of D2A's continue to rise - impacting on the ability to move patients from ED to IAAU
- Issues with the capacity in SDEC to enable Patient Flow within the department
- Escalation process for closure of SDEC including challenge with staffing
- Use of UCS rooms overnight to bed patients down resulting in a lack of rooms to see patients the following day

Key Risks
- Patient to staff ratios due to the numbers of patients within the department - this will be mitigated in DPOW with the go live of the new ED in Oct
- Number of red flag patients in the Waiting Room
- Failure to meet triage targets

Actions: ...
- Process is being reviewed and signed off in September to live validate all patients that are within the department more than 12 hours (Oct 22)

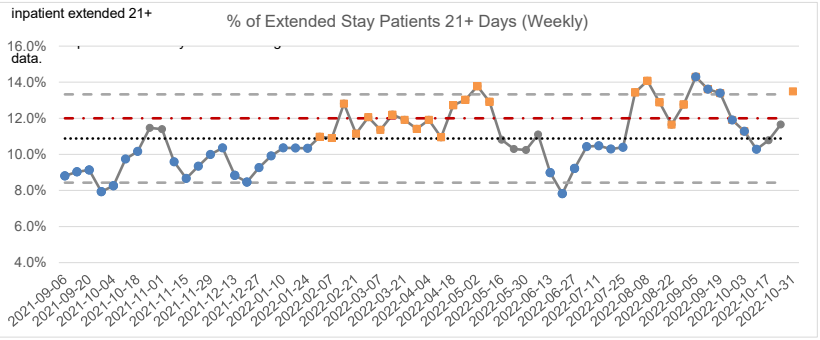
Mitigations
- Care standards are in place to ensure that the patients are being reviewed regularly
- Two hourly Board Rounds are taking place and patients are being reviewed where necessary
- Critical Meds Sheets are implemented where required to ensure patients are receiving the medication they require whilst waiting to be admitted
- Continued review of the patient numbers and alternative pathways within the department to ensure that the patients could be moved to the appropriate service and acquity improve

same day discharge

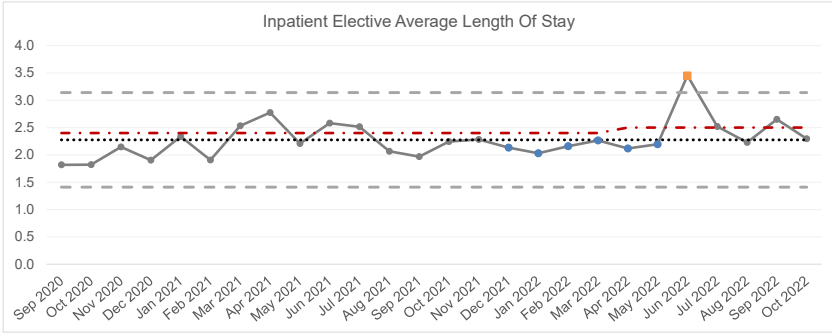


Oct 2022	Target	Variance	Assurance
40.5%	40.0%	Special cause of improving nature or lower pressure due to higher values	Inconsistently hitting passing and falling short of the target

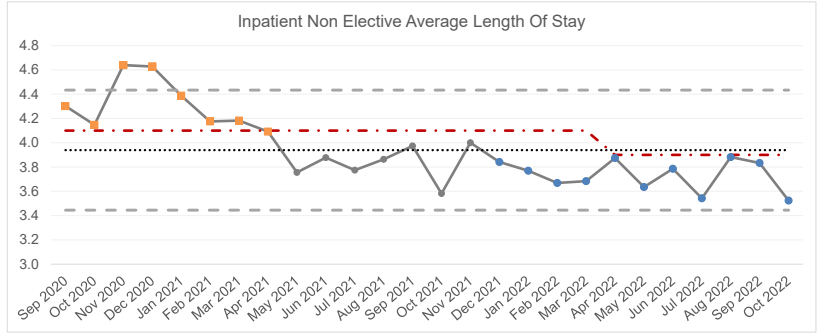
inpatient extended 21+



Oct 2022	Target	Variance	Assurance
11.65%	12.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Oct 2022	Target	Variance	Assurance
2.3	2.5	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Oct 2022	Target	Variance	Assurance
3.5	3.9	Special cause of improving nature or lower pressure due to lower values	Inconsistently hitting passing and falling short of the target

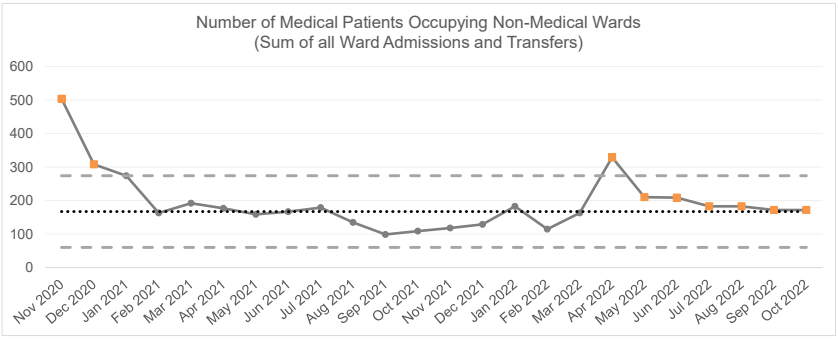
Data Analysis:
Discharged same day as admission: Note: Process limit re-calculation from May 21, and local target increased from 32% to 40% from April 22. Performance continues to show improvement with the most recent data points outside the expected range, showing the highest performance since 2020.
% Extended stay 21+ days: The indicator has recorded significant variation over the past 12 months. The indicator can be expected to achieve and fail the target at random.
Elective length of stay: Note: the target has been increased from 2.4 days to 2.5 days with effect from April 22. The performance of this indicator continues to largely fall within the expected range. The figure for Sept 22 may be an outlier. The target can be expected to achieve and fail at random.
Non elective length of stay: Note: The target has been decreased from 4.1 to 3.9 from April 22. This indicator has been showing an improvement coinciding with an increase in patients discharged on the same day as admission. The indicator can be expected to achieve and fail the target at random.

Challenges:
- Staffing constraints (sickness, vacancies, use of agency and bank staff)
- Covid & IPC constraints
- Exit block due to social care constraints (staffing, interim bed availability, lack of packages of care availability)
- Environment and ability to create (and staff) escalation beds
- Time of discharges need to be earlier in day
- Although discharge to Assess as a process is fully embedded within the trust there is a need to concentrate improvement work on the whole discharge pathway, work is taking place to understand the current position and build a system wide improvement plan with our partners
- Increased medical staff sickness in August and September & October 2022

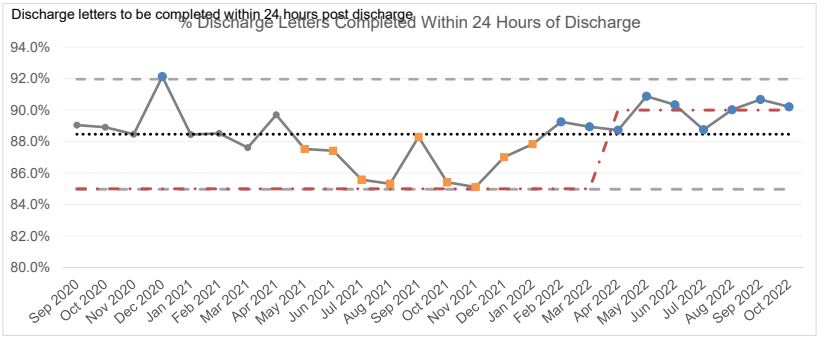
Key Risks:
- Space and capacity issues within SDEC/IAAU
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission and long patient waits in ED
- High acuity levels and patients means more patients require further support on discharge

Actions:
- Virtual Ward plan phased to go live (Dec 22)
- Plan to increase OPAT capacity (Dec 22)
- Daily board rounds on wards (ongoing)
- LLOS reviews in place for medicine twice per week led by the senior tri (ongoing)
- Perfect Fortnight (Nov 22)
- Paediatric service patient flow review to take place including C&D analysis of elective and non elective pathways, ward attenders (Nov 22)

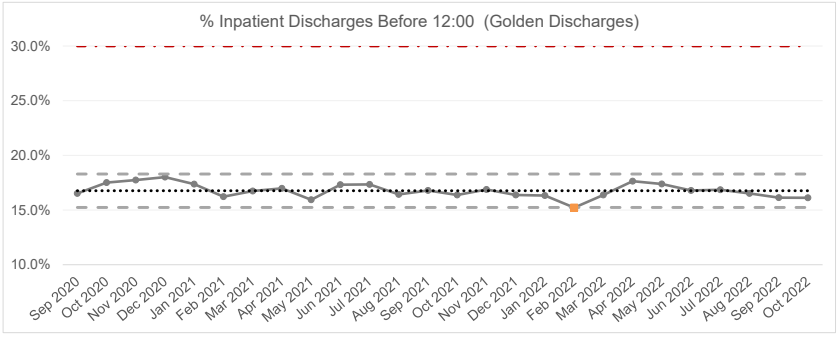
Mitigations:
- Home Care Discharge Programme initiated
- Acute and Community joint work group established between Medicine and Community & Therapies
- CRT GP suporting Category 3 & 5 calls
- 2 hour community response is performing at 96% against the 70% target
- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clear action plan for delayed discharge and escalation plan
- Themes are collated during the week from escalations and fed back to a fortnightly discharge improvement meeting which feeds our improvement plan
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire



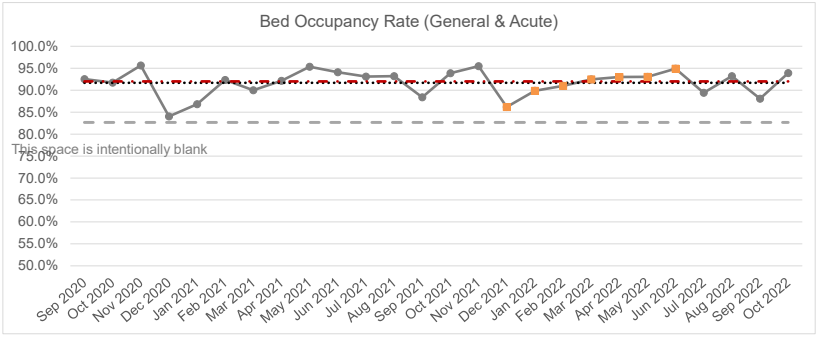
Oct 2022	Target	Variance	Assurance
172	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant



Oct 2022	Target	Variance	Assurance
90.2%	90.0%	Special cause of improving nature or lower pressure due to higher values	Inconsistently hitting passing and falling short of the target



Oct 2022	Target	Variance	Assurance
16.1%	30.0%	Common cause - no significant change	Consistently falling short of the target



Oct 2022	Target	Variance	Assurance
93.9%	92.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target

Data Analysis:

Medical Outliers: Following a period of stability, performance has triggered concern with figures for the past 7 months exceeding the 2 year average. The analysis of this indicator is very sensitive to ward re-categorisations including any temporary agreed usage of wards out of usual scope.

Inpatient discharge letters: Note: the local target of 85% has been increased to 90% in April 22. The data is falling within the expected range and has recorded improvement for the past 8 months. The indicator can be expected to achieve and fail the target at random.

Inpatient discharges before 12:00: Performance is currently stable and as expected. In terms of assurance, current data indicates that the target will not be met without action, planned actions outlined below.

G&A Bed Occupancy: Performance remains stable within the expected range for the data. The target can be expected to achieve and fail at random.

Challenges:

- Staffing constraints (sickness, vacancies, use of agency and bank staff)
- Covid & IPC constraints
- Exit block due to social care constraints (staffing, interim bed availability, lack of packages of care availability)
- Environment and ability to create (and staff) escalation beds
- Time of discharges need to be earlier in day
- Although discharge to Assess as a process is fully embedded within the trust there is a need to concentrate improvement work on the whole discharge pathway, work is taking place to understand the current position and build a system wide improvement plan with our partners

Key Risks:

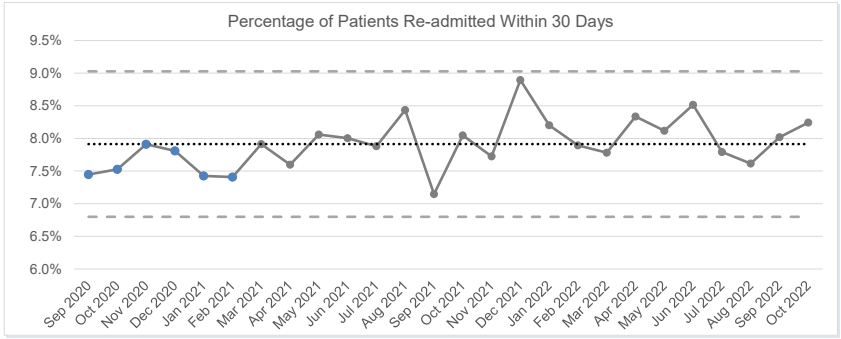
- Space and capacity issues within SDEC/IAAU
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission and long patient waits in ED
- High acuity levels and patients means more patients require further support on discharge

Actions:

- Virtual Ward plan phased to go live (Dec 22)
- Plan to increase OPAT capacity (Dec 22)
- Daily board rounds on wards (ongoing)
- LLOS reviews in place for medicine twice per week led by the senior tri (ongoing)
- Perfect Fortnight (Nov 22)

Mitigations:

- Home Care Discharge Programme initiated
- Acute and Community joint work group established between Medicine and Community & Therapies
- CRT GP suporting Category 3 & 5 calls
- 2 hour community response is performing at 96% against the 70% target
- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clear action plan for delayed discharge and escalation plan
- Themes are collated during the week from escalations and fed back to a fortnightly discharge improvement meeting which feeds our improvement plan
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire
- 2 hour community Response



Oct 2022
8.2%
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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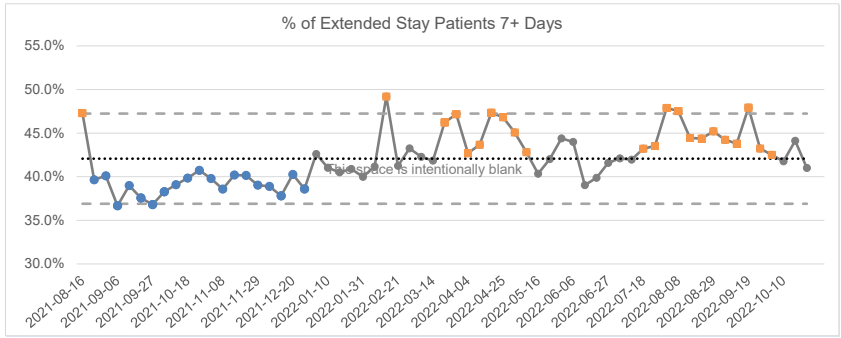
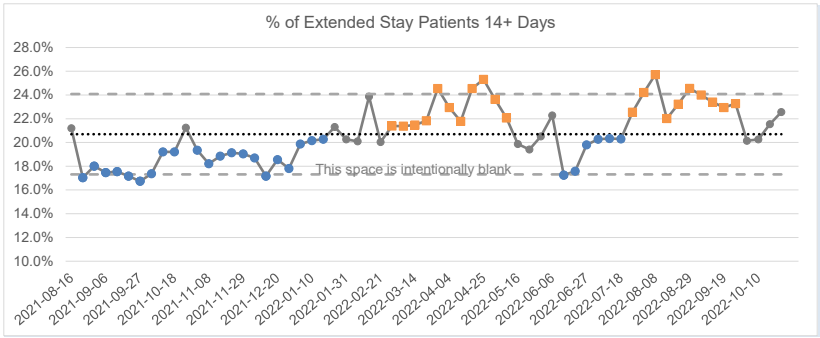


Oct 2022
41.0%
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Oct 2022
22.6%
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:

Emergency Re-admissions 30 days: Performance is currently stable and within the expected range. For context, the national benchmark figure for the 12 months to August 22 is 7.31%. NLAG's figure for August 22 was 7.62%.

Extended stay 7+ days: Performance remains largely within the expected range and is currenlty not a cause for concern, although the 7+ day extended stay has increased compared with autumn 2021. See Flow page 1 for the 21+ day position.

Extended stay 14+ days: Performance remains largely within the expected range and is recording no concern for the last 4 months, despite the overall 14+ day extended stay increase compared with 2021. See Flow page 1 for the 21+ day position.

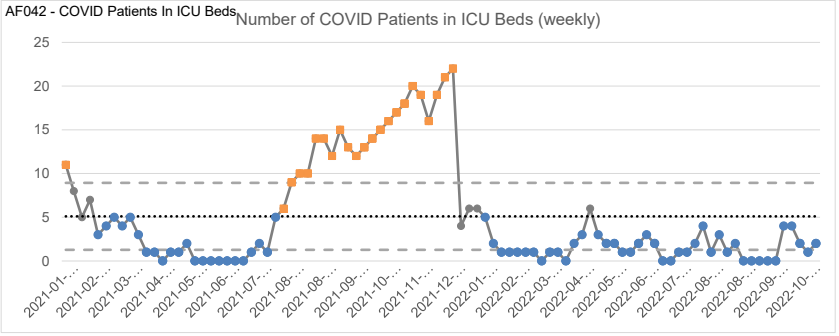
Challenges:
- Staffing constraints (sickness, vacancies, use of agency and bank staff)
- Covid & IPC constraints
- Exit block due to social care constraints (staffing, interim bed availability, lack of packages of care availability)
- Environment and ability to create (and staff) escalation beds
- Time of discharges need to be earlier in day
- Although discharge to Assess as a process is fully embedded within the trust there is a need to concentrate improvement work on the whole discharge pathway, work is taking place to understand the current position and build a system wide improvement plan with our partners

Key Risks:
- Space and capacity issues within SDEC/IAAU
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack of bed availability for patients requriing admission and long patient waits in ED
- High acuity levels and patients means more patients require further support on discharge

Actions:
- Plan to increase OPAT capacity (Dec 22)
- Daily board rounds on wards (ongoing)
- LLOS reviews in place for medicine twice per week led by the senior tri (ongoing)
- Perfect Fortnight (Nov 22)

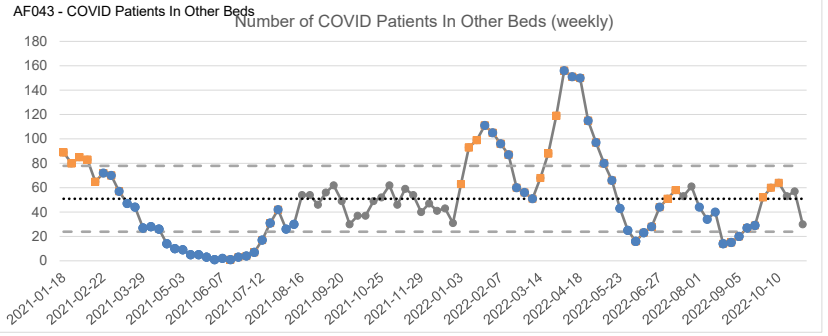
Mitigations:
- Home Care Discharge Programme initiated
- Work taking place with system partners to understand the current constraints and agree actions to elevate exit block from the acute trust
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clear action plan for delayed discharge and escalation plan
- Themes are collated during the week from escalations and fed back to a fortnightly discharge improvement meeting which feeds our improvement plan
- 7 Day Services for Equipment Provision at both North and North East Lincolnshire
- 2 hour community Response

AF042 - COVID Patients In ICU Beds



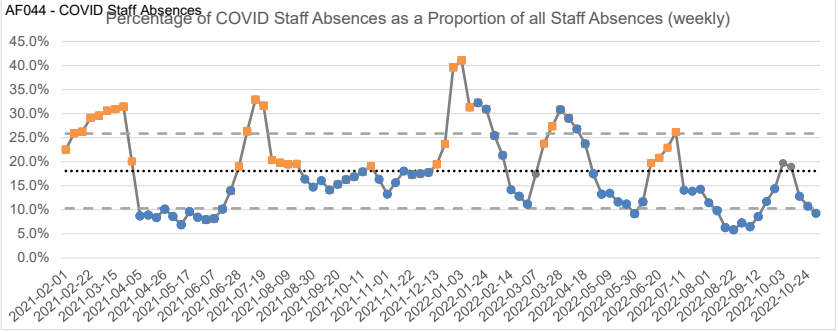
Oct 2022	2
Target	No Target
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant

AF043 - COVID Patients In Other Beds



Oct 2022	30
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant

AF044 - COVID Staff Absences



Oct 2022	9.3%
Target	No Target
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant

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Data Analysis:

COVID Patients In ICU beds: The number of COVID patients in ICU beds has consistently recorded lower than 5 for most of 2022 and remains predominantly at the lower bounds of the process limits for this indicator.

COVID Patients In Other Beds: The number of COVID patients in other beds remains low compared with spring 2022 and is not recording a cause for concern.

COVID Staff Absences: The rate has been volatile since 2021 with repeated changes between concerning and improving performance. However, for the past 3 months the indicator has recorded improvement.

Challenges:

• Minimal side rooms available within Critical Care, currently managing within PODS. !st patient with flu at DPOW.

Key Risks:

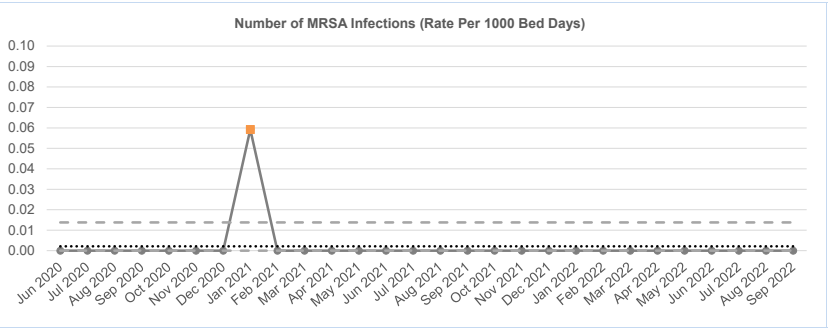
• Inability to manage activity within Critical Care

Actions:

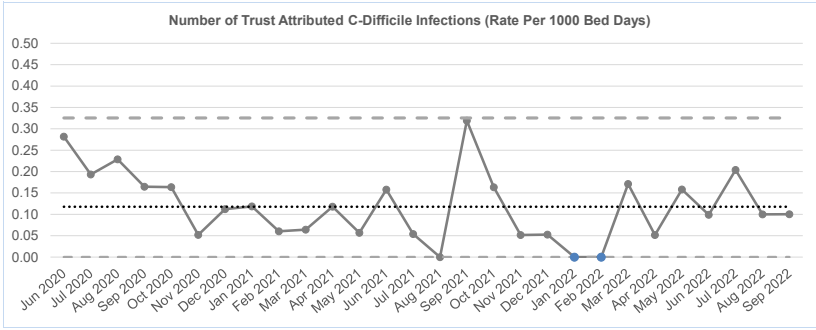
• Review Critical Capacity at all OPS meetings, monitor

Mitigations:

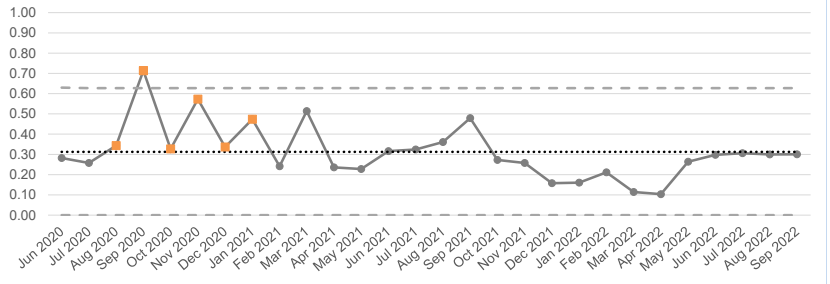
• Utilise Critical Surge plan



Sep 2022
0.00
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Sep 2022
0.10
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Sep 2022
0.30
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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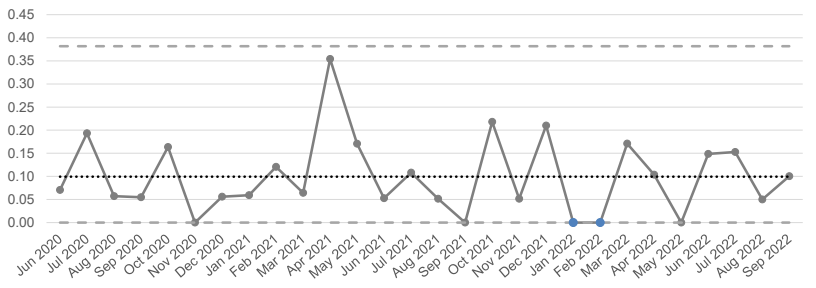
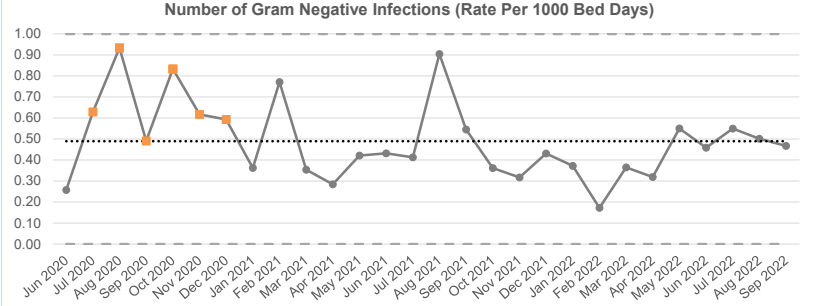
Data Analysis:
MRSA: Performance is stable and within the expected range of the data. The YTD figure is 0 against an annual target of 0.
C Diff: Performance is stable and within the expected range of the data. The YTD figure is 14 against an annual target of 21.
E Coli: Performance is stable and within the expected range of the data. The YTD figure is 33 against an annual target of 65.

Commentary:
There has been no hospital acquired MRSA bacteraemia for 2 years. To date there have been no lapses in care identified with C.diff cases. Ecoli bacteramia cases are as expected



Sep 2022
0.10
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Sep 2022
0.47
Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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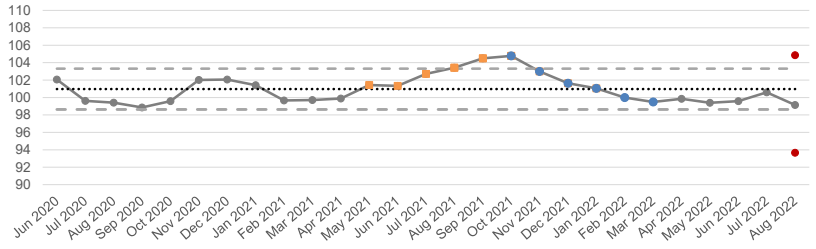
Data Analysis:
MSSA: Performance is stable and within the expected range of the data. The YTD figure is 10, there is no annual target.
Gram Neg: Performance is stable and within the expected range of the data. The YTD figure is 56 against an annual target of 97.

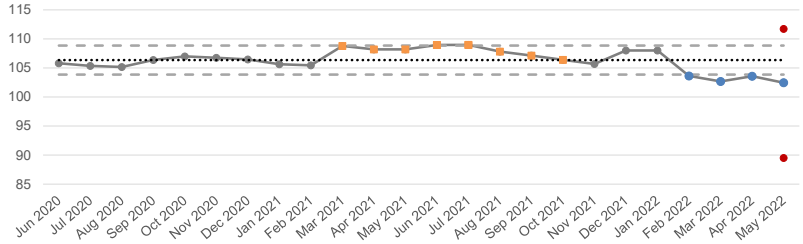
Commentary:
Gram negative cases are as expected. The case threshold for Pseudomonas aeriginosa has been exceeded, however the performance is good in comparison to peer trusts.

Hospital Standardised Mortality Ratio (HSMR)
Rolling 12 month position
Note: The red dots indicate the expected range



Aug 2022
99.1
Target
As expected
Variance
Common cause - no significant change
Assurance
Within 'as expected' range

Summary Hospital level Mortality Indicator (SHMI)
Rolling 12 month position
Note: The red dots indicate the expected range



May 2022
102.5
Target
As expected
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Within 'as expected' range

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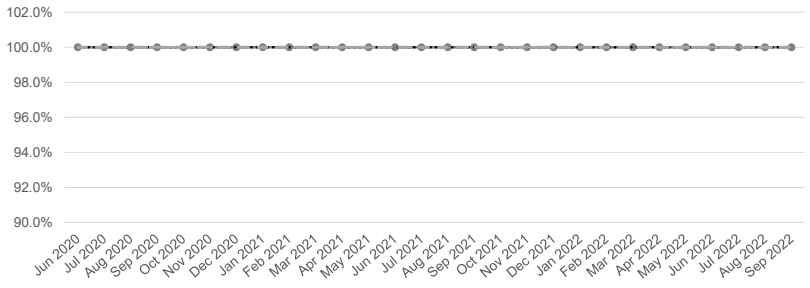
Data Analysis:
HSMR: Performance is within the expected range of the data. The data represents a rolling 12 month position.
SHMI: Performance has improved in recent months. The data represents a rolling 12 month position.

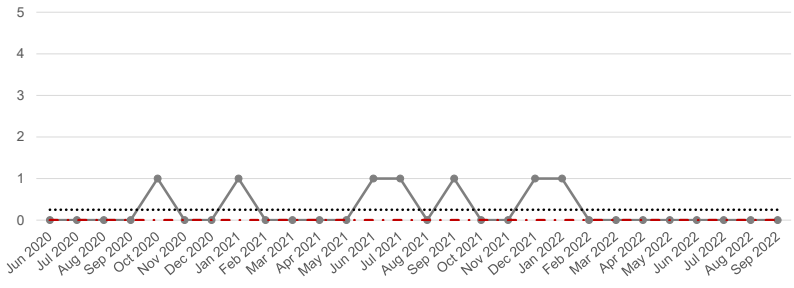
Commentary:

Patient Safety Alerts to be actioned by specified deadlines



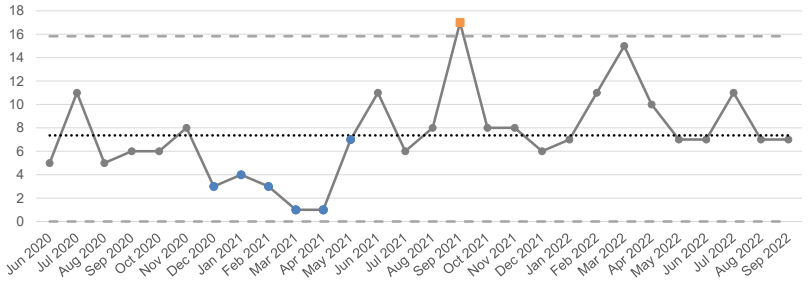
Sep 2022	100.0%
Target	No target
Variance	Common cause - no significant change
Assurance	There is no target therefore target assurance is not relevant

Occurrence of 'Never Events' (Number)



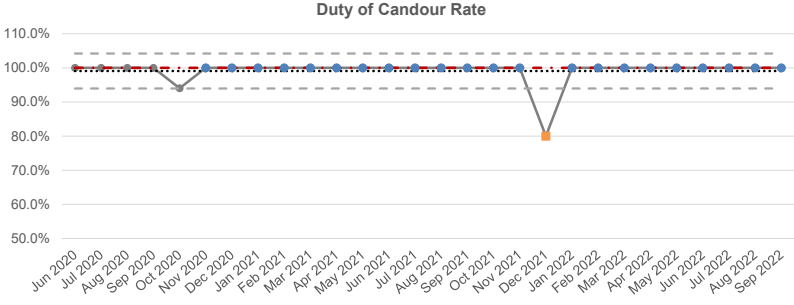
Sep 2022	0
Target	0
Variance	The data are not appropriate for an SPC chart, therefore varaince is not relevant
Assurance	The data are not appropriate for an SPC chart, therefore assurance is not relevant

Number of Serious Incidents Raised in Month



Sep 2022	7
Target	No target
Variance	Common cause - no significant change
Assurance	There is no target therefore target assurance is not relevant

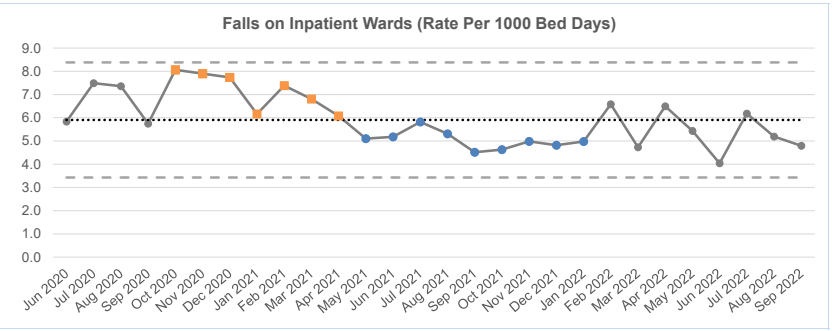
Duty of Candour Rate



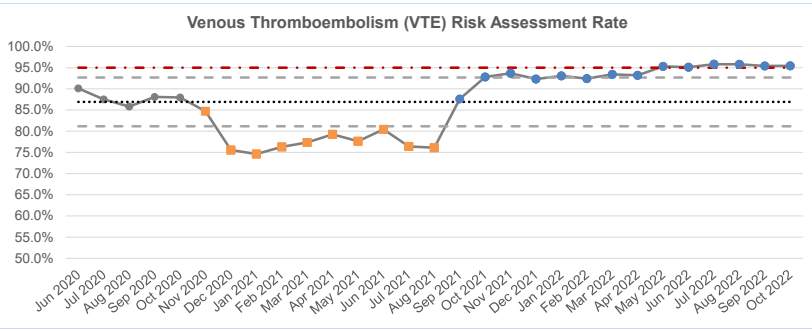
Sep 2022	100.0%
Target	100.0%
Variance	Special cause of improving nature or higher pressure due to higher values
Assurance	Inconsistently hitting passing and failing the target

Data Analysis:
Patient Safety Alerts: Performance continues at 100%.
Never Events: Due to the infrequency of never events an SPC is not appropriate. Never events data are a subset of the serious incidents data.
Serious Incidents: Note this data is updated retrospectively to reflect any de-escalated incidents. The data is within the expected range of variation.
Duty of Candour: With the exceptions of October 2020 and December 2021 performance has achieved the target consistently for over two years.

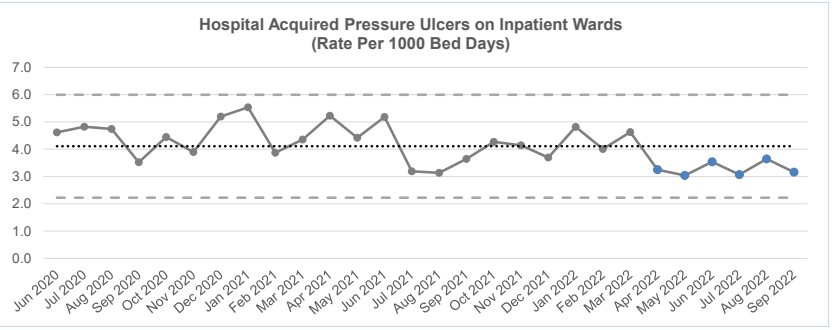
Commentary:
The Trust received one National Patient Safety alert on Friday 21 October in relation to the urgent recall of two batches of Targocid 200mg powder. Actions were due to be completed by the 26 October. Due to the tight deadline coinciding with the weekend and school holidays it was unfortunately not possible to complete all of the required actions before the deadline date. Steps were taken and assurance was provided that the actions were completed as soon as possible by the following day, 27 October.



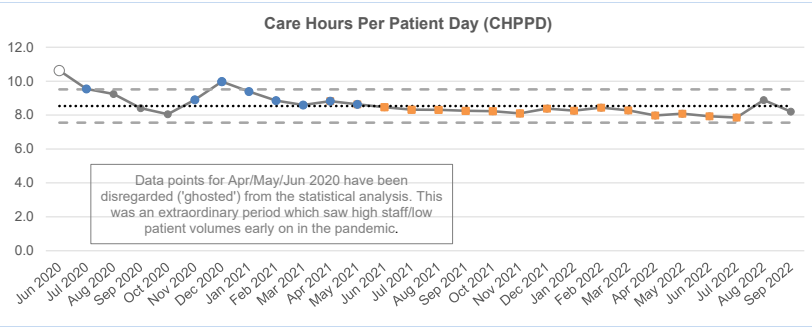
Sep 2022
4.8
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant



Oct 2022
95.4%
Target
95.0%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Consistently failing the target



Sep 2022
3.2
Target
No target
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
There is no target therefore target assurance is not relevant



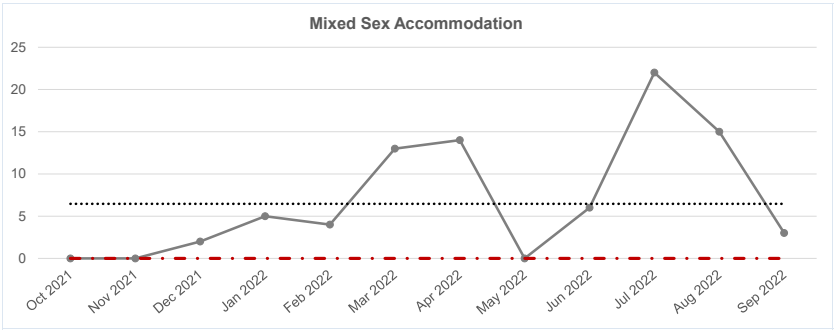
Sep 2022
8.2
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

Data Analysis:

Falls on Inpatient Wards: Performance in the last six months has been stable and within the expected range.
VTE Risk Assessment: Performance has shown a significant improvement over the past eleven months. The figure for September has achieved the target, however, it is not possible, at this stage, to give assurance that it will consistently achieve the target in future months. More data is needed.
Hospital Acquired Pressure Ulcers: Performance is consistently within the expected range and has recorded below average figures for six months and is showing improvement.
Care Hours Per Patient Day: Performance has been below the average value for 17 of the past 18 months, but is within the expected range in September.

Commentary:

Falls - the number of reported falls per 1000 bed days has reduced for the second consecutive month.
Hospital Acquired Pressure Ulcers - the number of reported pressure ulcers per 1000 bed days has reduced in September. The data demonstrates a reduction in the number of reported pressure ulcers over the previous six months with below average numbers reported.
The overall CHPPD was 8.2 in September compared to 8.9 in August. The latest model hospital data for August 2022 indicates a provider median of 8.0 and peer median of 8.2 against the trust value of 8.9 in August which was in quartile 4 – highest 25%. The reason for the increase in CHPPD for August and to some extend September is due to the Central Delivery Suite (CDS) at SGH showing a high CHPPD (31) and is reflected in an increase in Women & Children's CHPPD. Due to the maternity model, patients are moved to ward 26 once delivered and staff are flexed between CDS and Ward 26. Historically CDS was not included in the return due to this issue, but now that it is included work is being undertaken to ensure that staff are moved on the eRoster to ensure CHHPD is accurately reported.



Sep 2022
3
Target
0
Variance
There is currently insufficient data, therefore variance is not relevant
Assurance
There is currently insufficient data, therefore assurance is not relevant

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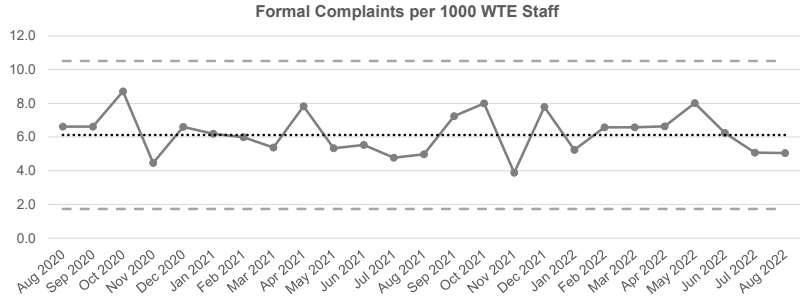
Data Analysis:
Mixed sex accommodation: There is insufficient data for SPC presentation.

Commentary:
In September the Trust declared 1 mix sex breach at DPOW which involved 3 patients and one action plan was commenced which contained all the actions for all patients affected. The theme for these was that the Trust had declared OPEL 4 on all occasions and there was a lack of capacity in step down beds.



Aug 2022	**5.0**
Target	**No target**
Variance	Common cause - no significant change
Assurance	There is no target therefore assurance is not relevant

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Aug 2022	**50.0%**
Target	**85.0%**
Variance	Common cause - no significant change
Assurance	Consistently failing the target

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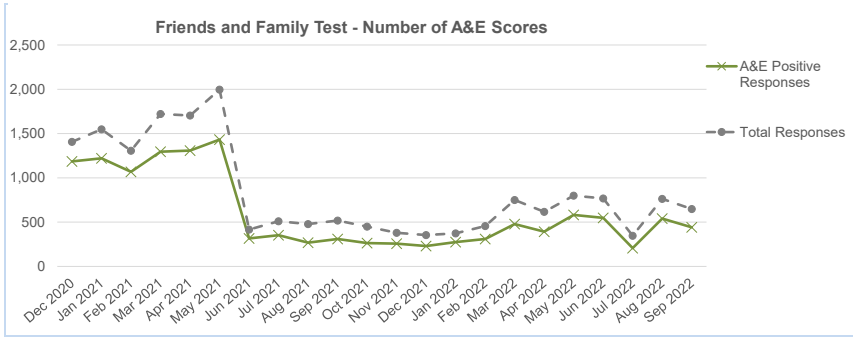
Data Analysis:
Formal Complaints: The data continues within the expected range.
Complaints Responded to on time: The data continues within the expected range but is consistently failing the target. Current data indicates that the target will not be met without action, planned actions outlined below.

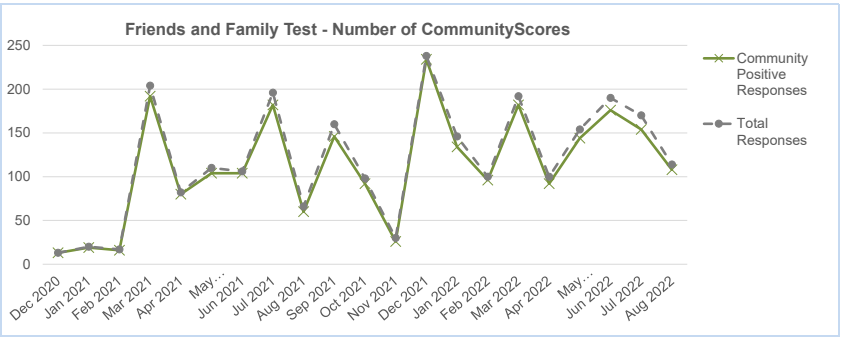
Commentary:
Progress
> Notable decline in responses in timescale - key themes identified (Lead Investigator leave/central team leave /delays in responding)
> Action plan in place to support addressing identified delays in process
> Divisional meetings with PALs and Complaint Manager
> Weekly reporting being commenced for divisional oversight
> Central team set weekly priorities

Risks
> Increased time by clinical staff to manage complex complaint investigations
> Compliance against KPI of 85% closed complaints managed in timescale
> Reputational risk to Trust
> Lack of sustainability evidence of new process
> Potential backlog if situation not resolved

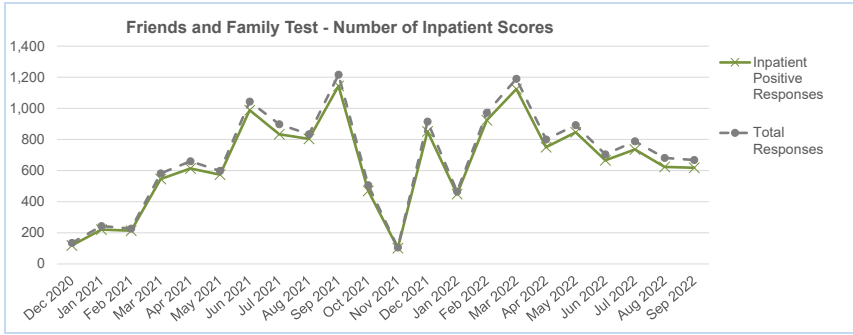
Mitigation
> Weekly Central Team Support and Challenge Meetings
> Chief Nurse Reporting
> PRIMS
> Monthly complaint report and feedback
> Escalation processes



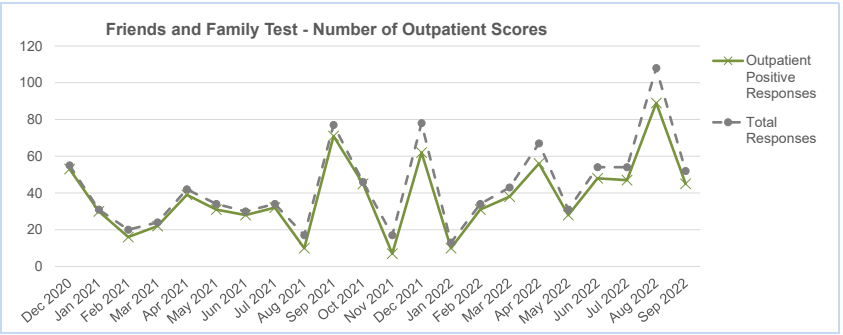
Sep 2022
442 out of 648
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Aug 2022
108 out of 114
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Sep 2022
618 out of 668
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



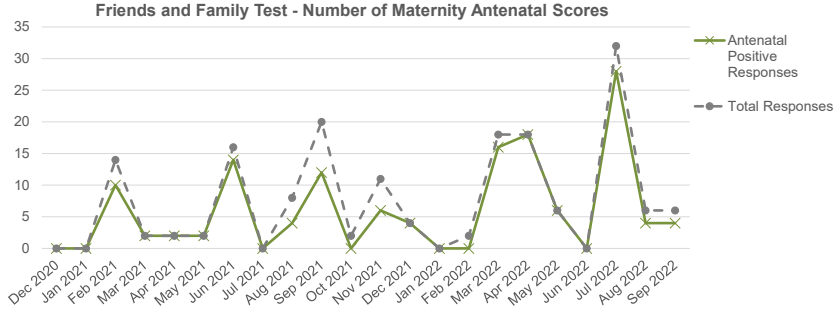
Sep 2022
45 out of 52
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

Data Analysis:
A&E FFT: There were 648 responses received in total for September 2022, and 442 were positive (68.2%).
Community FFT: There were 114 responses received in total for August 2022, and 108 were positive (94.7%)
Inpatient FFT: There were 668 responses received in total for September 2022, and 618 were positive (92.5%)
Outpatient FFT: There were 52 responses received in total for September 2022, and 45 were positive (86.5%)

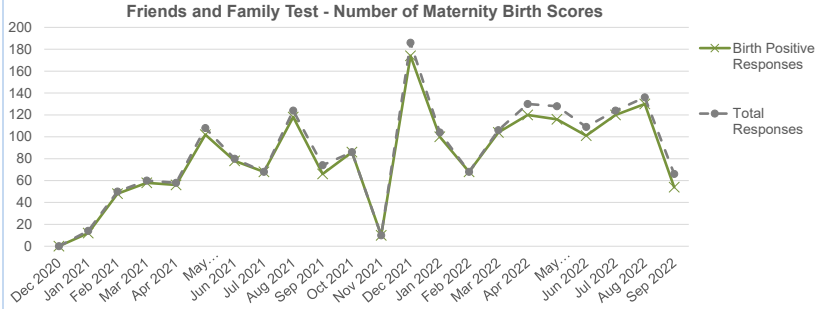
Commentary:
Progress
> Impact of annual leave evident across all responses
> Increased SMS across key areas planned
> Weekly meetings with IWGC reinstated with Patient Experience Manager
> Kiosks costs being identified for ED
> FFT on community smart phones
> Utilisation of new patient experience dashboard to share FFT data divisionally via Metrics

Risks
> Lack of representative feedback responses meaning reduced oversight of patient insights
> Staff engagement levels mean that response collection is impacted in many areas
> Methodologies are limited in some areas meaning accessibility is reduced

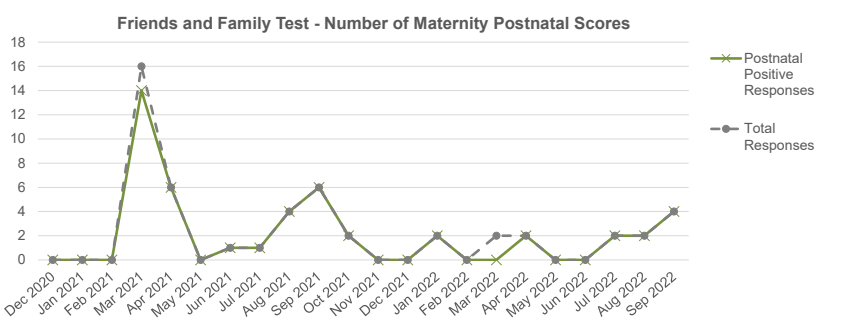
Mitigation
> Weekly meetings with IWGC
> Temporary Patient Experience Manager to focus on FFT
> Divisional Patient Experience Meetings highlighting issues
> Quarterly Divisional reported shared with PEG
> Full hierarchy review planned



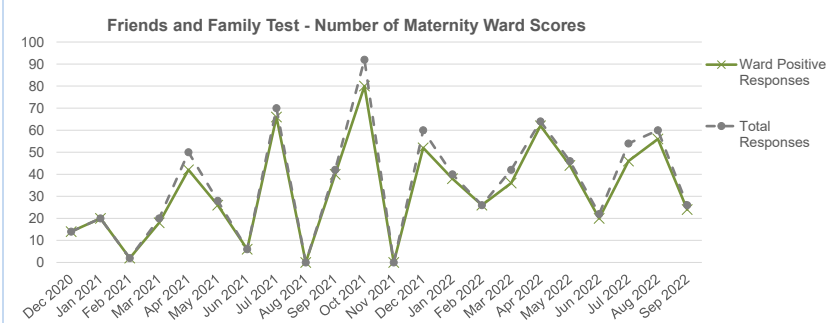
Sep 2022
4 out of 6
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Sep 2022
54 out of 66
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Sep 2022
4 out of 4
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



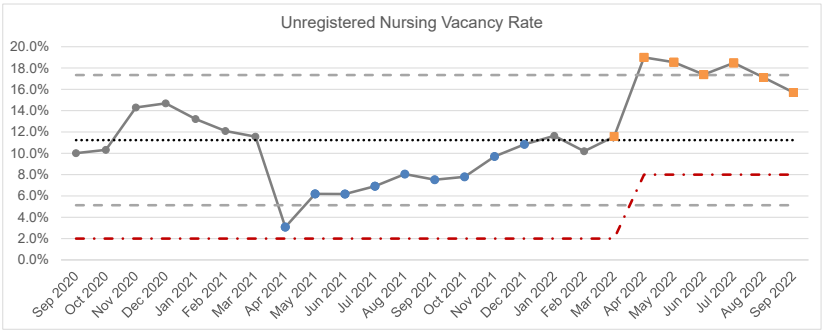
Sep 2022
24 out of 26
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

Data Analysis:
Maternity Antenatal FFT: There were 6 responses received for September 2022, and 4 were positive (66.7%)
Maternity Birth FFT: There were 66 responses received in total for September 2022, and 54 were positive (81.8%)
Maternity Postnatal FFT: There were 4 responses received for September 2022, and all were positive.
Maternity Ward FFT: There were 26 responses received in total for September 2022, and 24 were positive (92.3%)

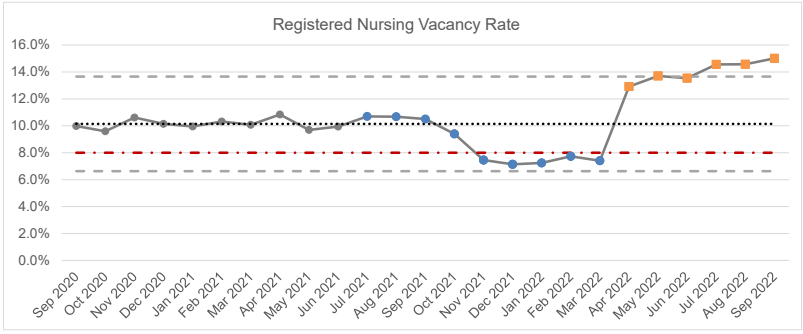
Commentary:
Progress
> Increased SMS across key areas planned
> Weekly meetings with IWGC reinstated with Patient Experience Manager
> IWGC continue to work to improve maternity platform for responses
> Exploring use of Badgernet to fulfil FFT requirements
> Utilisation of new patient experience dashboard to share FFT data divisionally via Metrics

Risks
> Lack of representative feedback responses meaning reduced oversight of patient insights
> Staff engagement levels mean that response collection is impacted in many areas
> Methodologies are limited in some areas meaning accessibility is reduced

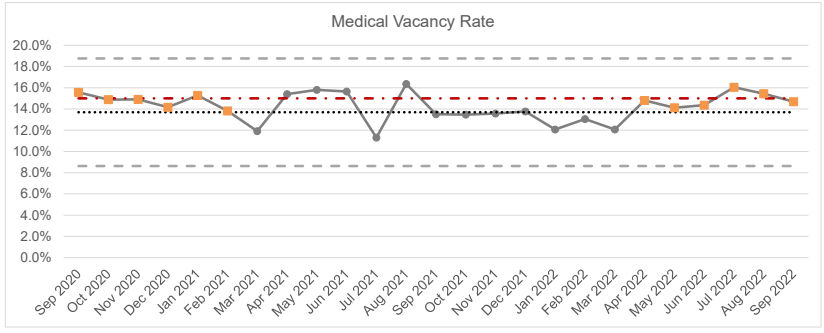
Mitigation
> Weekly meetings with IWGC
> Release of Patient Experience Manager to focus on FFT
> Divisional Patient Experience Meetings highlighting issues
> Quarterly Divisional reported shared with PEG
> Full hierarchy review planned



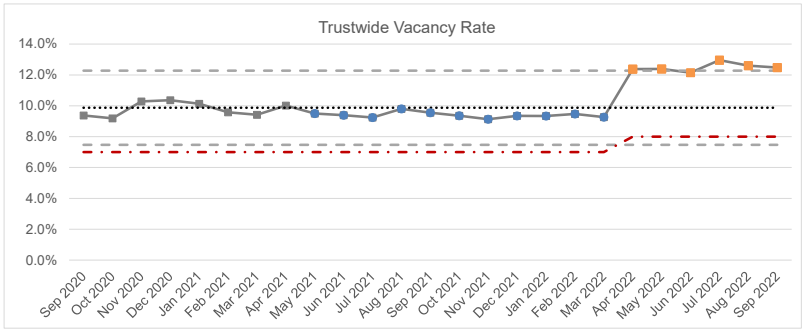
Sep 2022	15.7%
Target	8.0%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Inconsistently hitting passing and failing the target



Sep 2022	15.0%
Target	8.0%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Inconsistently hitting passing and failing the target



Sep 2022	14.7%
Target	15.0%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Inconsistently hitting passing and failing the target



Sep 2022	12.5%
Target	8.0%
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Inconsistently hitting passing and failing the target

Data Analysis:
Unregistered Nursing Vacancies: After a significant reduction last spring, the rate has gradually been increasing and has now risen outside of the expected range.
Registered Nursing Vacancies: After a period of improvement, performance has started to deteriorate in the last six months and is now recording concern.
Medical Vacancy Rate: Performance has been stable and as expected for over a year. The target can be expected to be achieved and failed at random.
Trustwide Vacancy Rate: Performance has fallen outside the expected range over the past six months after consistenly falling within the expected range. Current data indicates that the target will not be met without action.

Commentary:
Issues/Risks: Retention of HCAs. Unfamiliarity with the role and expectations of what the role entails influencing decisions to leave, current high vacancy rate.

Mitigations: A project group led by the Chief Nurse's office to oversee activity and consider mitigating actions. Successful mass recruitment events took place in September which exceeded plans, with 142 appointments made resulting in a pool of 180. The majority of these are planned to start by December 2022. HCA induction capacity has been increased to allow rapid onboarding of new HCAs from the September recruitment events.

Actions: Continue allocations of pipeline HCAs and facilitate starts as soon as possible.

Issues/Risks: Availability of accomodation can delay recruitment processes. CPD Team capacity to support international nurses. Significant increase in cost of flights adding pressure to international nurses.

Actions: Continue sourcing of nursing candidates via the Talent Acquisition Team - Domestic and international. Continued engagement with both Chief Nurse Directorate and Operations to review existing recruitment practices. Implementation of a nursing workforce plan as part of the Nursing Strategy inclusive of all pipelines including apprenticeship development and a strengthened domestic presence in the existing market place. Commence local/regional/national recruitment campaign in November 2022.

Mitigations: A project group led by the Chief Nurses office to oversee all activities. Newly qualified nurse (NQN) recruitment for 21/22 exceeded target with 89 appointments, the majority of which to start in Q3, and attendance at university events to further strengthen NQN engagement. International nurses - ongoing recruitment of international nurses with cohorts planned for start. Plans for 59 further international nurses to start by the end of December 2022. Nursing career frameworks and introduction of nursing apprenticeships currently being recruited to will will see reliance on international nurse sourcing reduce longer term.

Commentary Vacancies Cont/d:

Issues/Risks: Availability of accomodation can delay recruitment processes. Pausing of MTI candidates due to concerns from Royal College.

Actions: Ongoing recruitment activity across specialties. Resolving MTI issues.

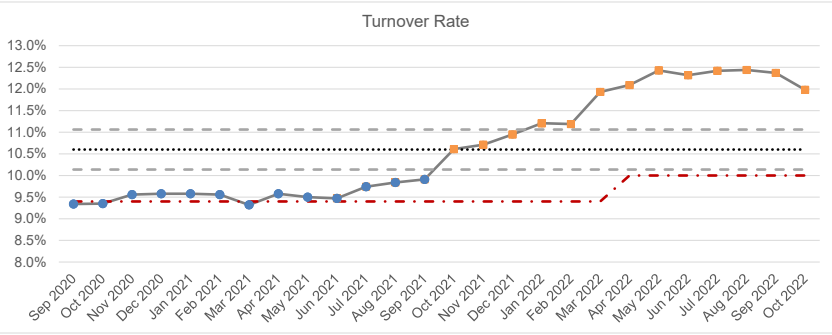
Mitigations: Recruitment team continuing to engage with candidates.. A pipeline of 81 medical staff has been established awaiting start. A network of private landlords has been established to support accomodation needs where the Trust is unable to accommodate locally, and work undertaken by the onsite accommodation team to free up onsite accommodation. Accommodation team have given notice to long term tenants to free up on-site accommodation for new starters and a change of policy relating to length of stay. Recruitment team are meeting the accommodation team weekly to review priorities and identify accommodation needs. Work is underway with the Royal College to address the issues raised, including reviewing induction and support to MTI candidates and job descriptions and a site visit planned for 7th December.

Issues/Risks: Travel difficulties are delaying starts for some new employees..Availability of accomodation can delay recruitment processes

Actions: Ongoing recruitment activity across various workstreams, engagement with candidates to reduce withdrawal rates.

Mitigations: Various projects for different staff groups, including international nursing and HCAs.

Northern Lincolnshire and Goole NHS Foundation Trust



Oct 2022
12.0%

Target
10.0%

Variance

Special cause of concerning nature or higher pressure due to higher values

Assurance

Consistently failing the target

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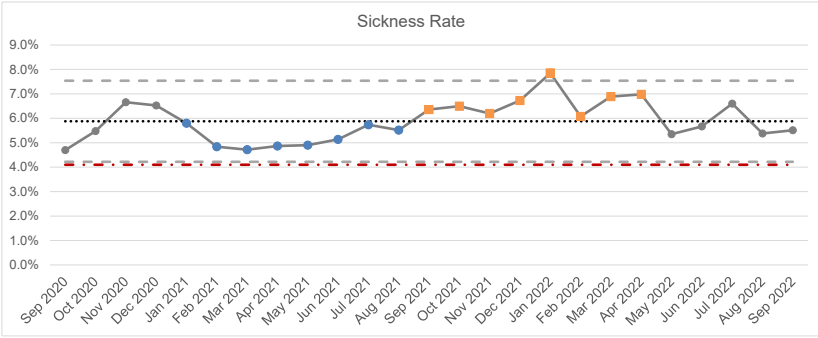

Sep 2022
5.5%

Target
4.1%

Variance

Common cause - no significant change

Assurance

Consistently failing the target

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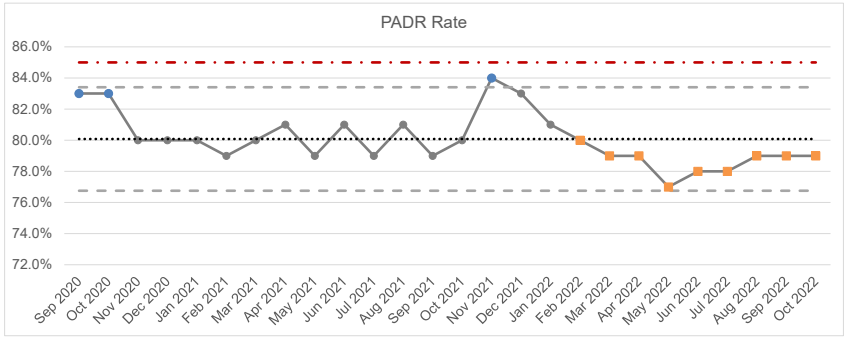
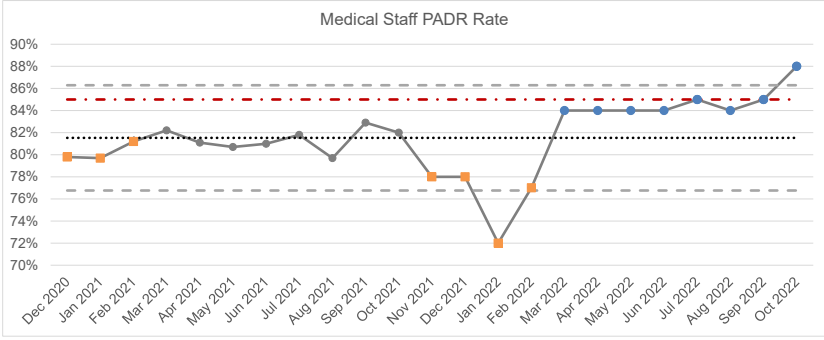
Data Analysis:
Turnover Rate: After having stayed fairly stable during the peak of pandemic, the turnover rate has been steadily increasing since the end of summer 2021 and has recorded concerning performance for the past year
Sickness Rate: This indicator has recorded a general increase in sickness rates since last summer but usually falls within the expected range for the data. Current data indicates that the target will not be met without action.

Commentary:

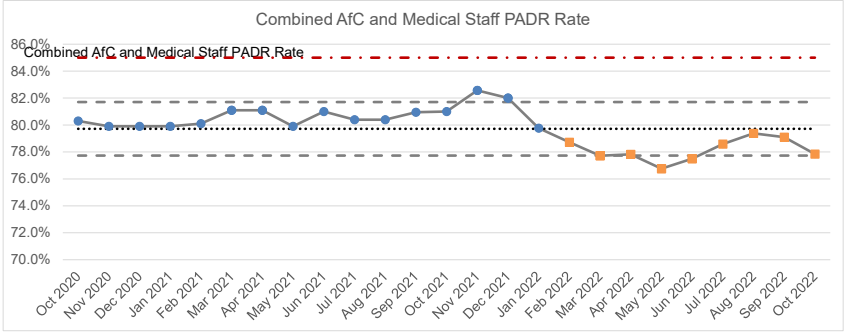
Sickness remains within normal variance but above target. Significant work is currently underway with a focus on increasing the management of long term sickness combined with increased support for individuals. This work aims to reduce the number of long terms cases. To date, a reduction of long term cases can be seen particularly within the Medicine division.



Oct 2022	79.0%
Target	85.0%
Variance	Special cause of concerning nature or higher pressure due to lower values
Assurance	Consistently failing the target



Oct 2022	88.0%
Target	85.0%
Variance	Special cause of improving nature or lower pressure due to higher values
Assurance	Inconsistently hitting passing and failing the target



Oct 2022	77.9%
Target	85.0%
Variance	Special cause of concerning nature or higher pressure due to lower values
Assurance	Consistently failing the target

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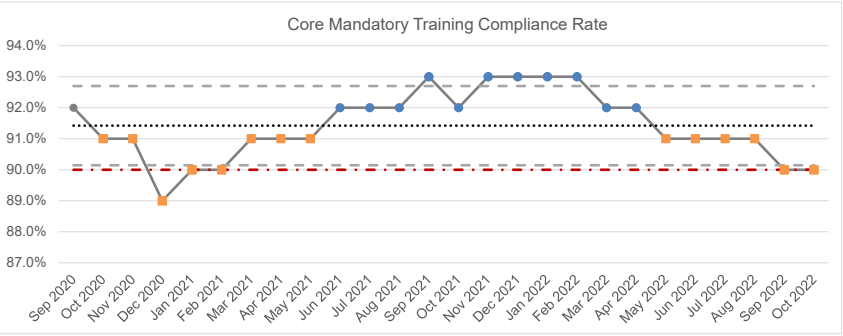
Data Analysis:
PADR Rate: Performance has been stable and is within the expected range since March 21, however current data indicates that the target will not be met without action.
Medical Staff PADR Rate: Performance has been predominantly within the expected range for the past two years with an improvement seen over recent months.
Combined AfC and Medical Staff PADR Rate: Following eighteen months of stable or improving figures, performance has deteriorated in recent months and is now recording concern since January 22. Current data indicates that the target will not be met without action.

Commentary:
The ETD Team are working with OD on the forthcoming Leadership Development Programme which includes assessing competency in the use of ESR for managing teams, including PADR compliance. ETD Team are finding that operational challenges continue to impact on staff capacity to complete PADR's but are continuing to work with HRBP's to target areas with low compliance.

ETD are also working closely with the ESR Team to monitor compliance through Power BI for PADR. This allows managers to look at real time data so it is important that our data is accurate.

Commentary-
The Medical Director's Office continues to support medical staff with their appraisal through the dedicated revalidation/Medical appraisals service which is managed by the Revalidation and Medical Appraisal coorindator. This includes providing support information such as incident and complaint informatio n,use of a decidated revalidation management system (L2P), 1:1 support sessions, flexibility built into the appraisal process (e.g phased return to work following sick leave or compassionate leave) and a procedure to manage late doctors. Doctors who There are doctors who are yet to complete appraisal cite 2 main reasons: operational pressures and Covid. These doctors are being supported by the Clinical Lead for Medical Appraisal. There are no doctors who are not engaging with the regulatory process of revalidation and appraisal.
Going forward, their will continued efforts to keep doctors engaged with the process as we go into winter and the additional operation demands this brings, and again as with previous years, flexibility will be built if required to support the medical staff community to ensure contined engagement with the process.



Oct 2022
90.0%

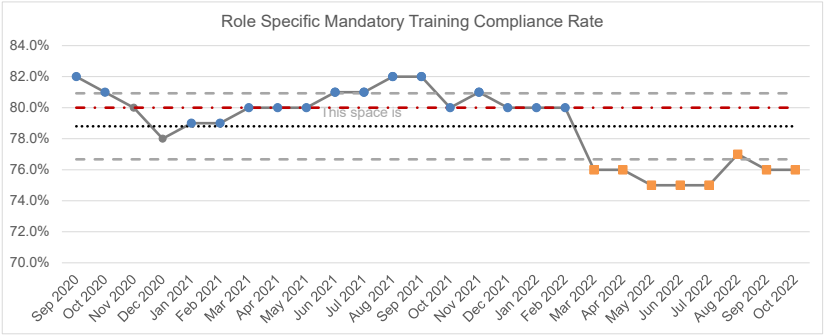
Target
90.0%

Variance

Special cause of concerning nature or higher pressure due to lower values

Assurance

Consistently passing the target



Oct 2022
76.0%

Target
80.0%

Variance

Special cause of concerning nature or higher pressure due to lower values

Assurance

Inconsistently hitting passing and failing the target

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Data Analysis:
Core Mandatory Training: Performance has recorded improvement for almost a year and the target has been consistently achieved during this time. The indicator can be reliably expected to achieve the target.
Role Specific Mandatory Training: After a long run of stable and improving performance, this indicator has deteriorated over the past six months and is now outside of the expected range, recording a concern.

Commentary:
ETD Team are completing regular deep dive sessions on Statutory and Mandatory Training and are currently workling with MT Leads to ensure the accuracy of competency mapping. There is also a new process in place to ensure all new and existing staff have the correct competencies mapped to their role which will be an ongoing task.

The ETD Team are in the final stages of preparing a fresh new Induction and People Leader Induction, both of which emphasis the importance of completing statutory and mandatory training. The new Leadership Programme, when up and running, will ensure managers have the ability to monitor staff compliance within their area and will also start a conversion as part of the PADR process.

The Team are also working with the HRBP's to target areas with low compliance. A data cleanse within ESR is undergoing to streamline competency mapping and Learning Paths are being set up to ensure staff find it easier to access relevant courses which will help maintain compliance.

ETD are working closely with the ESR Team to monitor compliance and accuracy through Power BI which allows managers to look at real time data so it is important that our data is accurate.

Appendix A - Benchmarking

Centiles from the Public View website have been provided where available (these are not available for all indicators in the IPR).

The Centile is calculated from the relative rank of an organisation within the total set of reporting organisations. The number can be used to evaluate the relative standing of an organisation within all reporting organisation)s. If NLAG's Centile is 96, if there were 100 organisations, then 4 of them would be performing better than NLAG. The colour shading is intended to be a visual representation of the ranking of NLAG (red indicates most organisations are performing better than NLAG, green indicates NLAG is performing better than many organisations. Amber shows NLAG is in the mid range).
Note: Organisations which fail to report data for the period under study are included and are treated as the lowest possible values.

Source: https://publicview.health as at 21/11/2022

* Indicates the benchmarked centiles are from varying time periods to the data presented in the IPR and should be taken as indicative for this reason

^ Indicates the benchmarked centiles use a variation on metholody to the IPR and should be taken as indicative for this reason

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Access & Flow	Planned	% Under 18 Weeks Incomplete RTT Pathways	Oct 2022	65.4%	92.0%	58	71/169	Sep 2022
	Planned	Number of Incomplete RTT pathways 52 weeks	Oct 2022	371	0	65	60/168	Sep 2022
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Oct 2022	28.6%	1.0%	35	101/155	Sep 2022
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Oct 2022	44.2%	85.0%	18	111/135	Sep 2022
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Oct 2022	61.2%	95.0%	26	96/130	Oct 2022
	Urgent Care	Number Of Emergency Department Attendances	Oct 2022	12,897	No target	50	72/144	Oct 2022
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Oct 2022	708	0	21	121/152	Oct 2022
	Flow	Bed Occupancy Rate (General & Acute)	Oct 2022	93.9%	92.0%	52	76/156	Q2 22/23
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Oct 2022	7.0%	5.0%	66	55/162	Sep 2022
	COVID	Number of COVID patients in ICU beds (Weekly)	Oct 2022	2	No target	46	111/203	Oct 2022
	COVID	Number of COVID patients in other beds (Weekly)	Oct 2022	30	No target			

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Quality & Safety	Infection Control	Number of MRSA Infections	Sep 2022	0.000	No target	100	1/137	Aug 22
	Infection Control	Number of E Coli Infections	Sep 2022	0.300	No target	90	14/137	Aug 22
	Infection Control	Number of Trust Attributed C-Difficile Infections	Sep 2022	0.100	No target	93	10/137	Aug 22
	Infection Control	Number of MSSA Infections	Sep 2022	0.100	No target	53	65/137	Aug 22
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	May 2022	102.5	As expected	39	74/121	Jun 2022
	Safe Care	Number of Serious Incidents Raised in Month	Sep 2022	7	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Sep 2022	8.2	No target	59	76/182	Aug 22
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Oct 2022	95.4%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Aug 2022	5.0	No target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Number of Positive Inpatient Scores	Sep 2022	618 of 668	No target	29	96/134	Sep 2022

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Sep 2022	5.5%	4.1%	40	129/214	Jun 2022

Appendix B - Access and Flow (F&P Sub-Committee)

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time. * Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR. n/a is stated for Assurance/Variation when the data is not presented as an SPC chart.

Planned	Percentage Under 18 Weeks Incomplete RTT Pathways*	Oct 2022	65.4%	92.0%	**Alert**			Board
	Number of Incomplete RTT pathways 52 weeks*	Oct 2022	371	0	**Alert**			Board
	Total Inpatient Waiting List Size	Oct 2022	10,920	11,563	**Alert**			Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Oct 2022	28.6%	1.0%	**Alert**			Board
	Number of Incomplete RTT Pathways*	Oct 2022	35,973	No Target	**Alert**		n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Oct 2022	17,164	No Target			n/a	FPC
	% of Inpatient Live Waiting List Risk Stratified	Oct 2022	100.0%	99.0%				FPC
	% of Inpatient Live Waiting List Overdue Risk Strat Date	Oct 2022	42.3%	37%				FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Oct 2022	34,028	9,000	**Alert**			Board
	Outpatient Did Not Attend (DNA) Rate	Oct 2022	7.0%	5.00%	**Alert**			Board
	% Outpatient Non Face To Face Attendances	Oct 2022	26.9%	25.00%	**Alert**			Board
	% Outpatient summary letters with GPs within 7 days	Oct 2022	21.4%	50.0%	**Alert**			FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Oct 2022	84.1%	99.0%	**Alert**			FPC
	% of Outpatient Waiting List Overdue Risk Strat Date (New and Review)	Oct 2022	29.8%	23.0%		n/a	n/a	FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Oct 2022	44.2%	85.0%	**Alert**			Board
	Cancer Waiting Times - 104+ Days Backlog*	Oct 2022	56	0	**Alert**			Board
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Oct 2022	10.0%	75.0%	**Alert**			Board
	Cancer Request To Test In 14 Days*	Oct 2022	83.4%	100.0%	**Alert**			Board
	Cancer Waiting Times - 2 Week Wait*	Oct 2022	95.9%	93.0%	**Alert**			FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Oct 2022	88.6%	93.0%				FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Oct 2022	65.2%	75.0%	**Alert**			FPC
	Cancer Waiting Times - 31 Day First Treatment*	Oct 2022	95.1%	96.0%				FPC
	Cancer Waiting Times - 31 Day Surgery*	Oct 2022	82.4%	94.0%	**Alert**			FPC
	Cancer Waiting Times - 31 Day Drugs*	Oct 2022	97.9%	98.0%				FPC
	Cancer Waiting Times - 62 day Screening*	Oct 2022	70.0%	90.0%				FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Oct 2022	61.2%	95.0%	**Alert**			Board
	Number Of Emergency Department Attendances	Oct 2022	12,897	No Target	**Alert**		n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Oct 2022	540	0	**Alert**			Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Oct 2022	708	0	**Alert**			Board
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Oct 2022	336	0	**Alert**			Board
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Oct 2022	40.5%	40.0%				Board
	% of Extended Stay Patients 21+ days	Oct 2022	11.7%	12.0%				Board
	Inpatient Elective Average Length Of Stay	Oct 2022	2.3	2.5				Board
	Inpatient Non Elective Average Length Of Stay	Oct 2022	3.5	3.9				Board
	Number of Medical Patients Occupying Non-Medical Wards	Oct 2022	172	No Target	**Alert**		n/a	Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Oct 2022	90.2%	90.0%				Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Oct 2022	16.1%	30.0%	**Alert**			Board
	Bed Occupancy Rate (G&A)	Oct 2022	93.9%	92.0%				Board
	Percentage of patients re-admitted as an emergency within 30 days	Oct 2022	8.2%	No Target			n/a	FPC
	% of Extended Stay Patients 7+ days	Oct 2022	41.0%	No Target			n/a	FPC
	% of Extended Stay Patients 14+ days	Oct 2022	22.6%	No Target			n/a	FPC
COVID	Number of COVID patients in ICU beds (Weekly)	Oct 2022	2	No Target			n/a	Board
	Number of COVID patients in other beds (Weekly)	Oct 2022	30	No Target			n/a	Board
	% COVID staff absences (Weekly)	Oct 2022	9.3%	No Target			n/a	Board

Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
n/a is stated when the data is not presented as a statistical process control chart (variation not applicable) or a target is not set (assurance not applicable)

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Sep 2022	0.00	see analysis			n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Sep 2022	0.30	see analysis			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Sep 2022	0.10	see analysis			n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Sep 2022	0.10	see analysis			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Sep 2022	0.47	see analysis			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Aug 2022	99.1	As expected			As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	May 2022	102.5	As expected			As expected	Board
	Number of patients dying within 24 hours of admission to hospital	Oct 2022	22	No target			n/a	Q&S
	Number of emergency admissions for people in the last 3 months of life	Oct 2022	198	No target			n/a	Q&S
	Out Of Hospital (OOH) SHMI	Jun 2022	140.4	110.0	**Alert**			Q&S
	Structured Judgement Reviews - Rate Completed of those required	Jun 2022	47.0%	100.0%	**Alert**			Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Sep 2022	100.0%	No target			n/a	Board
	Number of Serious Incidents raised in month	Sep 2022	7	No target			n/a	Board
	Occurrence of 'Never Events' *(Number)*	Sep 2022	0	0		n/a	n/a	Board
	Duty of Candour Rate	Sep 2022	100.0%	100.0%				Board
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Sep 2022	4.8	No target			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Sep 2022	3.2	No target	**Highlight**		n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Oct 2022	95.4%	95.0%	**Alert**			Board
	Care Hours Per Patient Day (CHPPD)	Sep 2022	8.2	No target			n/a	Board
	Mixed Sex Accommodation Breaches	Sep 2022	3.0	0		n/a	n/a	Board
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Aug 2022	5.0	No target			n/a	Board
	Complaints Responded to on time	Aug 2022	50.0%	85.0%	**Alert**			Board
	Friends and Family Test (FFT)							
	Number of Positive Inpatient Scores	Sep 2022	618 out of 668	No target		n/a	n/a	Board
	Number of Positive A&E Scores	Aug 2022	442 out of 648	No target		n/a	n/a	Board
	Number of Positive Community Scores	Sep 2022	108 out of 114	No target		n/a	n/a	Board
	Number of Positive Outpatient Scores	Sep 2022	45 out of 52	No target		n/a	n/a	Board
	Number of Maternity Antenatal Scores	Sep 2022	4 out of 6	No target		n/a	n/a	Board
	Number of Maternity Birth Scores	Sep 2022	54 out of 66	No target		n/a	n/a	Board
	Number of Maternity Postnatal Scores	Sep 2022	4 out of 4	No target		n/a	n/a	Board
	Number of Maternity Ward Scores	Sep 2022	24 out of 26	No target		n/a	n/a	Board
Observations	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Oct 2022	90.1%	90.0%				Q&S
	Percentage of Child Observations Recorded On Time (with a 30 min grace)	Oct 2022	95.0%	90.0%				Q&S
	Escalation of NEWS in line with Policy	Jun 2022	3.0%	No target		n/a	n/a	Q&S
	Clinical assessment undertaken within 15 minutes of arrival in ED	Sep 2022	45.0%	90.0%		n/a	n/a	Q&S
Sepsis	Rate of Adults Screened for Sepsis using the Adult Sepsis Screening and Action Tool *(based on Manual Audit)*	Jun 2022	47.0%	90.0%		n/a	n/a	Q&S
	Rate of those who had the Sepsis Six completed within 1 hour for patients who have a Red Flag - Adults *(based on Manual Audit)*	Jun 2022	0.0%	90.0%		n/a	n/a	Q&S
	Rate of Children Screened for Sepsis using the Sepsis Screening and Action Tool	Sep 2022	36.0%	90.0%		n/a	n/a	Q&S
	Rate of Children who had the Sepsis Six completed within 1 hour for patients who have a Red Flag - Children	Sep 2022	38.0%	90.0%		n/a	n/a	Q&S
Prescribing	Percentage of patients admitted to IAAU with an actual, estimated or patient reported weight recorded on EPMA or WebV *(based on Manual Audit)*	Sep 2022	67.0%	No target		n/a	n/a	Q&S
	Percentage of patients admitted to IAAU with an ACTUAL weight recorded on EPMA or WebV *(based on Manual Audit)*	Sep 2022	15.0%	No target		n/a	n/a	Q&S
	Percentage of patients admitted to IAAU whose weight was 50kg (+/- 6kg) who complied with prescribing weight for dosing standard	Sep 2022	100.0%	No target		n/a	n/a	Q&S
	Reduction in patients prescribed an antibiotic	Mar 2022	40.7%	50.0%		n/a	n/a	Q&S
	Percentage of Medication Omissions for Ward Areas Using EPMA	Sep 2022	2.4%	No target			n/a	Q&S
	Antibiotic prescriptions have evidence of a review within 72 hours	Mar 2022	69.1%	70.0%		n/a	n/a	Q&S

Appendix B - Workforce

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time. * Indicators marked with an asterix have 'unvalidated' status at the time of producing the IPR. n/a is stated for Assurance/Variation when the data is not presented as an SPC chart.

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Vacancies	Unregistered Nurse Vacancy Rate	Sep 2022	15.7%	8.0%	Alert			Board
	Registered Nurse Vacancy Rate	Sep 2022	15.0%	8.0%	Alert			Board
	Medical Vacancy Rate	Sep 2022	14.7%	15.0%	Alert			Board
	Trustwide Vacancy Rate	Sep 2022	12.5%	8.0%	Alert			Board
Staffing Levels	Turnover Rate	Oct 2022	12.0%	10.0%	Alert			Board
	Sickness Rate	Sep 2022	5.5%	4.1%	Alert			Board
Staff Development	PADR Rate	Oct 2022	79.0%	85.0%	Alert			Board
	Medical Staff PADR Rate	Oct 2022	88.0%	85.0%				Board
	Combined AfC and Medical Staff PADR Rate	Oct 2022	77.9%	85.0%	Alert			Board
	Core Mandatory Training Compliance Rate	Oct 2022	90.0%	90.0%	Alert			Board
	Role Specific Mandatory Training Compliance Rate	Oct 2022	76.0%	80.0%	Alert			Board
Disciplinary	Number of Disciplinary Cases Live in Month	Oct 2022	8	No Target			n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Oct 2022	0	12				WFC
	Number of Suspensions Live in Month	Oct 2022	5	No Target			n/a	WFC
	Average Length of Suspension (Weeks)	Oct 2022	0	No Target			n/a	WFC

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(22)257

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	December 6, 2022
Director Lead	Shauna McMahon, Chief Information Officer (CIO)
Contact Officer/Author	Shauna McMahon, Chief Information Officer (CIO)
Title of the Report	**Data Quality Assurance**
Purpose of the Report and Executive Summary (to include recommendations)	Response to letter dated November 22 from Stephen Eames CBE (as detailed in his letter to NLAG on page 17). Mr. Eames letter requests confirmation that assurance has been provided to boards on data quality and reporting. The attached paper, provides the details of how assurance is monitored at the two Trusts. There is no evidence that we have data quality issues and our internal monitoring and audits have not indicated any areas of concern. It is difficult to respond to a letter that provides no factual details that would enable investigation or follow up. Data quality is a continuous process. We are currently updating the Patient Administration System (PAS), implementing a new data warehouse and improving Electronic Patient Record (EPR) data entry fields. Those improvements will make the collection more efficient and should reduce workload on some people. We do not expect a significant change in quality as we do manual checks and balances now. Some of these will be able to be automated with the new technology. I have included the letter drafted back to the ICS. This is to indicate to the Board that we do have checks in place regarding data quality. We have processes in place to correct any data we believe may need updating and we are confident that at this time we have measures in place to audit our submissions.
Background Information and/or Supporting Document(s) (if applicable)	Letter Dated November 22 from Stephen Eames CBE (as detailed in his letter to NLaG on page 17) Reports and evidence of data quality assurance done at both NLaG and HUTH as well coding briefing.
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ☐ Other: Click here to enter text.

Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ✓ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ✓ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
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: Click here to enter text.

***Board Assurance Framework (BAF) Descriptions:**

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

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

Date: 28th November 2022

Dear Stephen

Thank you for your letter dated November 22, 2022. I can confirm that based on the audits and checks that we conduct, the data we submit is consistent and accurate.

As the Joint Chief Information Officer (CIO) for NLaG and HUTH, I have outlined what I have as assurance for our reporting:

- Both Trusts score highly on the national SUS Data Quality dashboards. As one example, on the national data quality dashboards covering CDS and ECDS where in both dashboards HUTH and NLAG score consistently higher on data quality and are above both the ICB and national averages.
- HUTH is in the CHKS Top 5 organisations for its data quality and clinical coding data quality.
- NLaG is in the process of negotiating to join the CHKS contract for data quality and clinical coding data quality.
- External Data Quality Audits (e.g., RTT) have consistently shown the organisations to have good quality data quality supported by robust processes and oversight/management of Data Quality.
- Where there are DQ issues on specific data items or areas, action is taken to improve DQ through training, education, and performance management supported by a range of Data Quality Reports and dashboards each with a named owner responsible for the report/area.

It is important as a reminder that data quality is everyone's responsibility (rubbish in rubbish out) and I would also make the point on the clarity (or lack of) in recent years on additional national reporting requirements, where the quality of the guidance published (the definitions and specifications- ISNs) has often been rushed out and quite poor making it open to interpretation, and therefore more likely to be comparing apples with pears with oranges (rather than apples with apples).

We have found providers are challenging the datasets and guidance **after** being published, which then leads to changes in the datasets and returns following debate and discussion which should have happened prior to publication. And finally, different organisations can record some activity in different currencies (e.g., one organisation counts something as inpatients/day cases) and another organisation counts something as outpatients or contacts. These will be reported in different datasets, and therefore like for like comparison is difficult. (SDEC is a good example of this).

In your letter you note that "*it is apparent that ongoing errors and omissions in key metrics have led to inaccuracies in our individual and collective reported positions and not always shown us in the best light.*" I cannot provide any evidence to give assurance on this as I would require specific details of what data has been perceived as inaccurate, what submission had errors or omissions? I would then be able to investigate and if it was found there was a quality issue, we would be able to find the root cause and resolve it.

I have wondered on several occasions that there is fragmented reporting across this ICS. That is not a model I have found conducive to providing consistent reporting. I have wondered if some of the data quality concerns might be associated with how datasets are being used and interpreted within the various RAIDR dashboards and other systems that come into play?
The data may be accurate however as noted above how it is interpreted can vary. As one of the members of the ICS Business Intelligence & Data Analysis group we are working toward how we can improve the dashboards and interpretation of data.

I have not had any evidence to suggest the data at either NLaG or HUTH has errors or is not of expected quality. Our external audits and internal checks and balances have not provided evidence to suggest otherwise. I would note that when we have had delays, it has been a technical issue with the NHS Portal, and we have worked collaboratively to help resolve it. These technical issues would impact more than one Trust.

By way of this letter, I can confirm that I have prepared a written report for Both Trust Boards including the list of quality including a list of the quality monitoring we conduct, a copy of your letter, and my response. This will be presented at the next scheduled Board meeting.

I hope this addresses your concerns however do feel free to contact me should you require further information.

Kind regards,

Shauna McMahon (she/her)
CHCIO (CDH-E) | FedIPLdgPra | FBCS | CHE | MA Leadership
Joint Chief Information Officer/ Executive
Northern Lincolnshire & Goole NHS FT & Hull University Teaching Hospitals
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Peter Reading, CEO, Northern Lincolnshire & Goole NHS Foundation Trust
Leaf Mobbs, Director of Performance & Improvement, North East & Yorkshire HNY ICB, Executive Directors
Nigel Wells, Executive Director Clinical & Care Professionals
Andy Williams, Interim CDIO

NLaG Business Intelligence and Data Analytics

NLaG Assurance on Trust Data Submissions **November 28, 2022**

Submissions to NHSE and NHSD – Assurance on Returns

Since the onset of COVID-19, there has been ever increasing numbers of mandated data returns the Trust must comply with. As an example, in the month of October-22, the Trust submitted 246 data returns, from the Friends and Family Test (FFT) questionnaires to daily data items on all visits to its A&E. These returns go to varying bodies, from local commissioners to NHSE. In the period above, no return was late and considered accurate as per our governance processes.

While the Trust endeavours to ensure all returns are accurate, the content of all returns is entirely dependent on accurate and timely data entry into its clinical and administrative systems, to then be processed into returns as required. Data Quality reporting on most, if not all, of our returns is a key process as part of the collection and quality checking of data.

While Digital Services are responsible for the processes around submissions of returns, everyone is responsible for timely and accurate data recording.

Beds

Beds open, including escalation beds, are now routinely recorded onto WebV, along with their closures – whether for IPC reasons or an escalation bed being stood down. These are completed by bed managers, and periodically checked by informatics to ensure they match the site sitreps.
Bed numbers, as part of both the COVID and UEC sitreps, are signed off daily by the Deputy Chief Operating Officer as part of the submission process.

Ambulances, UEC & Discharges

As is normal for Trusts across H&NY, Ambulance data is provided by both YAS and EMAS, and transcribed into our returns. NLAG relies on these data flows which are only provided on working days. Emergency care data is routinely collected with waits being reported in real time. Both Ambulance and Emergency Care data is part of the UEC sitrep mentioned above and are signed off daily by the Deputy Chief Operating Officer as part of the submission process.
Discharge data, along with criteria to reside, comes from a combination of manual data from the Discharge Team, along with data from WebV. The WebV team are currently in the process of developing further the Discharge Module which will greatly increase the availability, accuracy, and timeliness of data available for this removing the need for manual reporting. The planned system will allow the automation of the return, but more importantly increase the depth and richness of data available on discharge pathways, patient's right to reside and delays within the wider health system.

Electives

Elective activity data and waiting list data (WLMDS) is entered into the patient administration system and is routinely validated via the Patient Services teams. The Elective activity data is routinely monitored via the Planning & Performance group by the Deputy Director of Planning & Performance.

The Weekly Waiting List Minimum Data Set (WLMDS) is the weekly return showing the current waits within the Trust. This return is signed off weekly by the Deputy Director of Planning & Performance.

Digital System Upgrades for Known Issues

1. WebV V3.7 – Discharge Module – Expected to be available to implement December 2022.
   (Discharge known issues are siloed datasets, i.e., spreadsheets being kept to hold data which V3.7 will allow to be recorded within the EPR)
2. PAS Migration – Lorenzo – Expected March 23, 2023 (dependent on current data migration processes that is underway now)
   (The Lorenzo PAS enables further system-validation to minimise data entry problems)

Technical Guidance, Similar Returns & Duplication

Technical Guidance

The NHS mechanism to provide guidance on the data sets and how returns should be submitted traditionally has been via Information Standards Notices (ISNs) that gave detailed definitions and criteria for how that data should be collected and returned.
Since COVID-19, guidance has become less specific with more potential for differences in interpretation between Trusts. While the Trusts across H&NY have had more data and analytics collaboration than ever before, differences in the way the Trust's record data have impact on the reporting, potentially causing differences at ICS or regional level.

Overlapping Returns & Duplication

There has been an increasing frequency of returns being requested by adding new, smaller ones, the Trust is also experiencing overlapping and often duplicated reports externally. As an example, the Trust currently submits a monthly RTT return at aggregated level nationally, a weekly RTT return at aggregated level nationally, a weekly email containing long waiting RTT patients to the ICS, along with a weekly dataset of all RTT patients. These reports and datasets have slightly different expectations, at different times of the week/month, and are often subtly different due to this, causing confusion. People reading these reports may perceive a data error however that is not the case it is subtly in the ask, timing, and when reports are generated and how they are interpreted that may seem like the data quality is in question.

Due to the mentioned challenges, the BI and & Data Analytics groups across the ICS are working together to reduce duplication and varying interpretation of guidance to ensure consistency, while working towards a data repository which will have higher data quality integrity. We are working to develop a more centralized repository of data that contains validated data.

Examples of DQ Reports in use at NLAG

RTT and PTL Data Quality Dashboards

RTT and PTL data quality dashboard definitions – a set of metrics used daily to monitor and fix any problems. This dashboard is the core data quality dashboard for planned care. – 30+ metrics

Outpatient Activity Data Quality

Outpatients Data Quality items – 15 metrics across outpatient activity

Outpatient Cashing Up Performance

Showing speciality performance on how quickly clinic activity is entered into systems. The speed in which activity is recorded is key for good data quality. 4 core metrics

Inpatient Activity Data Quality

Showing the completeness of Inpatient activity recorded within the Trust's PAS. 15+ metrics

Maternity Services DQ

Quality report showing errors and monitoring performance of data quality within the CMIS maternity system. 20+ metrics

Cardiology Services DQ

Data quality report showing errors and monitoring performance of data quality within the TOMCAT cardiology system. 20+ metrics

National Data Quality Reports

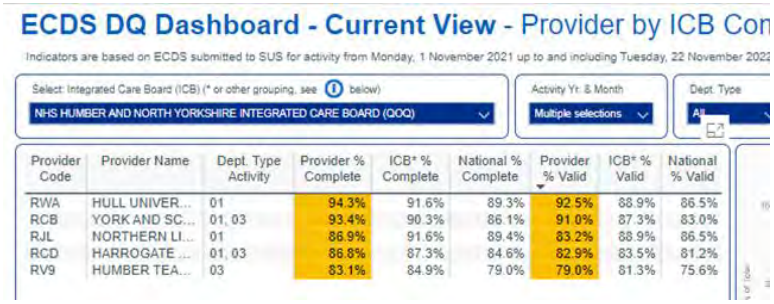
In addition to local data quality monitoring reports there are also national dashboards which are used to monitor and benchmark individual Trusts such as the CDS Dashboard and ECDS Dashboard.
The dashboards currently show that both HUTH and NLAG score consistently higher on data quality and are above both the ICB and national averages;

- Commissioning Dataset (CDS) Dashboard

  Admitted Patient Care (Apr22 to Sep22)

  Outpatient Care (Apr22 to Sep22)

- ECDS DQ Dashboard



HUTH Business Intelligence and Data Analytics

HUTH Assurance on Trust Submissions — November 28, 2022

The provision of timely and accurate data has been a challenge which our department has continued to meet despite an ever changing and pressured NHS. We have dealt and are dealing with significant digital projects including implementation of a new RIS, the project to implement a new MITS, NLAG coming onto the HUTH instance of Lorenzo and the data reporting impact of this. We are also routinely required to respond quickly to issues which arise such as the introduction of new and complex sitreps (with sometimes a day's turnaround and with often vague or poorly written guidance). Despite these regular and significant challenges, particularly in the last three years, all of our returns are submitted on time and our Analysts are fully versed in their processes for the provision of the data, getting that data validated, approved, and uploaded for every deadline and for every individual return.

UEC and Beds

The UEC figures are derived in the main from the live messaging out of Lorenzo and as such always reflect the most up to date position for metrics such as bed occupancy, ED figures, admissions, and discharges etc. This is also the case for our discharges sitrep (which covers our NCTR figures) and Covid sitreps.

Our bed availability figures follow a different process, but the core establishment is derived from Lorenzo and these figures are visible in the live ADT dashboard which is used in the control room based at HRI and so offers the site team the ability to monitor the bed position and there is also functionality for the site team to add any adjustments into this which feed through to the sitrep submission. With the current stress on bed availability there are time pressures to keep up with bed stock changes and ensure Lorenzo is kept up to date, but we ensure that any changes are communicated and approved via the CNIO and/or site team before Lorenzo is updated. These then feed through to sitrep submissions.

HUTH has recently procured a new dedicated Infection Prevention and Control system (IPCNET) which, with successful integration into Lorenzo, will digitally enhance the IPC team's ability to manage their service and provide a greater richness of data, particularly around bed closures. The data is currently provided to us via the stand-alone IPC team database for the sitreps which is validated by the IPC team. We have had meetings with the IPC team to look at Digital solutions via Lorenzo but have found that Lorenzo does not allow a bed to be closed with patients in it which impacts on our ability to close the bed. This is combined with bed closures not being within our live messaging from Lorenzo.

Elective

The construction and methodology behind our elective reporting submissions is always a joint effort with service leads in Clinical Administration Services, Performance, Digital and the services responsible for the individual return area e.g., cancer services. Likewise, any changes in recording practice or adjustments/new pathways within a service are communicated to our department who will then adjust or reassure that these changes are handled. The validation processes for our returns such as UEC, RTT, DM01 and all cancer returns involve regular interaction with our teams and the relevant Trust staff/services to ensure the position being reported is accurate. We have had a number of audits on our Trust

RTT PTL management processes, and we have always been commended on the accuracy of our PTL.

With regards the Waiting List Minimum Data Set (WLMDS), this is now an established return which has been developed in conjunction with the relevant services to ensure it is accurate against the guidance and definition. We are constantly reviewing to see if we can enhance our submission to cover more data and this, alongside other returns, are regularly reviewed to ensure accuracy and that they are in line with any changes in national policy or guidance e.g., the recent alteration of prioritisation codes has gone through a process of discussion with the affected Trust teams, introduction of a new coding schema on Lorenzo and then alterations to reporting to handle these changes.

With regards to our Cancer data, we are currently testing the live Lorenzo to Somerset integration which will replace our existing overnight data pull into Somerset. Live integration will allow pathways to enter Somerset seconds after the referral has been accepted on Somerset and moves away from the process established many years ago with agreement and direction from the Cancer Service to bring the pathways into Somerset at the point of first attendance. This methodology has been agreed with the service and the deputy COO with a proposed go-live of early January.

Validation and Assurance

All submissions have an established and approved process which ensures a senior manager has to validate and approve the submission. This process was established in conjunction with the Trust Performance Manager and Chief Operating Officer a number of years ago and goes through a regular review to ensure that the appropriate people still carry out the sign-off and that any highly sensitive returns/issues are provided to senior Trust staff prior to any submission. It was also established to ensure that each return is signed off to meet the national deadlines by one of a group of senior managers who would be available, particularly for the daily returns with an 11am deadline. Our daily submissions are sent post submission to senior Trust colleagues to ensure they are sighted on the numbers submitted. This includes our COO, CNIO, IPC lead and Trust Cancer lead.

Almost all our national submissions are supported by a wide range of BI reports which offer the relevant service and operational leads the opportunity to have sight of both aggregated numbers and the patient level detail which go towards making up the numbers and which can be used to understand any issues which may become evident in an upload. Regular meetings with affected services to understand any challenges to the figures or to get a refresher overview of the returns also take place. A recent example involved the Medicine Operational Lead working with the BI team to understand the NCTR to reside figures. Working together we have been able to adjust our processes and educate the service on the recording of data and how this is portrayed in reports to provide robust live NCTR figures.

Example of Data Quality monitoring reports used at HUTH

There are various data quality monitoring reports that have been set up at HUTH in order to provide assurance on key data items for both local and national statutory reporting. The below provides an example of 8 data quality monitoring reports covering key operational areas and collectively including around 150 data quality items.

- Access Plan DQ Dashboard
  Monitors 13 DQ items including: access plans against no specialty; access plans pending closure.

- Inpatient DQ Dashboard
  Monitors 8 DQ items including: discharges still ticking; TCI dates passed; IDS completion performance.

- Maternity DQ Dashboard
  Monitors 50+ DQ items including: missing demographics; antenatal booking date issues; deliveries attached to wrong encounter.

- Outpatient DQ Dashboard
  Monitors 16 DQ items including: open encounters; DNA & cancellations with no future appointment; uncashed ward attendances; added to pending list

- Referrals DQ Dashboard
  Monitors 13 DQ items including: referrals logged with no outcome; referrals in a created state; ASI's not ticking.

- RTT DQ Monitoring Report
  Monitors 14 DQ items including: RTT unvalidated pathways; RTT ticking pathways with closed referrals; RTT 90 but no 30.

- Cancer Waiting Time DQ Report
  Monitors 12+ DQ items including: PPI number incorrect; 1st appointment date missing; primary diagnosis code missing; missing faster diagnosis delay reason.

- ECDS DQ Dashboard
  Monitors 20 DQ items including: missing attendance type; missing chief complaint; invalid transferred to organisation

In addition to local data quality monitoring reports there are also national dashboards which are used to monitor and benchmark individual Trusts such as the CDS Dashboard and ECDS Dashboard.
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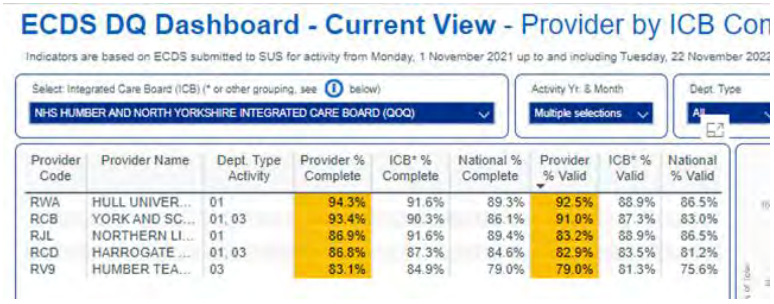

Coding for NLaG and HUTH

NLaG and HUTH Data Quality – Clinical Coding November 28, 2022

The Coding Departments have operated as a shared service since April 2022, the departments are currently going through a transition period whereby departmental structures, coding software, local policies and working practices are being reviewed and, where possible, aligned.

At present the two departments operate with some similarities but several differences and still need to be considered as two separate entities.

HUTH

In May 2022 the Trust decided to make a change to the recording of SDEC patients, these patients became Ambulatory Payment Classification Codes (APC) and required coding. With no spare capacity within the coding department to accommodate and additional 1000 FCEs per month, the coding of SDEC was outsourced to an external company.

Timeliness

HUTH's Coding deadline is one day before the national SUS submission deadline. The coding team aim to be 100% completed by Freeze submission and 90% completed by Flex submission. With the exception of patients discharged from SDEC this has been achieved throughout 2022.

Coding Quality

All the coding team with full time coding responsibility have attended a Standards course and have an in-date Refresher, 42% are also ACC qualified.

Coders are audited, by CCS approved auditors, every six or 12 months (depending on experience and audit results) all coders are expected to achieve the 'Standards Met' level of accuracy outlined in the Data Security Protection Toolkit guidance. Failure to attain this standard results in a period of re-training and re-auditing.

Coding Assurance

Following the first SUS deadline (flex) the completed coding is subjected to approximately 50 validation checks. The validations check for coding compliance against national and local standards, consistency of coding co-morbidities and HRG optimisation.

Currently all pneumonia deaths are reviewed with clinicians on a monthly basis.

NLAG

Timeliness

The coding team aims to be 100% complete by the 6th working day of the following month. Due to some vacancies (now filled) and significant levels of sickness absence throughout 2022 the team have struggled to meet this deadline and are currently 2-3 days behind deadline submission. They are catching up as the vacancies have filled.

Coding Quality

At NLAG coding is completed in one of three ways; outsourced, auto coded, or coded in-house.

Discharges from areas with good quality electronic documentation and with a LOS of three days or less are outsourced to a team of coders at CEC Healthcare (approx. 20% of total FCEs).

The outsourced team at CEC Healthcare are ACC qualified and achieved 'Standards Met' or 'Standards Exceeded' when recently audited.

Discharges with a LOS of one day or less and meeting certain criteria e.g., listed for a cataract procedure, colonoscopy, cholecystectomy etc. are auto-coded straight into the data warehouse (approx. 25% of total FCEs). All other discharges are coded by the Clinical Coding Team.

All the in-house coding team with full time coding responsibility have attended a Standards course and have an in-date Refresher, 46% are also ACC qualified.

A rolling programme of individual audits was re-started in August 2022, all coders have now received an audit, by CCS approved auditors, and will be re-audited every six or 12 months (depending on experience and audit results). All coders are expected to achieve the 'Standards Met' level of accuracy outlined in the Data Security Protection Toolkit guidance. Failure to attain this standard results in a period of re-training and re-auditing.

Coding Assurance

Following deadline all completed coding is subjected to approximately 50 validation checks. The validations check for coding compliance against national and local standards and HRG optimisation.

Currently all in hospital and out of hospital deaths are reviewed with clinicians on a weekly basis

Humber and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Our Ref: SE/EVJ

22 November 2022

To: Trust Chief Executives and Chairs

Sent by email: chris.long@nhs.net
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caroline.flint@nhs.net
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s.armstrong6@nhs.net

Dear Colleagues

As you will be aware further to Next steps in increasing capacity & operational resilience in urgent & emergency care ahead of winter (Aug 22) and Going further on our winter resilience plans (Oct 22) there is now a very significant focus on winter performance and the final preparatio ns being progressed by both ICBs and Trusts. This has increasingly involved very detailed scrutiny of individual Trust data at both a regional and national level.

Acknowledging the very significant burden of reporting on Trusts, it is apparent that ongoing errors and omissions in key metrics have led to inaccuracies in our individual and collective reported positions and not always shown us in the best light. Given this, I am writing to ask that Boards take early opportunity to reassure themselves regarding the quality of data submitted by their organisations in relation to winter and capacity plans.

Specific key metrics from the winter plan are shown below as a guide, but this list is not exhaustive.

1. G&A bed capacity plans and actuals as reported through the SITREP e.g., bed capacity, occupancy and closures.

2. UEC – ambulance and acute hospital provisions including patients with no criteria to reside.

3. Electives - the Waiting List Minimum Data Set, Cancer PTLs and elective recovery via SUS.

I would appreciate if you could confirm for yourselves that data relating to these areas are reported in a timely and accurate way.

With thanks for your ongoing support.

Yours sincerely

Stephen Eames CBE
Chief Executive
Humber & North Yorkshire Health and Care Partnership

Copy: Leaf Mobbs, Director of Performance & Improvement, North East & Yorkshire
HNY ICB Executive Directors

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6 December 2022	
Director Lead	Fiona Osborne, Non-Executive Director and Chair of Quality and Safety Committee	
Contact Officer/Author	As above	
Title of the Report	**Quality and Safety Committee Highlight Report (October & November)**	
Purpose of the Report and Executive Summary (to include recommendations)	The Trust board are asked to receive the Quality and Safety Committee highlight report and note: • The recommendation to amend the cancer request to test Trust targets in line with Best Practice Timed Pathway. • A recommendation for 7 day working in Pathology to be given consideration in the 2023/24 Business Planning process to aid delivery of Best Practice Timed Pathway • A never event in relation to a retained foreign body	
Background Information and/or Supporting Document(s) (if applicable)	None	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Highlight Report to Trust Board

Report for Trust Board Meeting on:	November 2022
Report From:	Incorporating Quality & Safety Committees held on 25th October 2022 & 22nd November

Highlight Report:

In October, the Committee received an update on the trust CNST position. Training of sonographers to complete Uterine Artery Doppler scans is offtrack. Detailed mitigations have been requested by the Committee.

The cancer highlight report was presented in November. The most pertinent issue identified is diagnostic delays. The Committee has two recommendations to raise:

- The Best Practice Timed Pathway (BPTP) target is 7+2 days for request to tests however the Trust target is 14+2 days. Most patients have sequential tests increasing the time patients wait. The Committee recommend that Trust targets are amended in line with BPTP.
- The Committee recommend that 7 day working in Pathology is given consideration in the 2023/24 Business Planning process to aid delivery of BPTP

The Committee wishes to highlight the following from the nursing assurance report:

- Midwifery vacancy levels continue to be a concern. This has been referred to the Workforce Committee for further scrutiny.
- Community nursing levels vs workload are challenged. The Community Safer Nursing Care Tool would assist however NHSI will not release the tool until all staff are trained

End of Life reports were presented to the Committee. The Committee wishes to highlight that a review is underway to refresh the project work, but the 3-month timescale may not meet the 2023/24 Business Planning deadlines.

One new maternity SI reported in October, immediate actions already taken. One never event has been reported just prior to the November meeting related to retained foreign body (1 year ago, foreign body now removed and patient is well). Investigation is in initial stages.

The annual SI report was presented. Using Datix the risk team previously been able to identify themes in incidents and take action before Serious Incidents occurred. With the replacement of Datix with Ulysses, thematic reporting had not been replicated. The Trust Chief Information Officer is supporting a solution.

A letter has been received from the regional medical director in relation to NLaG being an outlier for reporting babies with hearing loss. NLaG fully participated in a data request exercise and had already identified areas and concern and acted upon these. The CQC and Commissioners are aware. External colleagues have assured the trust there is no immediate risk to patient safety and services can continue during the investigation process.

Confirm or Challenge of the Board Assurance Framework:

The format of the BAF was discussed between Committee members and how the most pressing concerns are highlighted. The Chair to discuss progressing the BAF format with the Director of Corporate Governance.

Action Required by the Trust Board:
The Trust Board is asked to note the key points made and recommend: • Amending the cancer test Trust targets are amended in line with Best Practice Timed Pathway. • 7 day working in Pathology is given consideration in the 2023/24 Business Planning process to aid delivery of Best Practice Timed Pathway **Fiona Osborne** **Non-Executive Director**

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 6 December 2022
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Vicky Thersby, Head of Safeguarding
Title of the Report	**Safeguarding & Vulnerabilities Annual Report**
Executive Summary (to include recommendations)	The Trust Board is asked to receive and approve the Safeguarding and Vulnerabilities Annual Report. This Annual Report provides an overview of the national and local context of safeguarding and vulnerabilities and associated agendas related to safeguarding adults and children. The report highlights the key performance activity and informs the Trust Board of how its statutory responsibilities are being met and of any significant issues or risks and how these are mitigated. There are several priorities for 2021-22 linked to associated safeguarding agendas which will be monitored though the Vulnerabilities Board. Safeguarding Adults and Children is a trust key priority and the Safeguarding and Vulnerabilities team have continued to work throughout the pandemic ensuring that both our patients and staff have been supported. Developed our first Safeguarding and Vulnerabilities Strategy (2022-2024) which encompasses our Dementia and Learning Disability and Autism priorities and build on embedding real change and innovation. The Team has seen a number of new posts which will enhance the delivery and quality of care our patients receive:- • Learning Disability Band 6 post • Stabilisation of the CLA team in NEL reducing the use of bank and agency costs Greater collaboration as a Safeguarding and Vulnerabilities team and working towards a 'Think Family' approach to safeguarding children and adults. Robust oversight of safeguarding adult and DoLS authorisations and establishment of databases and statutory CQC notifications. The Mental Capacity (Amendment) Act received Royal Assent in May 2019 and introduces the Liberty Protection Safeguards to replace DoLS. The data of full implementation of the LPS has been postponed from April 2022 and anticipated earliest implementation is October 2023. The team are linked in the wider integrated partnership work and system as it develops. The Annual report highlights the key achievements for the year and priorities for 2022-23.

Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Vulnerabilities Board, Quality & Safety Committee
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
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1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Safeguarding & Vulnerabilities Annual Report 2021 - 2022

FOREWORD

Safeguarding is a statutory responsibility of all NHS organisations as detailed under the Care Act (2014), and the Children Act (1989/2004). Legislation and guidance are built upon the principle that the welfare of the most vulnerable in our society is paramount and that all statutory services consider and promote the needs of children, families, and adults at risk.

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) is committed to ensuring that safeguarding its patients, staff and the wider community is given the highest priority in all that the Trust does.

Safeguarding work across the Trust is underpinned by NLaG's core values by demonstrating our behaviours:

- Kindness
- Courage
- Respect

Safeguarding is an integral part of core business and is a shared responsibility. We work together with multiagency partners across the Districts of North Lincolnshire, North East Lincolnshire, and East Riding to improve the lives and protect the most vulnerable in our society from harm.

In line with the Trusts Strategic Plan (2019-2024) and Board priorities for (2022-23) we have several Quality Improvement projects planned and collaboration as a system with a partner-based approach. The Nursing, Midwifery and AHP strategy Future 5 and Beyond (2021-2024), and our first Safeguarding and Vulnerability Strategy (2022-2024) will help us build on our priorities and embed the agendas across the Trust to demonstrate real change and innovation.

Our Vulnerabilities and Safeguarding team collaborated this year to become the Safeguarding and Vulnerabilities team which has resulted in a shared vision of putting patients first, supporting wards and vulnerable patients and empowering patients/ their voice and hearing their views and wishes.

Our vision: to be a safe organisation that ensures safeguarding is everyone's business, by working holistically together to safeguard the most vulnerable in society.

Our Mission: to provide an exceptional service in our think family approach to safeguarding by working with our colleagues, our patients, and our safeguarding partners.

CONTENTS

INTRODUCTION

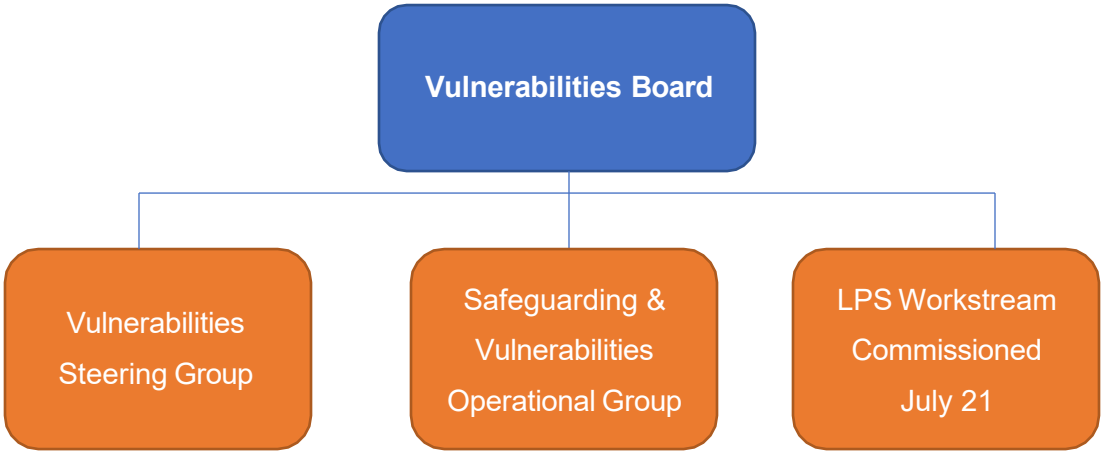
The 2021-2022 annual report provides the Trust Board with an overview of the national and local context of safeguarding and vulnerabilities and areas of associated practice across the Trust. The report will show safeguarding and vulnerabilities performance activity and inform the Trust Board of how its statutory responsibilities are being met and of any significant issues or risks, and how these are mitigated.

This report is a combined Safeguarding and Vulnerabilities Report that describes all areas of safeguarding activity. It includes an in-depth view of the current Mental Capacity and DoLS arrangements and focus moving forward through legislative changes in progress. The report describes how the Safeguarding and Vulnerabilities Team work together to demonstrate to the Trust Board and external agencies how Northern Lincolnshire and Goole NHS Foundation Trust discharges its statutory duties in relation to:-

- The Children Act (1989)
- The Sexual Offences Act (2003)
- Female Genital Mutilation Act (2003)
- Children Act (2004) - Statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11
- Domestic Violence and Victims Act (2004)
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007
- Registration standards, Health, and Social Care 2008 (Regulated Activities) Regulations 2014: Regulation 13
- CQC national standards of quality and safety - Outcomes 7-11: Essential standards of quality and safety
- Safeguarding Vulnerable People in the NHS- Accountability and Assurance Framework (2013)
- Care Act (2014)
- Counter- Terrorism and Security Act (2015)
- Working Together to Safeguard Children (2018)
- Adult Safeguarding: Roles and Competencies for Health Care Staff (First Edition: August 2018)
- Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (Fourth edition: January 2019)
- The Coronavirus Act 2020
- Domestic Abuse Act Statutory Guidance 2022
- Health and Social Care Act 2022
- Safeguarding Accountability and Assurance framework (July 2022)
- All staff have a statutory responsibility to safeguard and protect those who access our care regardless of their role/position in the Trust. However, some defined named safeguarding roles exist for safeguarding.
- The Executive Lead for Safeguarding Children and Adults is the Chief Nurse; this responsibility is delegated to the Deputy Chief Nurse.

- The Safeguarding and Vulnerabilities Team and Named and Designated Professionals provide both strategic support and direction to the governance and safeguarding arrangements within NLaG, and operational advice and support to all Trust staff.
- The Trust has in place a Named Doctor for Safeguarding Children at both sites, Named Midwife's, Named Adults Professional and Named Nurses for Safeguarding Children.
- Designated Doctors for Safeguarding Children and Looked After Children are employed by NLaG, and as well as their Trust roles also link with other Designated Colleagues in the CCG as part of their role.
- The Trust attends the Local Child Death overview panel meetings with representation from the SUDIC Paediatrician and paediatrics.

Our internal arrangements ensure that Safeguarding and Vulnerabilities remain core Trust business. More formally the Safeguarding and Vulnerabilities Operational group, Vulnerabilities Steering Group and LPS Workstream report directly to the Vulnerabilities Board. This Board sends highlight reports to the Quality Governance Group and the Quality and Safety Committee. This Board reports to the Nursing, Midwifery & AHP Board and the Trust Board.



During 2021-22 the Safeguarding team have been working collaboratively with CCG Safeguarding Colleagues across the Humber Coast and Vale to develop opportunities to work more collaboratively.

Integrated working across the health partnership arrangements across the Integrated Care System (north Lincolnshire, North east Lincolnshire, East Riding, Hull, North Yorkshire and York), could provide opportunities to represent each other at meetings, share training resources, policies etc. We are progressing with task and finish groups to support Health and Care Partnership Designated Nurses colleagues to review and look at joint working arrangements.

PREVENT

The Counter terrorism and Security Act (2015) places a duty on NLaG to have; *'due regard to the need to prevent people from being drawn into terrorism.'*

Our Prevent Strategy Implementation Policy is to support and safeguard those most at risk of radicalisation which is a form of exploitation. NLaG have met its statutory responsibilities in relation to ensuring:-

- Prevent training is delivered in line with the Prevent Competencies Framework(2021)
- The Policy is in place in the Trust
- Quarterly Prevent data is submitted
- Partnership links with Local arrangements and meetings are attended
- Fulfilling the requirements of the NHS Contract
- Prevent leads are in post

Key Achievements

- The Safeguarding team have provided 100% attendance at Channel Panel meetings
- 100% PREVENT returns within time frame to NHSE
- Provide assurance to the CCG via the quarterly report
- The safeguarding team have continued to supported staff in identifying possible PREVENT referrals during the COVID pandemic
- Reviewed the Prevent Policy in line with new Prevent Training and Competencies Framework 2021
- We have achieved all that we set out to do last year
- Continued attendance at Channel Panels for both North and North East Lincolnshire. Attendance at Gold and Silver Prevent/Chanel meetings in NL/NEL

Priorities in 2022 – 23

- Prevent lead to continue to attend regional meetings/Chanel meetings in North and North East Lincolnshire
- Continue to embed the Prevent message via the safeguarding newsletter and regular updates on the Hub
- Quarterly Prevent returns to NHSE

ADULT SAFEGUARDING

Following the introduction of the Care Act (2014) implemented in April 2015; adult safeguarding has been on a statutory footing. The Named and Specialist Nurse for Safeguarding have now been in post for a year working as part of the safeguarding team. They provide support to staff in all areas including all 3 hospitals and community. They contributing to internal strategic meetings including falls and pressure ulcers as well as attending the Local SAB subgroups and other multi-agency forums. NLaG has met our statutory, regulatory, and contractual Safeguarding Board requirements and obligations, by ensuring there are robust governance arrangements, policies and procedures, and support mechanisms in place to ensure these requirements are met.

There has been continued commitment from the Safeguarding team to attend and contribute to the local authority partnership safeguarding board subgroups as well as participating in multi-agency audits where appropriate. The Head of Safeguarding attending the strategic boards for North Lincolnshire.

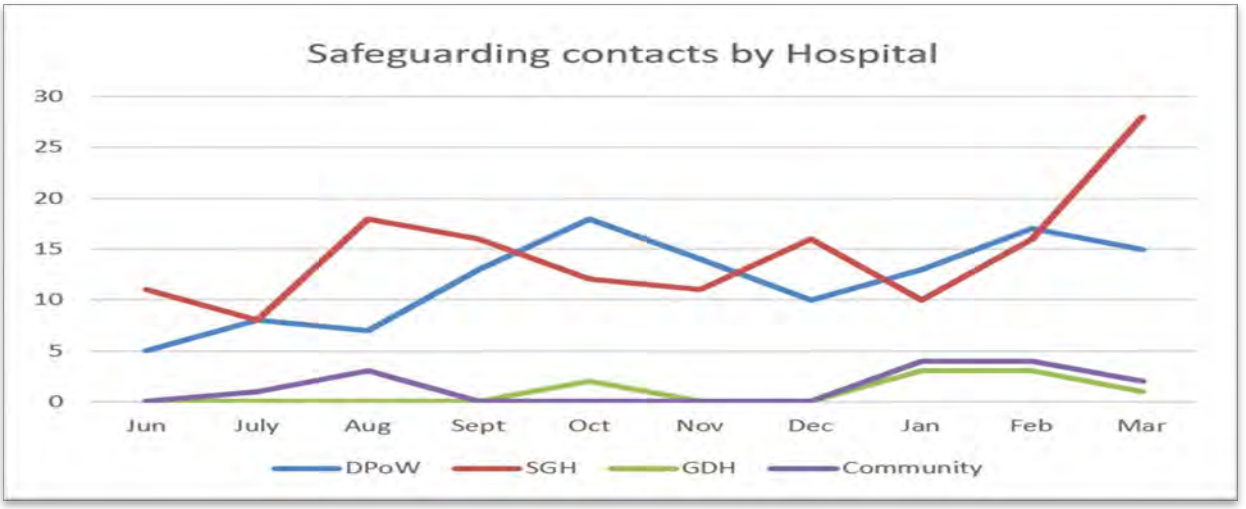
Data Analysis

a) Safeguarding Contacts

The number of contacts to the team for support and advice has been steadily increasing over the year from when we began to start capturing this in June. Calls now have increased from 15 in June 2021 to 47 in March 2022.

This is, at least partially due to the improved reporting and data collection. These contacts are primarily by telephone but sometimes via email or face to face. Only the data for the safeguarding contacts is collected. The team receive several calls which are not safeguarding related and are signposted elsewhere.

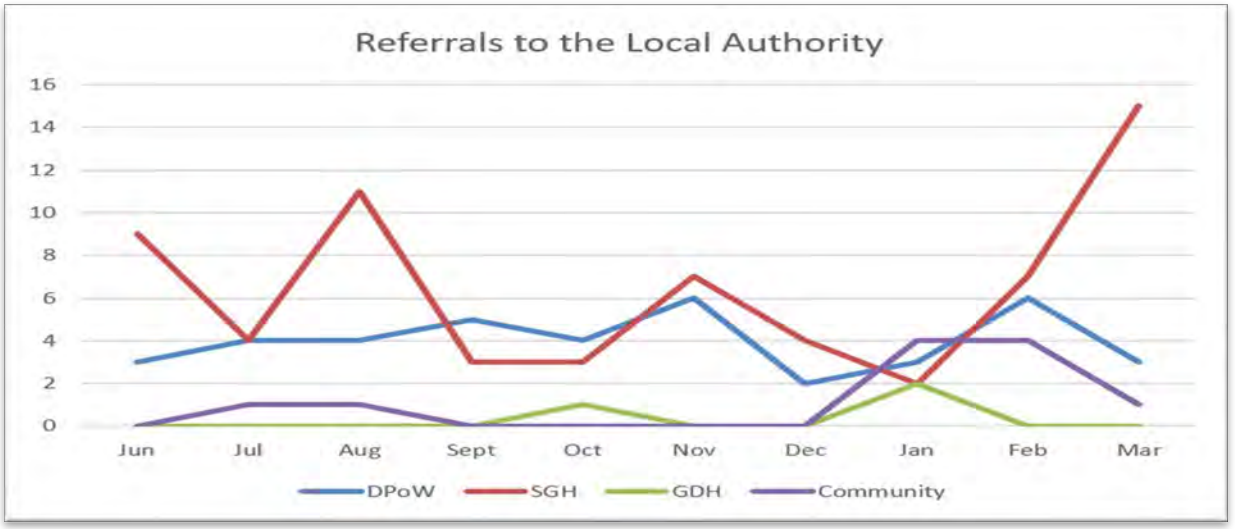
Contacts to the adult team can be further broken down by Hospital location. Overall, the greatest number of contacts are from Scunthorpe Hospital.



b) Safeguarding referrals to the Local Authority

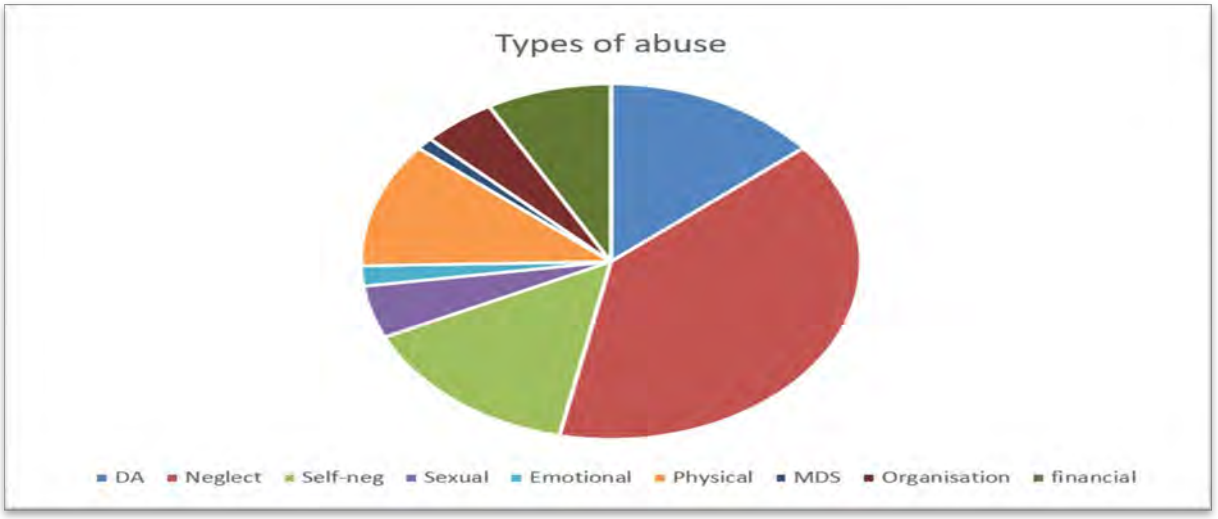
From February 2022 staff have been directed to WebV to send any referrals out to the Local Authority Safeguarding Adults teams in North/ Northeast Lincolnshire/ East Riding and Lincoln. This was agreed with all Local authority Safeguarding Teams. This means that we are more able to accurately monitor the number of referrals and where they are being sent to from staff within the Trust. This may account, at least in part, for the increased numbers of referrals. This number does not reflect the total number referrals; concerns externally related are reported onto Ulysses. For assurance all of our safeguarding concerns and referrals are reported on the Trusts Ulysses system and the safeguarding team review all incidents.

Further analysis broken down by hospital has shown that Scunthorpe has sent more referrals than the other areas, with the majority raising concerns about care homes.



c) Types of abuse

The predominant type of abuse that staff raise as concerns is that of neglect. This is often from care givers, either formal or informal. The second most common theme is self-neglect, followed closely by domestic abuse. These concerns are covered in depth in the Level 3 Adult safeguarding training. These themes are seen across the Trust. Most of the concerns are from external sources and are not citing NLaG as the source of harm.



d) Section 42's allegations against NLaG

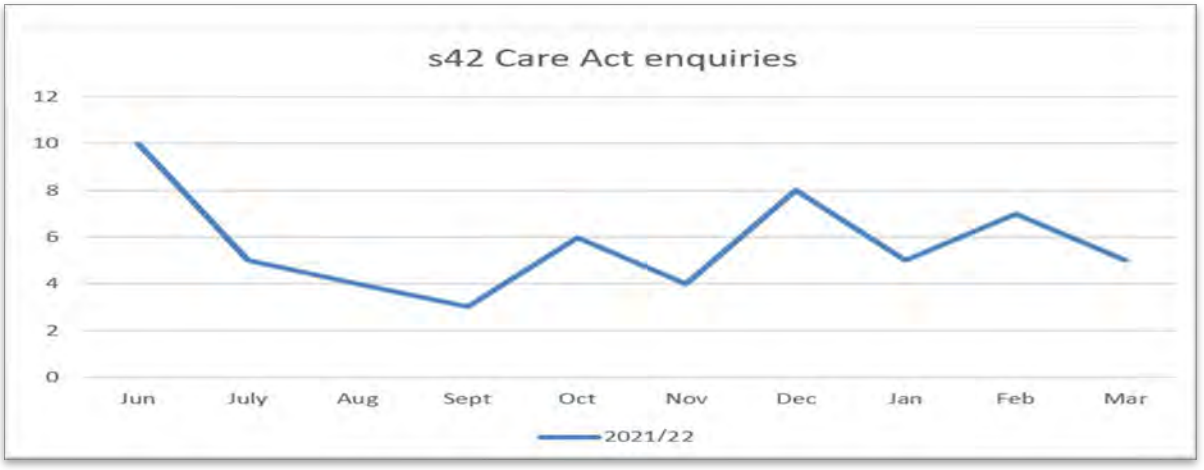
The Local Authority has a duty to make enquiries under s42 of the Care Act (2014) where an individual with care and support needs is experiencing, or at risk of abuse and if their care and support needs are preventing them from protecting themselves. The Trust may be asked to investigate when a patient, relative or another provider has referred a safeguarding concern to the Local Authority about abuse/neglect that an

individual has allegedly suffered in our organisation. These enquiries are all logged on Ulysses and sent to the appropriate ward department for a response.

Analysis

- A larger number were highlighted in June due to a delay in some S42's not being sent to the team (no adult post in place).
- There was also an increase in December 2021 as there were new staff and processes at North Lincolnshire and again, there had been some delays in getting these out in a timely manner.

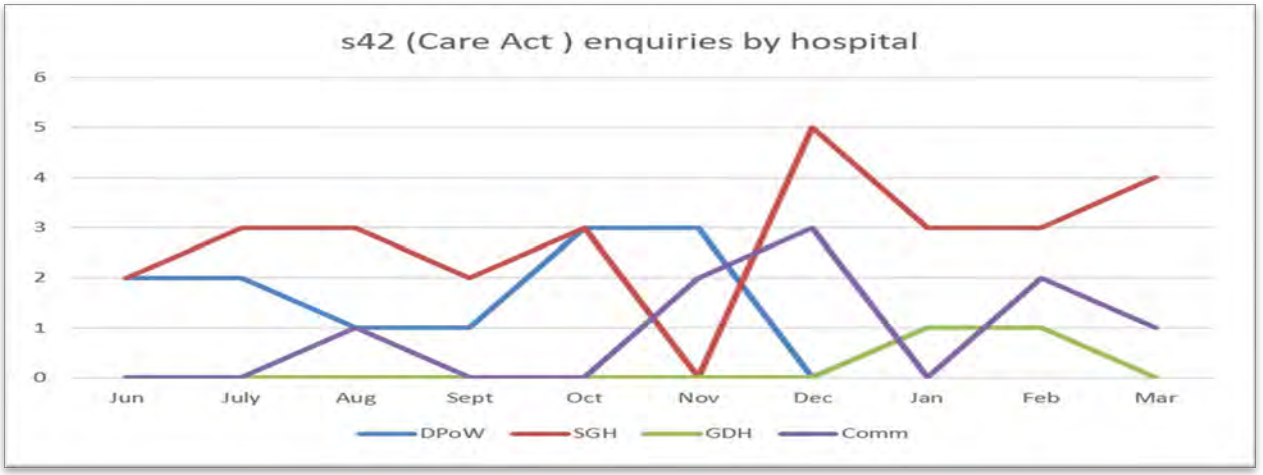
The process for dealing with these is now much smoother. We also challenge a small number and return to the relevant authority if we do not feel that they meet the criteria.



These enquiries can be broken down into the different hospitals/local authority areas.

- Scunthorpe has the greater number of referrals which correlates to the higher number of referrals being sent out although, at this present time there is no apparent reason for this.
- North and North East Lincolnshire have a different process for triaging and undertaking the enquiries and this could account for some of the variances.

The most common themes are neglect e.g. hospital acquired pressure ulcers, poor discharge planning, medication errors on discharge. These are often compounded by staff attitudes and an inability to answer the queries of those who raised the concern.



Conclusion

The data collection is improving month on month and in time we will be able to draw out more themes and trends. The WebV referrals have really given the team insight into the concerns that our staff have, across the Trust. They have also given us greater oversight and this has allowed us to direct our support more effectively.

Key achievements 2021 – 2022

- Increased compliance for Level 3 safeguarding training
- Electronic referrals via WebV to all 4 Local Authorities Safeguarding Adults teams
- Building upon relationships to improve communication with Local Authorities
- Responding to s42 enquiries in a timely manner
- Review and updating of the absconding/missing policy
- Supervision sessions for ECC staff
- Development and use of safeguarding/vulnerabilities template on WebV to record calls and advice.
- Updating of Safeguarding Hub pages
- The WEBV electronic referral asks the question regarding what the patient wants as a desired outcome. This continues to embed our Making Safeguarding Personal Culture.
- Attended falls huddles – improving staff knowledge and understanding and referring into safeguarding procedures
- Developed links with the Community Scrutiny Panel/ Trusts strategic Pressure Ulcer Group and pressure ulcer Group -oversight of themes / trends
- Developed robust databases on contacts- able to analyse themes and trends
- Audit the Missing/absconding policy

Priorities in 2022-23

- Work with adult social care to ensure that referrers receive feedback from concerns raised, and a consistent approach to referral thresholds is achieved
- Audit the Missing/absconding policy
- Develop the Adults Supervision Policy and implement a supervision and implementation strategy for the Trust
- Improving the quality of MARAC referrals
- Supervision sessions for Community staff
- Face to face training sessions for Level 3
- Bespoke training sessions for specific safeguarding topics
- Allegations policy (to include LADO and PiPoT)
- Launch Safeguarding and Vulnerabilities Champions

SAFEGUARDING WEEK & CAMPAIGNS

Over the last year the safeguarding team have participated in requests to participate in various campaigns and weeks using the power of social media/ awareness sessions in department huddles/ leaflet drops and promoting partnership training to highlight the importance of safeguarding and that this is everyone's business. We promote the training offered by NL, NEL and ER safeguarding children and adults partnerships, and ensure any learning is delivered as part of our level 3 children and adult training and within safeguarding supervision.

Key Achievements 2021 - 22

- Tabletop stall held in DPOW for Safer Internet Day
- Twice yearly Vulnerabilities newsletter
- Webinar sessions shared with Trust Staff promoting safeguarding awareness week (ERSCP and NEL SCP)
- Domestic Abuse awareness month in October 2021- table top stalls cross-site
- Promotion of MARAC training by Blue Door Domestic Abuse Agency
- Promoted DA training NEL
- Promoted Safeguarding Week East Riding Children's Partnership
- Promoted the Sexual Health Referral Centre in Hull and invited staff to a study day (CCG led)
- Promoted National Safeguarding Week
- Contributed to national promotions such as Safe sleeping for babies, dog safety during hot weather, highlighted by the liaison practitioner at DPoW, in conjunction with the CCG in NEL's and awareness videos such as water safety and CSE awareness, modern day slavery and DA.
- Dementia awareness week and celebrated wards that had gone over and above for patients with dementia
- Delirium awareness week - promoted use of the delirium care plan
- Carers action week - team attended the NL carers conference with a stand but also took part in the conference so lots of engaging with carers and partner organisations
- LD awareness week - promoted reasonable adjustments and the role of the LD liaison nurse

Priorities 2022 - 23

- Continue to be involved in safeguarding weeks and promotion of training and study days throughout the year
- Lead and contribute to Safeguarding Month in July and Domestic Abuse month in October

VULNERABILITIES (Learning Disabilities & Dementia)

Our Vulnerabilities team is committed to ensuring that vulnerable patients in our hospitals receive excellent patient centred care and that they and their relatives/carers have a quality experience. Our team structure builds upon Our 'Think Families Approach to Safeguarding' enhancing collaborative working and holistic support.

The NHS Long Term Plan (2019) recognises the importance of tackling the causes of morbidity and preventable deaths in people with a learning disability and for those with autism. Over the next five years, National Learning Disability Improvement Standards must be implemented and will apply to all services funded by the NHS. These standards will promote greater consistency, addressing themes such as rights, the workforce, and working more effectively with people and their families. Our team supports the Trusts strategic objectives 'reducing health inequalities;' engaging people with additional care and support needs and providing quality timely care that protects them from avoidable harm.

We ensure that meeting our obligations under the Equality Act (2010), the Human Rights Act (1998) and associated articles to ensure the rights of those less able to speak up are heard and any reasonable adjustments are made for our patients and their families/ carers.

The appointment of our Learning Disability Nurse and Complex Transition Nurse is supporting the development of transition pathways for young people with complex needs into adult services as part of a quality improvement project. Our recent survey carried out has identified that different areas are managing transition differently and there is a lack of knowledge around transition and preparing for adulthood, this has given us a good baseline process map our current services. Our transition steering group will help drive the agenda for these pathways. A business case has been developed to lead on this work reduction in admissions and readmissions, improve patient safety, and improved working between primary and secondary care.

Patient Story - 'Gareth is a 26 yr old gentleman with a learning disability, he lives at home and is cared for by his Mum. Gareth required surgery to an ingrowing toenail that was causing repeated infections but was extremely anxious about attending hospital. Following an MDT discussion prior to his admission a plan was put in place to support him through the experience of getting to hospital and subsequently to theatre. The plan worked very well and Gareth underwent his surgery with no problems and whilst he was under anaesthetic also underwent a dental check-up. Gareth was discharged an hour after surgery and the following Monday his Mum sent an email of thanks to the Trust particularly in relation to support of the Learning disability Nurse. As part of the plan Gareth was taken to one of the courtyards at SGH and has since emailed the Learning disabilities nurse to ask if he can be involved in making the courtyard a more pleasant environment for patient to sit in. This is a massive achievement for someone who struggled to come into a hospital a few months ago'.

Both our dementia and Learning Disability Nurse Specialists support the wards daily, giving advice based on an individual's needs, this advice includes medication, nutrition and hydration, reasonable adjustments, and mental capacity assessments. They are called upon to provide expert advice at falls huddles and best interests meetings. We continue to work closely with our lead nurse for patient safety to embed and evaluate the AFLOAT/supportive care policy. We undertook the National Audit for Dementia in August 2021 and have just registered to undertake this again in 2022, we are currently awaiting the results of the 2021 audit.

The Trust has been left a legacy through the Health Tree Foundation which it has been agreed with the Trustees will be utilised to make our wards more dementia friendly, we are currently working with the Health Tree Foundation to identify what could be provided within the budget to enhance the care provided to patients with dementia. This legacy was provided for Scunthorpe General Hospital only, but it is hoped that we will also be able make some improvements at Diana, Princess of Wales Hospital, Grimsby, in addition Cleethorpes Golf Club have chosen the Trust's 'Golden Leaves' dementia fund as their charity for 2022.

Learning Disability Mortality Review (LeDeR)
The NHS Long Term Plan made a commitment to continue LeDeR and to improve the Health and wellbeing of people with a Learning Disability and/or autism and subsequently prevent premature mortality in this group. The process for LeDeR reviews is currently being revised.

From 1st July 2022 the Integrated Care System will be responsible. Any patients with a Learning Disability and/or autism who pass away in the care of NLaG a structured judgement review (SJR) is completed by the Vulnerabilities team. Learning from SJR's and LeDeR reviews is shared at the Vulnerabilities Steering Group.

Number of Deaths of patients with a Learning Disability 2021/2022

Apr 21	May 21	Jun 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
2	2	1	1	2	0	1	1	0	0	0	0

Learning from regional LeDeR reviews are collated quarterly and shared with divisions, they are also discussed at MIG

Some identified good practice is

- Good use of health initiatives such as hospital passports
- Good Multi-disciplinary working and approaches
- The value of the learning disability acute liaison nurse

Some identified problems are

- Poor communication and transfer of information between teams and care pathways
- Transition issues
- Not following the rules properly around Do Not Attempt Resuscitation

Through our vulnerability rounds and Board rounds the team are promoting effective communication and working with staff and Divisions. We have drafted a Business Case to progress Transition.

Key Achievements 2021-22

- Twice weekly vulnerability rounds focusing on supporting staff and patients.
- Secured an additional Learning Disability Nurse to enable cross-site equitable arrangements
- Developed a vulnerabilities dashboard for oversight of activity and awareness
- Developed a vulnerabilities proforma in WebV for contacts and ensure good communication with staff/ oversight of data
- Completed the National Audit for Dementia and Learning Disability benchmarking audit
- Introduced the Vulnerabilities Steering Group
- Updated the Learning Disability and Dementia Strategies to form the Safeguarding and Vulnerabilities Strategy
- Collaborative working with the community LD team to reduce admissions and re-admissions and improve patient/carer experience.
- Audited the use of ReSPECT and end of life pathway documentation with Learning Disability patients
- Celebrated Learning Disability week and Dementia awareness week
- Funding secured for Changing Places facility at SGH
- Carer's Strategy developed in conjunction with HUTH, implementation group set up with carers and carers support group representatives
- Vulnerability training, including Learning Disability training embedded across the Trust
- Improved links with community Learning Disability team and community End of Life team
- Embedded and evaluated the AFLOAT tool and Supportive care policy

Priorities 2022 – 23

- Develop and embed a Transition Pathway/Policy working in collaboration with Children's services
- Flag on our PAS systems patients with Learning Disability and Dementia to improve identification of vulnerable inpatients and attendance at outpatient appointments
- Progression of the approved 'Changing Places' facility at SGH

- Develop business case to progress a Lead Transition Nurse for complex young people transitioning into adult based services.
- Combine the LD and Dementia training to Vulnerability training
- Priorities Develop and embed a Transition Pathway / Policy working in collaboration with Children's services
- Complete the National Audit for Dementia
- Community and Therapies engagement – improving links between primary and secondary care.
- Relaunch and lead Dementia training as Vulnerabilities training half day session for front line staff responsible for the delivery of care to our patients.
- Virtual Dementia Bus Tour Implementation of the Carers Strategy
- Develop accessible appointment letters on the patient administration system for vulnerable patients
- Develop a policy for managing vulnerable adults who do not attend/ were not brought to appointments
- Recruitment of Vulnerability Champions and planned re-launch day September 2022
- Develop a robust system to ensure the patient/carer voice is being heard when redesigning our services and that the Trust to be able to demonstrate this
- Relaunch utilisation of NHSE/I Ask, Listen, Do
- Work with North Lincolnshire Learning Disability partnership to develop a pledge for vulnerable adults
- Relaunch updated 'My life' document following ratification
- Work with the CCG on a data sharing agreement with the CCG for Learning Disability and carers registers
- Develop a survey monkey for gathering feedback from Vulnerabilities training
- Attend updates in relation to the mandatory Oliver McGowan training and implement as required

MENTAL CAPACITY & DEPRIVATION OF LIBERTY SAFEGUARDS

NLaG is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and Deprivation of Liberty Safeguards (DoLS, 2009). MCA DoLS training is delivered via eLearning and as part of level 3 safeguarding adults training.

NLaG MCA DoLS lead and Specialist Practitioner are part of the Safeguarding Team and the point of contact for advice and support in relation to MCA/DoLS. Helen Leary joined our team this year as new Named Professional.

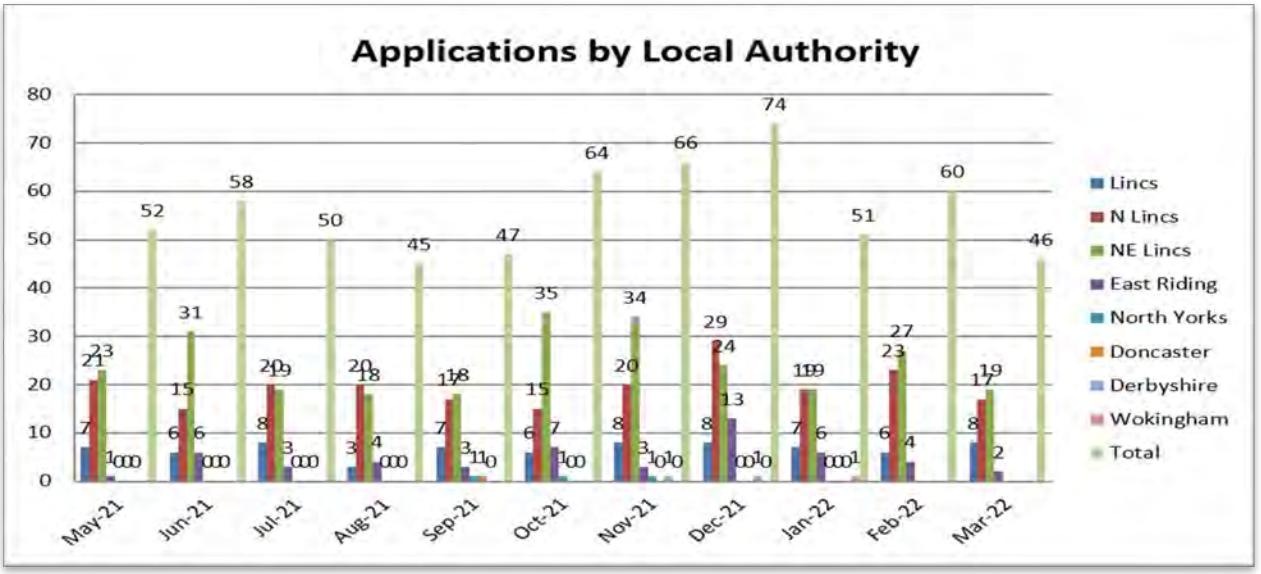
The Safeguarding Team continues to work closely with DoLS managers from our Local Authority partners to support consistency of applications across the Trust. The team now quality assure all DoLS applications before they leave the Trust. This allows us more oversight of areas where vulnerable patients are and where additional support and oversight is required. From May 2021 we have now oversight of our own internal data.

DOLS applications

Year	NEL	NL	Total	Average Per month
2014-15		14	14	1
2015-16	2	30	32	5
2016-17	170	51	221	2.6
2017-18	219	30	249	20
2018-19	255	109	364	30
2019-20	259	155	414	34
2020-21	294	164	458	38
2021-22	267	216	623	51

**We have seen a steady increase in the numbers of applications year on year. This data provides assurance and oversight that DoLS awareness is improving across the Trust. For 2021-22 we have one month data capture missing*

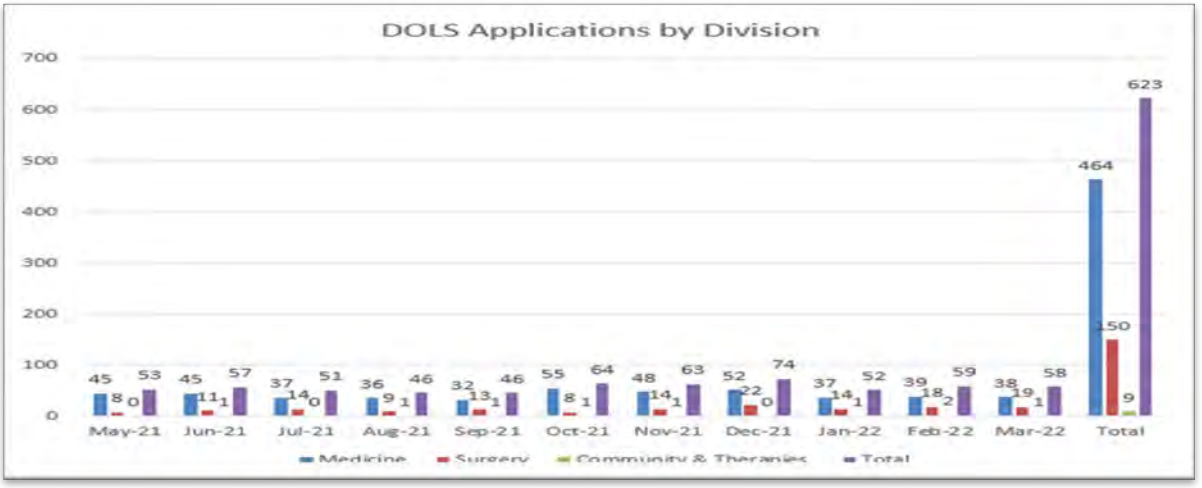
1.1 DoLS by Local Authority



Analysis

- The majority of DoLS applications are sent to NEL Council. We have a number of patients from out of areas whose applications are also sent to corresponding local authority councils.
- We have had 464 referrals from medical wards, 150 from surgical wards and 9 from community and therapies. We are further able to break this down to individual wards and report outcomes
- All outcomes of DoLS applications are sent to CQC

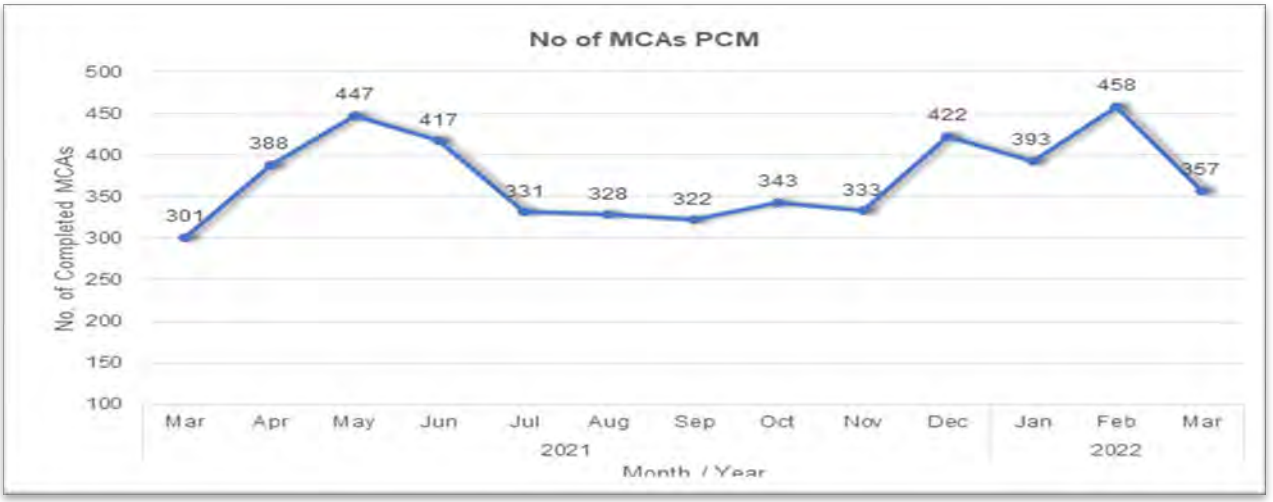
1.2 DoLS applications by Division



Analysis

- The majority of DoLS applications are submitted by the Medicine Division
- Our detailed database further breaks this down to ward areas and identifies areas where more vulnerable patients are located in the hospital

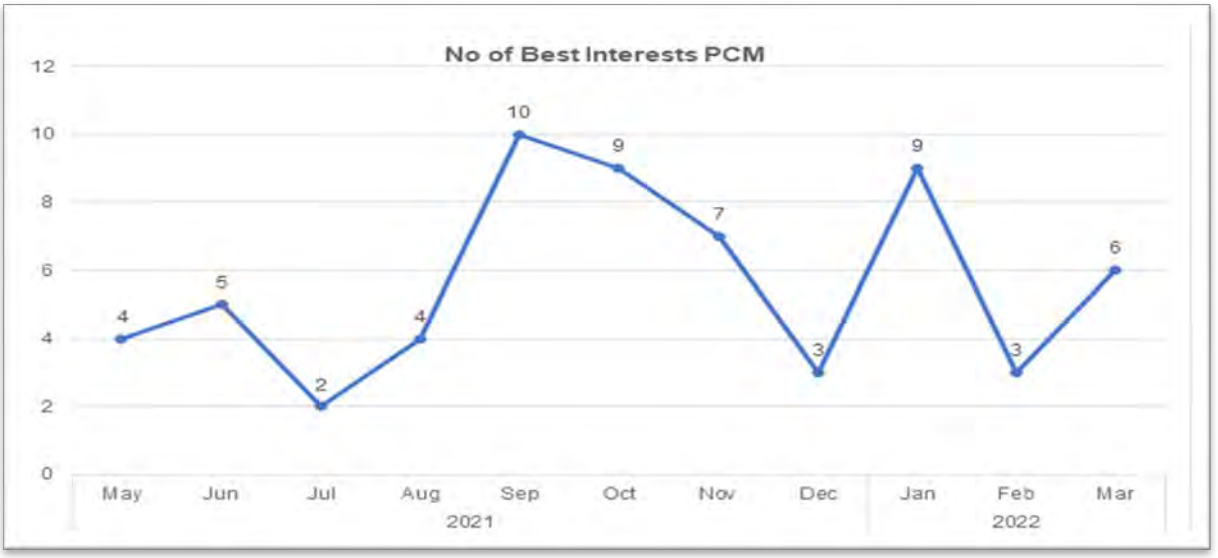
1.3 Mental Capacity Assessments



**to note this data shows the number of MCA completed on WEBV March 21- April 22.. This will not reflect assessments carried out and recorded directly in the paper records.*

'Whilst we appear to have a good awareness of the MCA and numbers of capacity assessments being completed a qualitative audit of the capacity assessments has identified further work for us to do. We are reviewing our current template, instigating a survey monkey and arranging regular audits and bespoke training. This year we are focusing on a 'back to basics' approach to build up readiness for Liberty Protection Safeguards next year'.

1.4 Best Interest Decision



Due to the discrepancy in the numbers of MCA and BI decision support tool used we know we have more work to do to close this gap.

- We have remodelled the Capacity Assessment and included a link to the Best Interest Tool to complete on WebV.
- We are also planning an MCA promotion campaign which will likely have a 'back to basics' theme where we work on improving our application of MCA and Best Interests in readiness for LPS.
- The team will also ensure they are available to support individual wards where required to ensure all staff are thinking and evidencing Consent / Capacity / Best Interests

Key Achievements

- DoLS data is recorded and shared at the Nursing Metrics meeting and Vulnerabilities Board.
- Our training compliance is now at 80% MCA and 87% DoLS
- We are now quality assuring all DoLS applications before they leave the Trust.
- We provide bespoke training; we have recently completed some sessions delivered to GNRC around the completing of mental capacity assessments with challenging patients.
- We have recently launched our electronic Best Interest Tool in partnership with WebV we believe that this will improve the documentation of best interest discussions/meetings which will in turn help us to meet our legal responsibilities around the MCA.

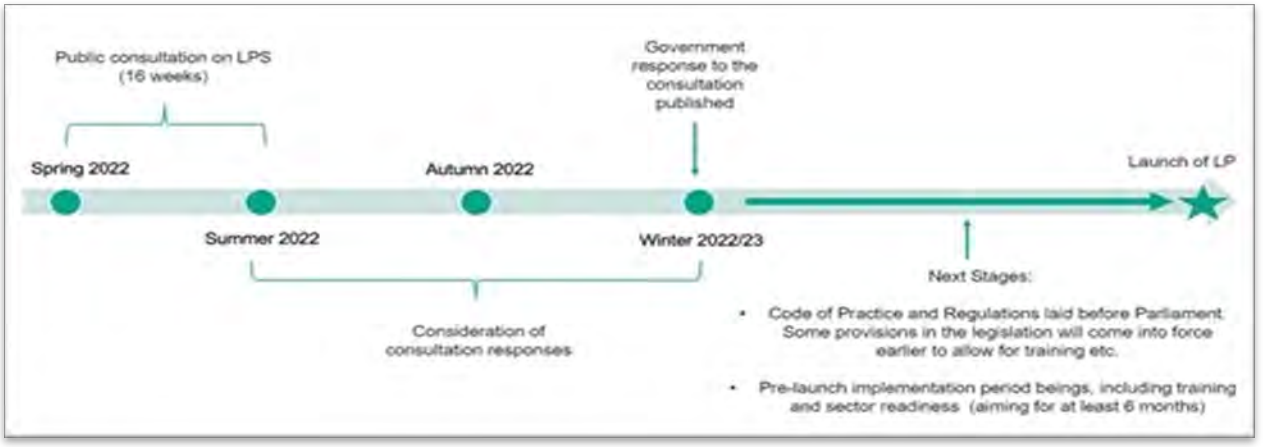
- Continued work embedding knowledge and skills in all areas regarding MCA/DoLS. We do this by working closely with the wider Vulnerabilities Team
- Reviewed the Mental Capacity and Deprivation of Liberty Policy

Priorities 2022 - 23

- To continue to support wards in completing their own DoLS applications
- To continue to support staff to embed MCA into practice
- To monitor closely the progression of the Bill and link with other Local NHS Trusts around implementation and plans for embedding LPS
- Work with legal services department to ensure plans for new systems are embedded.
- Review the MCA DoLS Policy when the LPS are implemented

MENTAL CAPACITY (AMENDMENT BILL)

Background



The Mental Capacity (Amendment) Act received Royal Assent in May 2019 and introduces the Liberty Protection Safeguards (LPS) to replace DoLS. The purpose of the Act is to provide a simplified legal framework and authorisation process which is accessible, clear, deliver improved outcomes for people deprived of their liberty and place the person at the heart of decision making.

The Minister of State announced post pandemic that they now aim for full implementation of LPS by April 2022. However, that date has now been put back significantly and no further dates have been released.

The LPS draft code of practice was released for consultation in March 2022 ending 14th July 2022. NLaG have contributed to this consultation which comprised of 25 questions centred around changes to the current MCA Code of Practice and the introduction of LPS. The Code and associated documents are around 720 pages in length and lots of time and effort has been spent understanding the implications for NLaG.

Several meetings have taken place with partners across the Integrated Care Partnership and the consultation responses have been shared across the areas. All partner agencies have highlighted similar issues with the code including:-

- The definition of a Deprivation of Liberty which appears to have lowered the threshold from the Cheshire West ruling
- Role of the Approved Mental Capacity Practitioner
- Role of the assessors

- Availability of IMCA's
- Use of emergency provisions which are an extension of the Ferreira Judgement and section 4B (MCA 2005) that enables Life sustaining treatment or a vital act to be undertaken without an authorisation under LPS. Many other questions have been raised to Department of Health and Social Care which will hopefully be addressed when they publish the final version projected to be Winter 2022/ 23

Implications for NLaG

- NHS Trusts (the Responsible Body) will be responsible for authorising the deprivation of liberty (it will no longer be the Local Authorities responsibility, but instead the Hospital Manager)
- The Responsible Body will therefore have a duty to arrange assessments under LPS / Publish information around the process of LPS / authorise proposed Deprivations of Liberty under the LPS and ensure individuals have access to the appropriate advice and support.
- Referral pathways and authorisation process will need to be considered.
- For the responsible body to authorise any deprivation of liberty, it needs to be clear that:-
    - The person lacks capacity to consent to the care arrangements
    - The person has a Mental Disorder as defined in the MHA
    - The arrangements amount to a Deprivation of Liberty
    - The arrangements are necessary and proportionate to the risk of harm
- People can be deprived in a variety of settings (i.e.) those who live at home and have respite care at a day centre. These can all now be authorised under LPS rather than previously some were authorised via the Court of Protection.
- Staff will need to be trained and aware of what the new Liberty Protection Safeguards constitute, how to 'trigger' the process as well identifying objections which may need a referral to an Advanced Mental Capacity Practitioner for heightened scrutiny prior to being authorised.
- Young people – although MCA has always applied to over 16's, DOLS has only applied to over 18's and applications to deprive a young person have been made via the Court of Protection. LPS will cover young people and therefore additional support will be required for our staff who work with young people who may be deprived of their liberty.

Priorities 2022-23

- Consider implications for NLaG Acute and Community Services once the public consultation is completed.
- Continued promotion of the person at the heart of all decision making including supported decision making wherever possible.
- Continue to build on sound MCA practice including Capacity Assessments and Best Interest Records to prepare staff for the changeover.
- Provide detailed report to Board of Directors regarding Liberty Protection Safeguards, implications of the Bill and Codes of Practice.
- Review team and Trust resources to implement the new LPS scheme including training, new processes, and expertise.
- Commence LPS workstream meetings to ensure preparedness for transitional phase and full implementation and oversight and assurance prior to implementation.

MENTAL HEALTH

This year has seen the Trust's first Mental Health Strategy, which focuses on improving patients experience, patients' safety, and flow of services. Our strategy cannot be met in silo and representation for the Trust at core meetings regionally and locally is essential in meeting our strategies aims. The strategy has been shared with colleagues but also our partners within mental health, commissioning, and regional and place-based services.

NLaG have continued to work in partnership with our mental health providers across North (RDASH) and North East Lincolnshire (NAVIGO) and Lincolnshire Partner Trust (Young Minds Matter- DPOW) to ensure that our patients presenting with acute general health needs who have mental health concerns are treated holistically throughout their stay and receive the right care, at the right time in the right place.

The lead Nurse for Mental Health is responsible for strategic and operational oversight of all mental health patients and pathways throughout the trust and works collaboratively with the safeguarding and vulnerabilities team to ensure our patients are kept safe. The Mental Health Lead Meets regularly with the Mental Health Liaison teams both sites which establishes strong operational links and Young Minds Matter CAMHS service and RDASH SMAHS Service.

The Lead Nurse for Mental Health meets quarterly with RDASH and NAVIGO Mental Health Act Officers and reports internally (6 monthly) to the Operational Management Group, Trust Management Board, and Quality and Safety Committee. Key updates are shared with the Vulnerability Oversight Board. This reports on MHA and Mental Health activity and quality improvement workstreams.

There are clear robust oversight arrangements with Suicide Prevention work and working with partners.

Key Achievements 2021-2022

- Developed a Mental Health Strategy- focusing on patient safety, experience and flow of services and collaborative working.
- NCEPOD- Treat as One (adults) and Mental Health Care for Young People and Young Adults (children)- achieved some of the recommendations
- Reviewed relevant NICE Guidance
- Safe Mental Health Rooms in both ECC- ligature reviewed every year/ training available
- Reviewed the Missing and Absconding Policy with Safeguarding Colleagues
- Developed a Mental Health Resource on the Hub
- Provided teaching for newly qualified nurses
- Met assurances following an internal audit – Mental Health Act Compliance progressing as a QI project
- Established Surveys to capture mental health patient experience

Priorities 2022-23

- A Mental Health Pathway (Goole District Hospital)
- Continue suicide prevention work
- Embedding compliance with the Sections of the MHA
- Establish links with higher education systems (student nurse training - Hull University)
- Work closely with the Adult Named Nurse focusing on patients with an underlying MH disorder and self-neglect.
- Continue to progress NCEPOD- Treat as One (adults) and Mental Health Care for Young People and Young Adults (children)
- Review the formal agreements with RDASH and NAVIGO
- Provide themed teaching session
- Review Restraint/ rapid tranquilisation policies/ training.
- Explore pathways for joint working to ensure children and young people do not have delays in waiting for appropriate services

SAFEGUARDING & MIDWIFERY

As part of our commissioning arrangements and Intercollegiate Document standards NLaG is required to provide Named Midwives to support our maternity services for safeguarding children and vulnerable women and families. Our Named Midwives have robust oversight of complex work at both SGH and DPOW who support our midwives and obstetricians, midwifery support workers and health care assistants with complex cases both antenatally and postnatally where there are concerns that relate to both adults and children. Our Named Midwives both support midwives and mothers in the most complex cases, where concerns arise in relation to unborn babies and women. This might include concerns relating to Domestic Abuse, substance misuse, neglect, or poor mental health. Previous children may not be in the care of their parents or have input and support from children's social care.

High risk women with a diagnosed mental illness, such as bipolar, schizophrenia, previous puerperal psychosis and/ or severe depression are referred to the perinatal mental health midwife for close partnership working where safeguarding oversight is required, and appropriate referrals and signposting to appropriate external agencies. The named midwives and the specialist perinatal mental health midwives engage in regular supervision for high-risk cases to ensure a safe outcome for mother and baby. Mental ill health, both in the ante natal or post-natal period can have a negative impact upon the attachment between the mother, baby, and family unit. This which may result in safeguarding issues or concerns that parenting may be affected.

The named midwives work closely with the specialist learning disability nurses within the safeguarding and vulnerability team. Together they can enhance the care given to a woman with a learning disability or difficulty or a partner to ensure that all appropriate services are included in the pregnancy care. This can include support at hospital appointment and liaison with children's social care at meetings to support the family.

The named midwives also work closely with the teenage pregnancy specialist midwives. All teenagers who are pregnant under 19 years, depending on situation and vulnerability will have support from the specialist midwives, named midwives will become involved if there are concerns of a safeguarding nature or if the young person needs extra support that may impact on their parenting. Might include social care referral, pre-birth pathway support and support with housing or their mental health. Professionals would meet for regular supervision to discuss each case. this would be documented in the electronic family file.

Key Achievements

- Continue to promote the ICON within the maternity services
- Continued to provide supervision and maternity specific safeguarding training (Day 1 Mandatory Training) to midwives and NICU virtually and face to face throughput Covid.
- Increased referrals into children's social care since the development of the MARF multi-agency referral form from midwifery services.
- Worked collaboratively with the vulnerabilities and adult safeguarding professionals to support the care of our most vulnerable pregnant women with additional learning needs.
- Deliver face to face mandatory midwifery training
- Attend Monthly MAPLAC meetings in NL- high risk unborn meetings
- Seen an increase in referrals in children's social care since the development of the MARF form
- Developed and implements training for Targeted support- this will be ongoing into 2023
- Actively participated in the Domestic abuse strategy delivery group working closely with the safeguarding children's partnership and partner agencies to improve the quality and provision of support for those at risk of domestic abuse.
- Safeguarding midwives have attended strategy meetings, case conferences, core groups with social care and other agencies throughout Covid, supporting midwives to do the same.
- Worked closely with the specialist perinatal mental health midwife for NLAG to discuss women who have complex mental health needs and safeguarding concerns.
- Robust links with named midwives in other provider organisations and attended Regional and National Named Midwife Forums.
- Developed Electronic family files on web V where safeguarding information is recorded
- Used virtual technology to continue deliver training and supervision
- Safeguarding leads within the Midwifery COC teams

Priorities 2022 - 23

- Develop and implement a cascade safeguarding supervision model within midwifery
- Audit the effectiveness of the ICON rollout
- Develop a Learning Disability and Pregnancy guideline for Midwives.
- Health Visitor liaison form to be implemented electronically in North Lincs to align the process with North East Lincolnshire following the pilot within NE Lincs.
- Promote the 'Myth of Invisible Men' project that includes fathers in the pregnancy booking pathway which will look at consent from fathers in relation to their mental health and probation history
- Implement the Subconjunctival haemorrhage in Infants Policy
- Develop the safeguarding communication pathways when Badgernet is implemented

CHILDREN AND YOUNG PEOPLE

NLAG is fully committed to the principles set out in the government guidance 'Working Together to Safeguard Children - 2018,'the Children Act 1989/2004 and to joint working with both the North Lincolnshire MARS and North East Safeguarding Children Partnerships.

NLaG work closely with our neighbouring local authorities, North and North East Lincolnshire, East Riding and Lincolnshire. Links to their policies are including in NLaG's safeguarding policy as well as highlighted to staff via supervision and training. NLaG safeguarding team ensure that policies are aligned with multiagency procedures when developed or updated and hyperlinks are inserted to assist professionals when accessing the policies.

NLaG's safeguarding responsibilities are effectively discharged by the provision of day-to-day advice, supervision, support and promoting good professional practice. This includes identifying the training needs of all staff and volunteers in relation to safeguarding children and delivering a comprehensive mandatory programme of training, which includes key safeguarding messages from research, safeguarding incidents, and safeguarding children practice reviews / learning lessons reviews and lines of sight.

The Covid 19 Pandemic has brought its own challenges for vulnerable children and young people. As the year has progressed and easing of national and global lockdown restrictions., our activity has been monitored closely in the team.

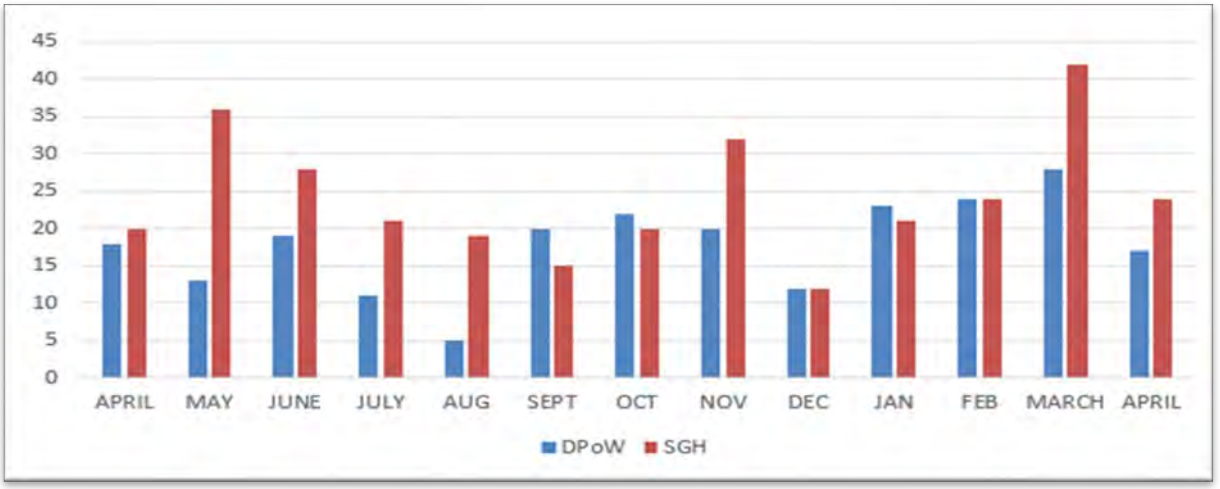
Key Highlights

- This year we have escalated an increased number of children and young people attending the Emergency Departments within North Lincolnshire.
- There are more children on CP plans in NEL than NL. As a partner agency we will attend both Strategy meetings when required and CP conferences.

Requests to attend Child Protection Conferences

** The number of requests to attend child protection conferences reflects the number of children on child protection plans in both N and NE Lincs. NLaG are copied into all requests for attendance for information only. All information is filed in the child / young person's records following the child protection conferences.*

Attendance at Emergency Care with self-harm



Key Achievements

- Continued to provide safeguarding children supervision to ECC, paediatric, midwifery and NICU teams
- Developed and distributed safeguarding newsletters which have covered topics such as safeguarding adults' awareness, MARAC, LADO/ PiPoT, Safeguarding referrals and thresholds, Neglect awareness and Legal Orders.
- Continue to disseminate updates from NE Lincs, N Lincs and East Riding children's services with NLaG staff and promoted multi-agency virtual training.
- Continued professional development virtually to maintain level 4/5 Safeguarding
- Continue to benchmark NLaG against the RCPCH standards for safeguarding paediatric medicals and action plan in development.
- Implemented a SOP for CP-IS in both Accident and Emergency Departments
- Improved and developed Paediatric liaison data bases which enable the team to identify themes and trends.
- Worked collaboratively with NLaG legal team where cases become complex.
- Joint working with the Deputy Head of Surgery to embed a streamlined process of notifications to the team of attendances at 'Hot Clinics'.
- Collaboration with the CCG to update the MARS board 'Perplexing presentations and FII guidance' in line with the RCPCH guidance.
- Joint partnership audit with the CAMHS service in relation to children and young people attending ECC with mental health presentation.
- Paediatric monthly peer reviews for children who have had child protection medicals.
- Partnership paediatric reviews following child protection medicals in development.
- Development of quarterly data reports from the liaison teams highlighting themes and trends which has led to working with the CCG and public health around dog bites during Covid
- Developed a safeguarding and vulnerabilities dashboard which has identified themes and trends within the team.
- Embedding of the Web V electronic community and meeting templates within paediatrics.
- Development of a MARAC attendance induction workbook for safeguarding staff who attend MARAC presenting NLaG.
- Continue to be an active participant in Lines of Sight, Rapid Reviews and Safeguarding Practice Reviews, identifying learning and the development of action plans for future learning
- Developed a programme of audits.
- Developed Web V safeguarding communication templates

Priorities 2022 – 23

- Embed the actions from the medical report audit and the identified actions from the safeguarding paediatric medical standards (RCPCH 2019)
- Review of the liaison professional's role to include increased support to paediatric safeguarding medicals by providing background health information to the examining paediatrician.
- Review the Failure to be Brought policy
- The roll out of CP-IS in paediatrics.
- Roll out the safeguarding Journal Club
- Embed safeguarding Peer Review meetings at DPoW following the retirement of the previous named doctor.
- Develop and embed the Champions role
- Establish the use of the WEBV referral template and process
- Review Paediatric nursing documentation to include SBAR
- Establish a new daily update and communication between Paediatric Ward and Safeguarding team at DPOW for inpatients (Pilot project)

THE SUDIC (SUDDEN DEATH IN CHILDHOOD) ARRANGEMENTS

Since April 2008 Local Safeguarding Partnerships have been required to review the deaths of all children in their area as outlined in 'Working Together to Safeguard Children 2018.'

The Child Death Review (CDR) arrangements cover North and North East Lincolnshire (Northern). The CDR managers sit externally to NLaG as the responsibility for the arrangements sits with safeguarding children's partnership. NLaG (Deputy HOM and Associate Chief Nurse Paediatrics) chair the CDR and JAR meetings. A JAR meeting is arranged when there is an unanticipated death. The purpose of the meeting is to collate information from all agencies to understand any immediate safety concerns, support for wider community when tragedies occur. All child deaths are reviewed anonymously.

The statutory partners must ensure CDR arrangements are in place to review all deaths of children who are normally resident in the local area and as appropriate for any non-resident child who has died in their area with appropriate referrals to other area CDR managers. It runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP). This can take place over several years on occasion.

The purpose of a review is to:

- ensure that lessons are learnt from child deaths, that learning is widely shared and that actions are taken - locally and national to reduce preventable child deaths in the future.
- Identify cases giving rise to the need for a serious practice review
- matters of concern affecting the safety and welfare of children in the area
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the local area

Our SUDIC (Sudden Death in Childhood) nurse Trust wide ensures that NLaG fulfils its requirements along with the Designated Doctor for Child Deaths to maintain this joint agency response (JAR) by supporting the lead clinician in identifying the correct professional attendance at the JAR and CDR meetings. The SUDIC nurse attends and is an active participant of the CDR operational group; they link with the NLaG mortality lead and attend the paediatric end of life group.

Our SUDIC Nurse will support staff and families in the hospital when a death has occurred by offering bereavement support/ signposting to bereavement services and liaise with the CDR meeting where families have queries. Any cases of concern are escalated to the SI Panel for review. If there is a case where safeguarding concerns arise our Named Nurse for Safeguarding Children will link with the Designated Nurse for Safeguarding Children and the Safeguarding Children Partnership Manager. Our bespoke SUDIC proforma allows a detailed comprehensive gathering of information

for the JAR meeting. Our SUDIC nurse will also support staff debriefs following a SUDIC or child death.
Whilst some deaths are unavoidable (terminal illness / life limiting conditions) some may have contributory factors such as changes in weather (heat waves), poor road conditions or poor sleeping conditions. When modifiable factors are noted, these are shared nationally and local initiatives are adopted (Social media adverts / Facebook in relation to hot weather and suitable sleeping advice). A water safety video was released by Humberside Fire and Rescue to raise awareness in relation to water safety.

The Children Death Review Annual Report is shared with NLaG. Of the cases discussed in 2020-21 2 of the cases had modifiable factors and related to unsafe sleeping practice. The strengthened Northern Lincolnshire Safe Sleeping Protocol Guidance is now being followed by all partners and funding for baby thermometers was agreed by Public Health.

Key achievements

- All families allocated a keyworker as part of the CDR process and are offered bereavement support and signposting as required
- Continued monthly SUDIC training on the Paediatric Mandatory training
- Delivered training regarding CDR processes with Health Visitors and School Nurses in NE Lincs and NL
- Attend the CDR Operational Group, Paediatric End of Life group and Divisional Mortality meeting
- Contributed to the Family Services: Learning from Deaths Report

Priorities 2022-23

- SUDIC nurse to lead on a task and finish group to improve the memory work provided to families
- SUDIC nurse and bereavement midwife to develop a study day for 2022
- To continue to embed arrangements regarding the Key worker role to support families who are bereaved
- Deliver training to the Paediatric Medical Staff around child deaths (anticipated/unanticipated) regarding CDR process.
- Develop a bereavement booklet for children

CONTEXTUAL SAFEGUARDING

Contextual Safeguarding is an approach to understanding young people's experiences of significant harm beyond their families and recognises the impact of the public and social context on young people's lives, and consequentially their safety. It seeks to identify and respond to harm and abuse posed to young people outside their home, either from adults or young people. This can include CSE, peer or peer violence, abuse, modern day slavery, harmful sexual behaviour, abuse in gangs and groups, criminal exploitation and going missing from home or care; should not be seen in isolation as they often overlap, creating a harmful set of circumstances and experiences for children, young people, families, and communities.

The safeguarding team works closely with our local partnership arrangements in developing local protocols and working in partnership to ensure how individual cases are managed locally.

Key Achievements

- Active partnership members of the NE Lincs Operational Vulnerabilities Meeting and then Lincs and N Lincs Multi Agency Child Exploitation meetings (now MACE meetings).
- High risk children and young people are flagged following this meeting on SystmOne and symphony.
- CSE /CCE is included and discussed in the Level 3 safeguarding children training (face to face training.)
- The safeguarding team continue to promote the CSE/CCE in supervision and encourage staff to use the KYSS tool and the "Warning and Vulnerability Check List" which has been made available to all staff in Gynaecology, midwifery, paediatrics an ECC.
- Prior to all training moving to eLearning the safeguarding team included awareness of modern-day slavery in the level 2 and it is included in the supplementary reading that is sent to all staff who attend level 3 eLearning.
- Through attendance at OVM /MACE and the pre-birth pathway any concerns relating to CSE /CCE are raised, shared and appropriate referrals made.
- Reviewed the Flagging Policy

Priorities 2022-23

- To continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multi-agency meetings to share intelligence around this.
- Develop the KYSS Tool in WebV
- Audit records cross-site

FEMALE GENITAL MUTILATION

Female Genital Mutilation (FGM) encompasses 'all procedures which involve partial or total removal of the female external genitalia, or any other injury to the female genital organs, for non-therapeutic reasons.' FGM can have far reaching consequences for the physical, psychological, and sexual health of those women and girls affected. It is a violation of their human rights, a form of child abuse and is illegal in the UK.

Since the introduction of the Female Genital Mutilation Act (2003; replacing the Prohibition of Female Circumcision Act (1985), FGM has been a criminal offence). The first successful prosecution took place in February 2019. With increasing international migration, the UK has become host to many women affected by FGM. Research suggests 279,500 women and girls in the UK have undergone FGM and a further 22,000 girls are at risk of the procedure. Since 2008 women with FGM have made up about 1.5% of all women delivering in England and Wales.

To ensure that NLaG meets its statutory requirements:

- The Trust has an identified FGM Lead
- FGM-IS Standard Operating Procedure
- All cases are reported to the Trust FGM lead
- Quarterly reporting to NHS Digital

Number of FGM cases	DPOW	SGH
11	7	4

- *All cases are adults, no children identified. Female children born are flagged as at risk of FGM on the national spine. More reported cases at DPOW than SGH. All disclosed at time of pregnancy booking.*

Key Achievements

- Mandatory reporting of all cases of FGM is embedded within NLaG reported quarterly to NHSE
- FGM is routinely asked within maternity services.
- Safeguarding training is included in mandatory midwifery training.
- FGM training is delivered in all levels of safeguarding training.
- Female infants identified at risk at birth are flagged via the FGM – IS system. Information is then shared with the HV service and GP via discharge information and liaison meetings with any concerns shared via a multi- disciplinary forum and strategy meetings with children's social care.
- FGM policy including a flow chart to support staff in assessing

the levels of risk in relation to FGM is accessible on the documents hub
- Statutory FGM reporting is carried out and reporting internally through the Safeguarding children Forum)
- Updated the FGM Policies and Procedures
- Contributed to National Audit (publish September)

Priorities 2022-23
- Update guidance and policies for staff and provide information leaflets for families
- Ensure that clinical staff working in the Paediatrics arena can identify female children at risk of FGM by having the tools to do so – such as access to the NHS Spine via SMART cards
- Participate in multi – agency task and finish groups to promote best practice in safeguarding women and children re the responsibility all agencies to report to NHS digital and share information
- Embrace local and national networking opportunities to share knowledge and learning around FGM.
- Explore routine enquiry in all areas of Gynaecology

DOMESTIC ABUSE

Domestic abuse is any incident or pattern of incidents of controlling behaviour, coercive behaviour or threatening behaviour, violence, or abuse between those aged 16 or over who are family members or who are, or have been, intimate partners. This includes psychological, physical, sexual, financial, and emotional abuse. It also includes 'honour'-based violence and forced marriage.
To ensure the Trust has robust arrangements there is

- A Named Lead for Domestic Abuse (DA).
- Domestic Abuse Guidance for all staff
- Policy for Trust staff affected by Domestic Abuse

Ongoing risks/challenges

It has been publicised and discussed nationally around the impact of COVID 19 lockdown may have in relation to increased and unseen domestic abuse. This has been reflected in NE and N Lincs by the number of victims discussed at high-risk MARAC meetings which increased and have continued to remain high throughout 2021/22.

The Domestic Abuse Bill 2021

The prevention of domestic abuse and the protection of all victims lies at the heart of the Domestic Abuse Act 2021 ('the 2021 Act') and its wider programme of work. The measures in the 2021 Act seek to:

- Promote awareness
- Protect and support victims
- Hold perpetrators to account
- Transform the justice response
- Improve performance

Domestic abuse is a high harm, high volume crime that remains largely hidden. The Crime Survey for England and Wales (CSEW) for the year ending March 2020 estimated that 2.3 million adults aged 16 to 74 had experienced domestic abuse in the previous year. 5 Childhood Local Data on Risks and Needs estimated that, between 2019 and 2020, approximately 1 in 15 children under the age of 17 live in households where a parent is a victim of domestic abuse.

The Domestic Abuse Bill has identified that DA costs the country £66 billion and the cost implication of DA for health alone is £2.3 billion.

Case study

This case demonstrates how services can work together and respond quickly to a safeguarding situation in order to protect and support an individual attending the hospital and disclosing Domestic Abuse and requiring immediate protection. The supportive actions included the children's safeguarding and adult safeguarding nurses, the patients consultant and nurse, Police, MARAC, Children's social care, online language interpreter, children's school and hospital security all working together.

Safeguarding Concern

As her partners mother waited in the waiting room Sian a young polish lady asked a member of staff to help her to the toilet and immediately disclosed DA from her partner and exploitation from their family.

A coordinated response was required to keep this lady safe for the 4 hrs she then remained in hospital. The safeguarding team immediately visited the lady in the unit to support her and staff and gather all the information regarding the concern, completed all safeguarding referrals and reach out to professionals to support an immediate response

Learning:

The safeguarding nurses, hospital nursing and medical staff and the victim all felt a little vulnerable and worried that the partner would turn up and Sian was on edge looking at the door. It highlighted that the hospital would benefit from a safe room whereby no one could enter this room and the victim and supporting staff could feel safe.

Outcome

The plans in place and the support which was offered to the patient were entirely successful she was fully supported and protected to flee this relationship and be reunited with her children.

Key Achievements

- Continue to be proactive member of MARAC in both N Lincs and NE Lincs and in Lincs as required.
- Safeguarding team have attended and are active participants at Domestic Abuse Strategy Groups for both N Lincs and NE Lincs
- Promoted MARAC training for Trust staff
- Provided support to NLaG staff where domestic abuse has been identified
- Continued close working arrangements with Blue Door staff and have an Independent Domestic Abuse Advocate (IDVA) aligned with the team at both DPoW and SGH site
- Continued to flag domestic abuse victims on the ECC electronic system
- The safeguarding team have seen an increase in staff disclosing domestic abuse and have continued to offer support and signposting.
- Domestic abuse is included in Level 3 safeguarding adults training and the updated safeguarding adult's policy

Priorities 2022 - 23

- Review and update Domestic Abuse Policy and Guidance to come into line with the new DA Bill
- NLaG to be benchmarked against N Lincs and NE Lincs DA strategies
- To continue to develop and embed routine enquiry with the Trust
- To include routine enquiry into nursing admission documentation.
- Re-establish onsite IDVA's

CHILDREN LOOKED AFTER NORTH AND NORTH EAST LINCOLNSHIRE

Our Children Looked After Health teams work in partnership with North and North east Lincolnshire Councils to ensure that the health needs of children who are looked after (CLA) and young people are met, reduce health inequalities, improve health and wellbeing outcomes for children who are looked after, care leavers and those placed for adoption. The health team provides advice and support to health and social care practitioners to improve these health outcomes.

A Looked after Child is subject to a care order (placed into the care of local authorities by order of a court), and children accommodated under Section 20 (voluntary) of the Children Act 1989. Looked after children may live within foster homes, residential placements or with family members (connected carer's).

The services are monitored by the Vulnerabilities Oversight Board, Women and Children's Governance Group/Family Services and partners in North and North East Lincolnshire Council and North and North East Lincolnshire Clinical Commissioning Group (now the NHS Humber and North Yorkshire Integrated Care Board (ICB) Humber and North Yorkshire Health and Care Partnership and Safeguarding Children Partnership.

Key Performance Indicators

The Local Authority must notify the CLA team within 48 hours of a child/ young person becoming 'Looked after'. If the notification is late this will impact on the timeliness of the statutory health assessment undertaken by the paediatrician. The Designated Doctors for Children Looked After form part of this team and they complete all the initial health assessments (IHA) for all children and babies placed in the areas. Our nurses on the teams complete all review health assessments (RHA) undertaken every 6 or 12 months depending on the age of the child. In North Lincolnshire the under 5-year-old health assessments are undertaken by Health Visitors in RDASH.

Key Performance Indicators- Assessments completed within timescale

North East Lincs	Quarter 1	Quarter 2	Quarter 3	Quarter 4
IHA	24.25%	45.94%	34.54%	33%
RHA	92.49%	90.69%	92.96%	96.15%

*Initial health assessments are carried out when the child/young person comes into the 'care system'. The IHA compliance is always below 95%. This is due to the late notifications to the CLA team who arrange these with the paediatrician within 20 days. Notifications can come out of the 20-day timescale for completion.

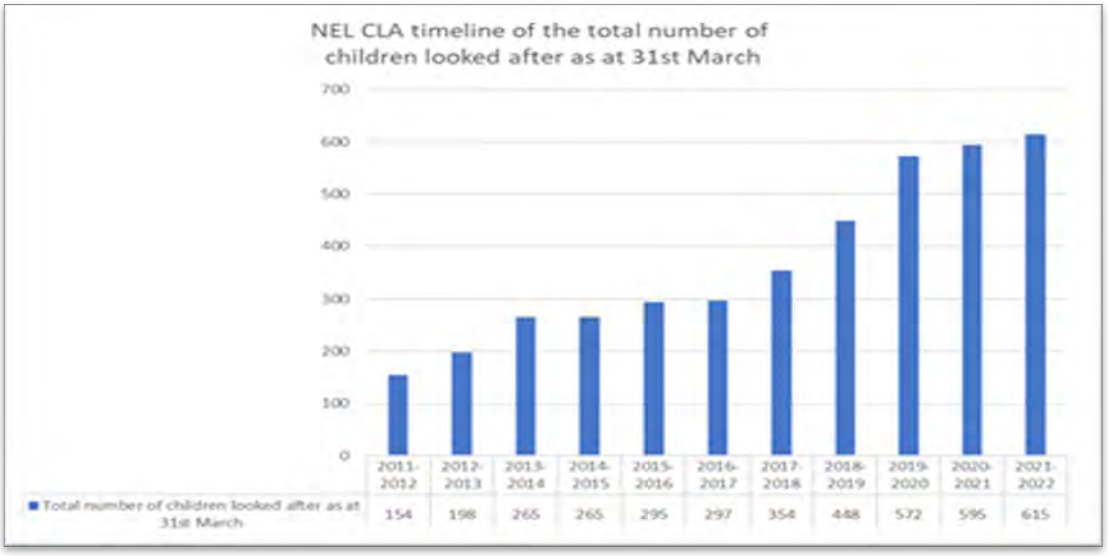
North Lincs	Quarter 1	Quarter 2	Quarter 3	Quarter 4
IHA	100%	100%	88.24%	95.83%
RHA	86.44%	82.98%	91.22%	93.35%

North East Lincolnshire late notifications of children becoming looked after 2021– 2022

North East Lincs	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Became Looked After	33	37	55	64
Late Notifications	29	32	50	58
%	87.87%	86.48%	90.9%	89.06%

Key challenges

- Continued late notifications of children and young people new into care has resulted in not meeting statutory timescales for IHA within 20 working days.
- Late and poor-quality documents returned to the team from the Local authority has contributed to impact on performance and children not having a health plan in place within 20 working days of becoming looked after or six monthly/annually thereafter during their care experience.
- Continued trend of children becoming looked after continued into 2021-2022



these figures are end of March each year. There will have been more children that came into care and cease to be CLA.

- Placements of our children to other local areas has further contributed to delays and poor performance as out of area health teams will not undertake a statutory health assessment without good quality paperwork.
- Further delay is now prevalent where out of area health teams lack capacity to undertake our health assessments for our children who are now on waiting lists to be seen- this is a national issue.

Actions taken

Appropriate escalations to NELC Senior Management, Corporate Parent, Specialist Lead – Quality, Performance and Practice, Service Manager for Children in Care who are actively following up with social workers. Internal escalation through Women and children's Governance meeting, our Vulnerabilities forum and Oversight Board, Quality Governance Group and Quality and Safety Committee meetings, and to Designated Nurse Children Looked After, NHS Humber and North Yorkshire Integrated Care Board (ICB) Humber and North Yorkshire Health and Care Partnership. Escalation to Safeguarding Children Partnership via providing reports to Designated Nurse.

Recent joint monitoring meetings (NELCCG, NELC and NLAG) have taken place and an initial agreement to pilot an extension of 7 workings days (from 48 hours) has been agreed for notification including minimum paperwork. NELC agreed to create business support in May 2022 to work with CLA health team to act as one point of contact. This pilot is being reviewed.

We will continue to have robust oversight of all cases where delay is occurring to ensure that assessments are undertaken despite being late and through oversight and monitoring of these cases ensuring that health needs continue to be met whilst awaiting a more formal review of their health needs.

Key Achievements

- Continued good performance for Review Health Assessments for CLA NEL placed in area.
- Permanent funding secured for 2022 to recruit to Band 2 and 3 administrative posts for Band 6 Specialist Nursing posts.
- The use of telephone consultations and NHS Anywhere video consultations has allowed efficient and effective use of resource. This has now returned to face-to-face consultation.
- Return to face-to-face consultations for all children looked after
- Innovative opportunities to capture CLA health care plans from safeguarding medicals; records as new-born; chat tool in secure setting and seeing/using medical records for child on ward. This improves timeliness and reduces duplication for the child/young person.
- NEL review of the health passport work in collaboration with the child in care group.
- NEL and NL performance of Statutory Initial Health Assessments has been good although outside statutory timeframe
- NEL and NL performance of Statutory Review Health Assessments
- Maintained regional and national links with specialist looked after children's meetings.
- Continue to work in collaboration with our children and young people capturing their voices central to all service delivered.
- Our 'Garage clinic room' in North East Lincolnshire that was completed in collaboration with our children; This has meant we have been able to provide a COVID secure environment and see our children face to face for statutory Initial and Review Health Assessments.
- Foster carer training took place on 25th March 2022 to offer foster carer training to 16 NEL Foster Carers at Grimsby Town Hall after this being cancelled due to COVID 19. This was particularly good as we had speakers from our speech and language department, CAMHS, health Visiting team, the out-reach immunisation team and our Nursing and Paediatricians. This day evaluated well, and we felt proud of our day.
- NL provided support to the foster carer's induction day on 20.07.2022
- In NEL we continue to undertake monthly multi-agency meetings to discuss our children's Strengths and Difficulties Questionnaires to work with our partners to contribute to planning for our children.
- NL is involved with the multiagency emotional and wellbeing meetings held monthly

Priorities 2022-23

- For NEL to continue to work in partnership and support children's social care to improve late notification and the timeliness of health assessments
- To continue to develop a training passport for CLA and CL within the provider organisation
- For NL to develop a role within the team to complete the review Child in Care (CIC) reports in time for the CIC reviews arranged by the IRO.
- To formalise the Service Level Agreement with NEL ICS.

TRAINING AND SUPERVISION

The provision and delivery of safeguarding training for both children and adults remain a key priority. It is a mandatory requirement for all staff to undergo this training to attain competencies appropriate to their role in line with the Intercollegiate Document for Safeguarding Children (2019) and Adults (2018).

Key Challenges

The Coronavirus Pandemic (2019) as such brought additional challenges ensuring all our staff received and maintained their mandatory safeguarding training compliance. This has continued throughout 2021-22 whilst restrictions to social distancing and operational pressures in departments continues. This last year we have re-stabilised the delivery of our face-to-face training over MS teams. a two hour top up for the Level 3 safeguarding children training to ensure all our staff are complaint with the Intercollegiate Document 2019, and are aware of local issues, thresholds, themes etc. and are given the chance to discuss their learning in a virtual MS team environment. Level 3 Adults and MCA DoLS training is delivered all over MS teams.

Key Changes

The Department of Health and Social Care mandate to Health Education England: April 2019 to March 2020 states the requirement to 'further develop the core skills training framework to reflect the future service needs to the NHS'. Additionally, NHS England and NHS Improvement has committed in its Long-Term Plan to enable "staff to more easily move from one NHS Employer to another". This aim was reinforced in the NHS People Plan for 2020/2021 and with the release of the NHS England » Enabling staff movement toolkit.

In November 2021, as part of the above initiative, work was completed to align all the Safeguarding Training Level competencies to the Core Skills Training Framework (CSTF) Standards CSTF Review Summary Report (hee.nhs.uk) which allowed the Trust to simplify and align the appropriate level of training to the correct staff groups for Safeguarding Adults/Children all levels; allowing ease of access to the right level of training relevant to role as soon as possible.

In order to measure compliance, NLaG have a Trust Board Key Performance Indicator to achieve Core Specific Statutory Mandatory Training at a 90% and Role Specific at 85%. Safeguarding Children and Adults therefore measures all core (Level 1) at 90% and Level 2-5 as Role Specific with a KPI of 85%.
This brought an additional challenge when adult and children level 1 compliance reduced to under 90%. Focused areas of work is ongoing to improve this.

Training	March 2021	March 2022	Variation
Deprivation of Liberty	86.4%	85.6%	Decrease 0.8%
MCA	81.8	80.6	Decease 1.2%
FGM	78.2%	84.6%	Increase 6.4%
Prevent Level 1	84%	90.6%	Increase 6.6%
Prevent Level 2	91.3%	87%	Decrease 4.3%
Adult Safeguarding Level 1	86% (Target 85%)	89.5% (Target 90%)	Increase 3.5%
Adult Safeguarding Level 2	82.5%	88.4%	Increase 5.9%
Adult Safeguarding Level 3	54.4%	70.4%	Increase 16%
Adults Safeguarding Level 4	87.5%	100%	Increase 12.5%
Children Safeguarding Level 1	85.7% (Target 85%)	89.3% (Target 90%)	Increase 3.6%
Children Safeguarding Level 2	87.8%	88.1%	Increase 0.3%
Children Safeguarding Level 3	86.3%	76.2%	Decrease 10.1%
Children safeguarding Level 4	76.4%	100%	Increase 23.6%
Children Safeguarding Level 5	50%	50%	Static

Analysis

- We have seen an increase in FGM, Prevent level 1, adult and children level 1, level 2, level 3 and level 4 adults and children training.
- Adults and children level 1 has reduced to amber when the training was aligned with the core skills despite the compliance increasing.
- Significant decrease in children's level 3 despite offering numerous opportunities for staff to attend
- Precent compliance remains above NHSE target of 85%
- Level 5 children is assigned to 2 members of staff which will account for the 50% compliance.

Key Achievements

- Continued to deliver safeguarding training through eLearning platform and re-stabilised the delivery of level 3 training over MS teams and eLearning.
- Continued to provide individual and ad-hoc safeguarding supervision
- Delivered Adult safeguarding training in-line with the Adult Intercollegiate Document (2018)

Priorities 2022-23

- Increase compliance of Level 4/5 training in adults and children
- Develop the Adults Supervision Policy and implement a supervision and implementation strategy for the Trust for Adults
- Review and Implement the Looked After Children: Roles and Competencies of healthcare staff (December 2020)
- Increase compliance in all levels of safeguarding training to meet Trust Targets
- Focused offer of training aligning with numbers of staff becoming out of compliance
- Increasing compliance of medical staff

SAFEGUARDING REVIEWS

The safeguarding team are active participants in Safeguarding Children Partnership reviews, Safeguarding Adult reviews and Domestic Homicide Reviews. These types of review will analyse
in detail how partner agencies have worked together to prevent abuse and neglect.

The purposes of safeguarding reviews are to enable Local Safeguarding Boards/Safeguarding Partnerships and Community Partnerships to fulfil their obligations under the Children Act (2004), The Care Act (2014) and the Domestic Violence and Victims Act (2004).

There have been a total of 18 requests this year for information, and 34 records reviewed. This is an increase of 9 requests from last year.

Cases for 2022/23

Serious Practice Reviews

- There have been 2 new Serious Practice Review's commissioned by the Local Safeguarding Children Partnerships.
- The Trust has been involved in 2 cases from previous years at varying stages of progress.

Thematic Reviews (Children Line of Sights / Rapid Reviews)

- There have been 16 thematic reviews led by the Children's Partnerships.

Serious Adult Reviews

- There has been 6 new Serious Adult Review commissioned by the Local Safeguarding Adult Boards, and a learning lessons review.
- The Trust has been involved in 1 case from previous years where action plans have been re-visited by the Safeguarding Board.

Domestic Homicide Reviews

- There have been 4 new DHR's commissioned locally.

Challenges

Due to the high number of DHR requests and LOS we have prioritised our attendance at multi-agency meetings to ensure our contribution as a safeguarding partner remains paramount.

Key Achievements

- Fulfilled partnership requests for information and contributed as authors and panel members to Line-of-Sight meetings, Children's Practice Reviews, Serious Adults reviews and Domestic Homicide Reviews.
- Met the Rapid Review timescale process of 5 days in sharing information.
- Continued to monitor reviews and action plans though the safeguarding operational group and safeguarding committee meeting

Priorities 2022-23

- To strengthen lessons learned arrangements for external reviews into revised internal processes.

LEARNING & AUDIT

In line with our internal governance arrangements and multi-agency partnership arrangements we have participated in several audits this year. We are required to assure our Safeguarding Adults Boards and Children's Partnership arrangements that safeguarding is embedded in our organisation. We do this by attending safeguarding Board meetings and their sub-groups across NEL, NL and East Riding in a limited capacity and our commitment to working together to safeguard children and adults. There are several statutory audits we complete and report on.

Key achievements

- East Riding Safeguarding Adults Board Assurance
- CCG Self-Declaration – we have further work in relation to the Restraint Policy, closer working with Complaints Dept. and our Safeguarding Adults Supervision Policy development.
- Internal audit to ensure vulnerable patients are being flagged on WebV- this audit provided assurance to our organisation that inpatients were flagged correctly and followed up appropriately. Further work currently ongoing with Patient Administration Team to ensure flagging in the PAS system.
- Child protection medical audit completed.
- Self-harm audit
- Audited the use of ReSPECT and end of life pathway documentation with Learning Disability patients- data collection completed.
- Developed an internal audit schedule this year.
- National Dementia Audit- no outcomes as yet

Priorities 2022-23

- Develop links with all Clinical Governance meetings in Medicine, Surgery, Women's and Children's, Community Therapies to share learning from audits, reviews and highlight reports from our operational forums.

- National Learning Disabilities Benchmarking Audit- based on the LD Improvement Standards for Trusts (2018) to measure the Care provided to people with a LD and/or autism.
- Service users stated that they had been provided with information in an easy read format when they had had the need to complain
- 79% of patients with a Learning Disability or autism who completed the survey stated that flexible appointment times had been arranged for them
- 85-90 % of patients with a Learning Disability or autism who completed the survey responded that whilst utilising NLaG services both them and their families felt cared for, respected, and listened to. In addition, they were given choices and explanations were given in a manner they could understand.
- 89% of patients with a Learning Disability or autism who completed the survey felt safe whilst utilising NLaG services
- An improvement plan has been developed to address areas of the audit in which we still have some progression to make most of this was around the

SAFEGUARDING BOARDS AND PARTNERSHIPS

Safeguarding Children Partnerships and Safeguarding Adults Boards were set up as statutory bodies. They are a partnership of the relevant statutory, voluntary and community agencies involved in safeguarding and promoting the welfare of all children and young people / Adults at Risk of Abuse. They do this by co-coordinating the safeguarding work of member agencies so that it is effective. Monitoring, evaluating and when necessary, challenging the effectiveness of the work and advising on ways to improve safeguarding performance.

Following the Wood Report (2016), Safeguarding Children's Boards were replaced in 2019 by Partnership arrangements. There are now three organisations that are jointly responsible for the partnership arrangements to keep children safe. They are Local Authority, Police and the CCG working alongside other relevant agencies. The key messages are still around improving partnership working and joint responsibility. Whilst the statutory partners hold lead responsibility, NLaG will still be held to account for undertaking and delivering on its key safeguarding duties.

The Local Safeguarding Children Partnerships (SCP) / Adult Boards of North Lincolnshire, North East Lincolnshire and East Riding all have Independent Chairs and membership has been reviewed ensuring that attendance at the Partnerships / Boards is at the required levels and members have sufficient seniority
The Trust is represented by the Head of Safeguarding at the following Partnerships and Boards:

- North East Lincolnshire SCP and LSAB
- North Lincolnshire MARS and LSAB
- East Riding SCP and LSAB
  There is representation by other key professionals on the sub committees of the above Partnerships/Boards.

Safeguarding Children Priorities	Safeguarding Adult Priorities
Domestic Abuse Transition Child Exploitation Neglect	Neglect Self-neglect Domestic Abuse
Training Voice of the Child	Making Safeguarding Personal

Key achievements

- Attended Safeguarding Adults Boards and Children's Partnership meetings and associated subgroups
- Attended Local partnership Health Meetings to ensure the Governance and accountability for the Children's Partnership arrangements are robust, and the Executive lead in the CCG and safeguarding partnership meets their statutory responsibility.
- Attend Learning Disability Partnership, Chair of Health and Wellbeing Group (Subgroup of LD Partnership
- Attend NL and NEL Autism partnership meetings
- NL and NEL Adult Dynamic Support Network meeting
- NL Carers Strategy and Delivery Plan Partnership Group
- Dementia Leads Meeting

CONCLUSION

The Safeguarding Annual report demonstrates that safeguarding children, young people, families and adults at risk remains a key Trust priority, demonstrating that NLaG is meeting its statutory responsibilities in relation to safeguarding children and adults in a highly complex and changing legislative framework and from a national perspective.

The Trust has responded to these changes and to ensure that everyone is aware of their own individual responsibilities as part of a wider multi-agency partnership arrangement.

Whilst significant progress and achievements have been made in all the key safeguarding agenda's detailed in this report, the team have prioritised and identified the key strategic developments required for 2022-23. These may change in line with other Trust priorities, emerging challenges nationally and the wider partnership priorities including national directives.

Our key underpinning message is that Safeguarding is everybody's responsibility regardless of their role within the Trust.

Appendix 1

Priorities 2022-23

1. **Prevent**

- Prevent lead to continue to attend regional meetings/Channel meetings in NEL/NL
- Continue to embed the prevent message via the safeguarding newsletter and regular updates on the Hub
- Quarterly Prevent returns to NHSE

2. **Adult Safeguarding**

- Work with adult social care to ensure that referrers receive feedback from concerns raised, and a consistent approach to referral thresholds is achieved.
- Audit the Missing/absconding policy
- Develop the Adults Supervision Policy and implement a supervision and implementation strategy for the Trust
- Improving the quality of MARAC referrals
- Supervision sessions for Community staff
- Face to face training sessions for Level 3
- Bespoke training sessions for specific safeguarding topics
- Allegation's policy (to include LADO and PiPoT)
- Launch Safeguarding and Vulnerabilities Champions

3. **Safeguarding Week and other prominent days**

- Continue to be involved in safeguarding weeks and promotion of training and study days throughout the year
- Lead and contribute to Safeguarding Month in July and Domestic Abuse month in October

4. **Vulnerabilities**

- Develop and embed a Transition Pathway / Policy working in collaboration with Children's services
- Flag on our PAS systems patients with Learning Disability and Dementia to improve identification of vulnerable inpatients and attendance at outpatient appointments
- Progression of the approved 'Changing Places' facility at SGH
- Develop business case to progress a Lead Transition Nurse for complex young people transitioning into adult based services.
- Combine the LD and Dementia training to Vulnerability training
- Priorities Develop and embed a Transition Pathway / Policy working in collaboration with Children's services

- Complete the National Audit for Dementia
- Community and Therapies engagement – improving links between primary and secondary care.
- Relaunch and lead Dementia training as Vulnerabilities training half day session for front line staff responsible for the delivery of care to our patients
- Virtual Dementia Bus Tour
- Implementation of the Carers Strategy
- Develop accessible appointment letters on the patient administration system for vulnerable patients
- Develop a policy for managing vulnerable adults who do not attend/ were not brought to appointments
- Recruitment of Vulnerability Champions and planned re-launch day September 2022
- Develop a robust system to ensure the patient/carer voice is being heard when redesigning our services and that the Trust to be able to demonstrate this
- Relaunch utilisation of NHSE/I Ask, Listen, Do
- Work with North Lincolnshire Learning Disability partnership to develop a pledge for vulnerable adults
- Relaunch updated 'My life' document following ratification
- Work with the CCG on a data sharing agreement with the CCG for Learning Disability and carers registers
- Develop a survey monkey for gathering feedback from Vulnerabilities training
- Attend updates in relation to the mandatory Oliver McGowan training and implement as required

5. MCA and DoLS/Amendment Bill

- Consider implications for NLaG Acute and Community Services once the public consultation is completed
- Continued promotion of the person at the heart of all decision making including supported decision making wherever possible
- Continue to build on sound MCA practice including Capacity Assessments and Best Interest Records to prepare staff for the changeover
- Provide detailed report to Board of Directors regarding Liberty Protection Safeguards, implications of the Bill and Codes of Practice
- Review team and Trust resources to implement the new LPS scheme including training, new processes, and expertise
- Commence LPS workstream meetings to ensure preparedness for transitional phase and full implementation and oversight and assurance prior to implementation
- To continue to support wards in completing their own DoLS applications
- To continue to support staff to embed MCA into practice
- To monitor closely the progression of the Bill and link with other Local NHS Trusts around implementation and plans for embedding LPS

- Work with legal services department to ensure plans for new systems are embedded
- Review the MCA DoLS Policy when the LPS are implemented

6. Mental Health

- A Mental Health Pathway (Goole District Hospital)
- Continue suicide prevention work
- Embedding compliance with the Sections of the MHA
- Establish links with higher education systems (student nurse training - Hull University)
- Working closely with the Adult Named Nurse focusing on patients with an underlying MH disorder and self-neglect.
- Continue to progress NCEPOD- Treat as One (adults) and Mental Health Care for Young People and Young Adults (children)
- Review the formal agreements with RDASH and NAVIGO
- Provide themed teaching session
- Review Restraint/ rapid tranquilisation policies/ training
- Explore pathways for joint working to ensure children and young people do not have delays in waiting for appropriate services

7. Safeguarding and Midwifery

- Develop and implement a cascade safeguarding supervision model within midwifery
- Audit the effectiveness of the ICON rollout
- Develop a Learning Disability and Pregnancy guideline for Midwives.
- Health Visitor liaison form to be implemented electronically in North Lincs to align the process with North East Lincolnshire following the pilot within NE Lincs.
- Promote the 'Myth of Invisible Men' project that includes fathers in the pregnancy booking pathway which will look at consent from fathers in relation to their mental health and probation history
- Implement the Subconjunctival haemorrhage in Infants Policy
- Develop the safeguarding communication pathways when Badgernet is implemented

8. Children and Young People

- Establish a new daily update and communication between Paediatric Ward and Safeguarding team at DPOW for inpatients (Pilot project)
- Embed the actions from the medical report audit and the identified actions from the safeguarding paediatric medical standards (RCPCH 2019)

- Review of the liaison professional's role to include increased support to paediatric safeguarding medicals by providing background health information to the examining paediatrician.
- Review the Failure to be Brought policy
- The roll out of CP-IS in paediatrics.
- Roll out the safeguarding Journal Club
- Embed safeguarding Peer Review meetings at DPoW following the retirement of the previous named doctor.
- Develop and embed the Champions role
- Establish the use of the WEBV referral template and process
- Review Paediatric nursing documentation to include SBAR

9. SUDIC

- SUDIC nurse to lead on a task and finish group to improve the memory work provided to families
- SUDIC nurse and bereavement midwife to develop a study day for 2022
- To continue to embed arrangements regarding the Key worker role to support families who are bereaved
- Deliver training to the Paediatric Medical Staff around child deaths (anticipated/unanticipated) regarding CDR process.
- Develop a bereavement booklet for children

10. Contextual Safeguarding

- To continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multi-agency meetings to share intelligence around this
- Develop the KYSS Tool in WebV
- Audit records cross-site

11. FGM

- Update guidance and policies for staff and provide information leaflets for families
- Ensure that clinical staff working in the Paediatrics arena can identify female children at risk of FGM by having the tools to do so – such as access to the NHS Spine via SMART cards
- Participate in multi – agency task and finish groups to promote best practice in safeguarding women and children re the responsibility all agencies to report to NHS Digital and share information
- Embrace local and national networking opportunities to share knowledge and learning around FGM
- Explore routine enquiry in all areas of Gynaecology

12. Domestic Abuse

- Review and update the DA Policy and guidance to come into line with the new DA Bill
- NLAG to be benchmarked against N Lincs and NE Lincs DA strategies
- To continue to develop and embed routine enquiry within the trust
- To include routine enquiry into nursing admission documentation
- Re-establish onsite IDVA's

13. CLA

- For NEL to continue to work in partnership and support children's social care to improve late notification and the timeliness of health assessments
- To continue to develop a training passport for CLA and CL within the provider organisation
- For NL to develop a role within the team to complete the review Child in Care (CIC) reports in time for the CIC reviews arranged by the IRO
- To formalise the Service Level Agreement with NEL ICS

14. Training and Supervision

- Increase compliance of Level 4/5 training in adults and children
- Develop the Adults Supervision Policy and implement a supervision and implementation strategy for the Trust for Adults
- Review and Implement the Looked After Children: Roles and Competencies of healthcare staff (December 2020)
- Increase compliance in all levels of safeguarding training to meet Trust Targets
- Focused offer of training aligning with numbers of staff becoming out of compliance
- Increasing compliance of staff

15. Safeguarding Reviews

- To strengthen lessons learned arrangements for external reviews into revised internal processes.

16. Learning and audit

- Develop links with all Clinical Governance meetings in Medicine, Surgery, Women's and Children's, Community Therapies to share learning from audits, reviews and highlight reports from our operational forums

NLG(22)214

Northern Lincolnshire and Goole NHS Foundation Trust

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 6 December 2022
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jane Warner, Associate Chief Nurse
Title of the Report	**Maternity/Ockenden Update**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this report is to provide an update on progress with The Ockenden Report (2020, 2022), Continuity of Carer and East Kent Report – Reading the Signals, 2022. The Trust Board is asked to note progress against the actions to be met within the Ockenden Reports.
Background Information and/or Supporting Document(s) (if applicable)	https://www.donnaockenden.com/downloads/news/2020/12/ocken den-report.pdf https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Quality Governance Group
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Board of Directors – 6 December 2022

Maternity / Ockenden update

Introduction

The purpose of this report is to provide an update on progress with The Ockenden Reports (2020, 2022); recommendations; Maternity Improvement Advisor support, Clinical Negligence Scheme for Trusts – year four, Continuity of Carer provision and the recent 'Reading the Signals' - East Kent Report (2022).

Ockenden report, 2020

Of the 12 Immediate and Emerging actions, there are 11 completed actions. The outstanding action is 'Risk Assessment throughout pregnancy). The SOP is now embedded and the audit process to establish compliance is commencing. It is anticipated that this will be completed by 31 January 2023.

There are 11 outstanding actions from the wider action plan, a reduction from 17 in August 2022. These are actively being worked on. It is anticipated that these are completed by 28 February 2023.

Ockenden report, 2022

There continues to be no requirement at this time to provide evidence of compliance or assurance however following the publication of the East Kent Maternity Report on 19 October 2022 it is anticipated that there will be an expectation to provide assurance, probably in early 2023.

Currently there are 41 of the 92 actions met with an additional 12 actions in progress. The 2022 report is much larger with 92 actions within it. Many actions are at a national and regional level.

On-going work includes –

- Successful bid for funding to support Clinical Leadership with the Ockenden work, increasing bereavement midwifery monies to support enhanced training for midwifery support workers.
- Local universities are designing an academic course to support labour co-ordinators
- A Humber and North Yorkshire LMNS wide policy to manage conflict of clinical opinion has been ratified.

Maternity Improvement Advisor(s)

Support continues to be provided by the Maternity Improvement Advisor (MIA) programme and the midwife and obstetric advisors regularly join maternity meetings and visit the sites.

Support is on-going including suggested improvements to various elements of the service with an ultimate aim for the maternity service to no longer be on the programme.

The MIA QI lead, Sophie Kellaway, visited Scunthorpe Maternity Unit on 27 September 2022 to provide support for the on-going QI projects.

Continuity of Carer teams

Diana Princess of Wales maternity unit continues to provide care to a cohort of women from 2 teams – Daisy and Poppy. Current data highlights that 8% of women in our care received continuity throughout their pregnancy, labour, delivery and in the postnatal period. This figure is static and is likely to remain so whilst there are only 2 Continuity of Carer teams in operation. The targets set out in the Maternity Incentive Scheme (CNST) for women to be cared for in continuity teams has been removed as from 21 September 2022 until such time that the midwifery workforce nationally has improved. These targets did form part of the CNST compliance however are no longer required.

Midwifery staffing is not currently at a position in which further teams can be established however this is under review regularly.

Maternity Incentive Scheme (CNST), year four

There is an expectation that all 10 Safety Actions are met by 2 February 2023 which has recently been extended from an earlier date of 5 January 2023.

The mandatory training elements and Saving Babies Lives v2 have been challenging to meet however it is expected that due to the consolidated work of the division and that of ultrasonography and Surgery & Critical Care it is hopeful that they will be met.

Safety Action	Expectation to meet compliance
1 Perinatal Mortality Review Tool	Yes
2 Maternity Services Data Set	Yes
3 Avoiding Term Admissions to Neonatal Unit	Yes
4 Clinical Workforce	Yes
5 Midwifery Workforce	Yes
6 Saving Babies Lives v2	Yes
7 Service User Feedback	Yes
8 Mandatory Training	Yes

9 Safety Champions	Yes
10 NHS Resolution	Yes

A ‘confirm and challenge’ event has been undertaken with Ellie Monkhouse, Chief Nurse and the triumvirate on 24 November 2022 and a further one is planned later in December 2022.

There will also be a ‘confirm and challenge’ with the LMNS and the ICB prior to the 2 February 2023 as there is an expectation that they too are assured in the evidence and work that the maternity service has undertaken to comply with the Safety Actions.

East Kent Report – Reading the Signals, 2022

Summary

- Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48% of the 202 cases assessed by the
- Panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases.
- Did not find that a single clinical shortcoming explains the outcomes.
- Shortcomings in the physical infrastructure at both hospitals, and periods of staffing and resource shortages, but they did not find that these played a causative role in what happened.
- Found that the origins of the harm identified and set out in the Report lay in failures of teamworking, professionalism, compassion and listening.

Action areas

1. Monitoring safety performance – finding signals among noise
2. Standards of clinical behaviour – technical care is not enough
3. Flawed teamworking – pulling in different directions
4. Organisational behaviour – looking good while doing badly

Next steps – Regionally and Locally

- Regional heatmap in place (no specific detail as yet)
- Regional and Local Perinatal, Quality and Safety Oversight Group established
- Consideration of Ockenden final report findings and the East Kent report
- Refreshed delivery plan - ?February 2023
- Working closely with MVP and LMNS
- Culture and behaviours work – Leadership, Kindness and Compassion work

Jane Warner
Associate Chief Nurse – Maternity, Gynaecology and Breast Services

NLG(22)216

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	6th December 2022	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance & Performance Committee Highlight Report**	
Purpose of the Report and Executive Summary (to include recommendations)	To highlight to the Board the main Performance and Estates & Facilities areas where the Committee was assured and areas where there was a lack of assurance resulting in a risk to the delivery of the Trust's strategic objectives.	
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Executive Leads
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
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: Click here to enter text.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	6th December 2022
Report From:	Finance & Performance Committee – 19-10-22 and 23-11-22

Highlight Report:

Unplanned Care Month 7

The Committee worked through the access and flow IPR which raised several questions around

- ED Performance
- Ambulance Handovers
- Bed Occupancy

The committee discussed the effect that SDEC was having on performance and questioned when performance benefits would be seen from the new Emergency Department at Grimsby; the Committee were told that it is a better environment, and the cubicles were much improved but there had been no improvements in performance as that would only come with better patient flow. The bed occupancy position was also questioned as this seemed low compared to what the Committee were expecting to see given the flow difficulties and it was explained that there was an issue with live updates of the system leading to some inaccuracies in the figures. The Committee did not get full assurance over the future achievement of the performance standards.

Unplanned Care Month 8

The Committee worked through the IPR as well as the Patient Flow Improvement Group presentation which raised questions around similar areas as last month. The Committee questioned whether the previously presented ambulance handover actions had been completed. It was confirmed they had been completed but they had not had the desired outcome on performance as there was still a flow issue. The Committee queried the category 2, 3 and 4 calls and were informed that category 2 calls were an outlier nationally but work with the SPA will divert up to 50% of the calls away from the hospital. The Committee praised the work done improving flow within the perfect fortnight carried out in November and looked forward to seeing the resultant performance improvements next month.

Planned Care Month 7

The Committee worked through the access and flow IPR as well as the Planned Care Improvement Program paper and had questions around

- Cancer Performance
- Diagnostic Performance

The Committee requested assurance around the Cancer 62 days waiting performance and was told that a tumour level deep dive was taking place to identify the delays in the pathways. The Committee also requested further information in future meetings around the diagnostic position.

The Committee did not get full assurance over the Cancer and Diagnostic performance metrics and requested deep dives into individual cancer and diagnostic pathways to gain assurance that improvement activities taking place would improve performance in future.

Planned Care Month 8

The Committee worked through the access and flow IPR and requested further assurance on Cancer performance. The Committee were told that it wasn't just NLaG not performing well and that it was similar across the country. It was confirmed that the Trust was involved with the Humber Cancer Board, who requested a review of demand and capacity. The Committee questioned the increase in waiting lists and were advised that that was directly linked to the provision of mutual aid support and asked if it was known what potential future support may be requested. The response was that the System Elective Board had set up a Tactical Board to oversee all mutual aid requirements. Diagnostic reporting was a further area of concern, although a potential solution was possible, and the Cancer Alliance were working on diagnostic access. HIT lists in theatres had been successful in treating more elective patients. The Committee were not assured over achievement of the cancer performance standards but noted that the Trust's relative performance remained one of the best.

GIRFT High Volume Low Complexity September Pack
The Committee worked through a GIRFT High Volume Low Complexity paper and asked if there was an improvement plan with milestones. The Committee were told that GIRFT was brought to Planned Care Improvement Program meetings and an update could be provided to the Committee in a few months' time. The update would include a plan for efficiency which included several milestones.

EPRR Core Standards
The Committee were presented with a paper on EPRR core standards that detailed 91% compliance against 64 core standards. The Committee understood that outstanding elements were due to the standing down of face-to-face training, updating of evacuation and lockdown plans and the need for additional loggists. Assurance was requested over timescales to complete the outstanding aspects and how the Trust could gain assurance that the plans had been tested to ensure they worked.

Winter Plan
The Committee received a summary of the Winter plan and asked for assurances on collaboration with external stakeholders. It was confirmed that a planning forum had been arranged with stakeholders on a fortnightly basis to keep the communication lines open all Winter. The Committee also queried the input from other divisions into ED during high pressure periods and were assured that the divisions had included that as part of their seasonal variation in their plans.

Asbestos
The Committee received a comprehensive paper which provided full assurance.

Medical Gas Pipeline SI Report
The Committee received an updated SI paper on the Medical Gas Pipeline incident. Assurance was given to the Committee that all the SI actions had been closed. Updates would be brought back to the Board on an annual basis within the scheduled EPRR report.

Public Sector Decarbonisation Scheme
The Committee received a bid application paper that NLaG submitted to the public sector decarbonisation programme for funding to invest in reducing carbon emissions from the Trust. If successful, there would need to be a 12% funding commitment from the Trust which would equate to £8.5m over 5 years if the full bid was successful. If unsuccessful, the Trust would still need to invest a significant amount of money on the energy centre and associated equipment at Scunthorpe General Hospital. Announcement of whether this bid was successful would be made in January 2023. The Committee requested assurance the Trust could afford the financial commitment which was given.

Civils Infrastructure
The Committee received a paper regarding the infrastructure at the Trust. The CCTV system had been completed which allowed a high risk to be closed and work was underway on the improvements required to the water reservoir at Scunthorpe hospital which would satisfy the improvement notice The Committee were assured but recognised the risks from the lack of funding for backlog maintenance and felt that further discussions about potential sources of funding would be useful.

Confirm or Challenge of the Board Assurance Framework:

A deep dive into SO1-1.2 and SO1-1.4 was carried out and the Committee were assured on the risks, control gaps and mitigations for SO1-1.2. However, clarity was requested by the Committee over the difference between the risk appetite and the risk tolerance for SO1-1.4.

Action Required by the Trust Board:

The Trust Board is asked to note the key points made and consider whether any further action is required by the Board at this stage.
Gill Ponder
Non-Executive Director / Chair of Finance and Performance Committee

NLG(22)217

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6th December 2022	
Director Lead	Christine Brereton, Director of People	
Contact Officer/Author	Liz Houchin, Freedom To Speak Up (FTSU) Guardian	
Title of the Report	**FTSU Board Reflection and Planning Tool**	
Purpose of the Report and Executive Summary (to include recommendations)	FTSU Board Reflection and Planning Tool is the Trust Board's self-assessment evaluating existing FTSU arrangements and identifying areas for development and planning. It is for approval and assurance	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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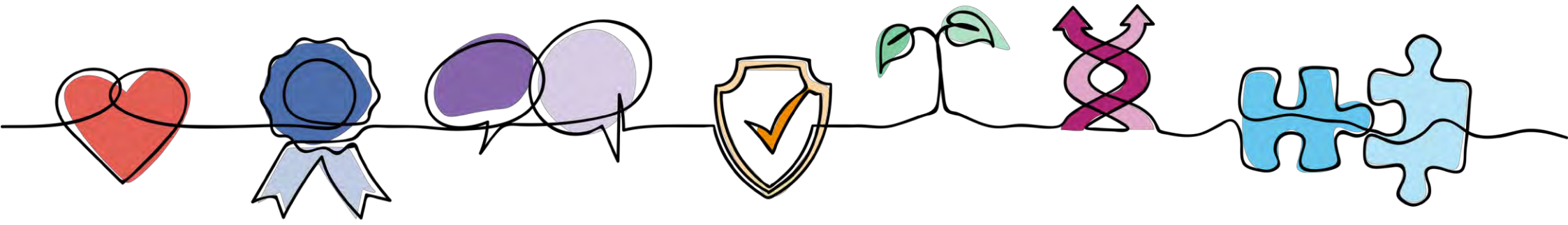
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5 (Yes)
I have led a review of our speaking-up arrangements at least every two years	2 (No)
I am assured that our guardian(s) was recruited through fair and open competition	5 (Yes)
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5 (Yes)
I am regularly briefed by our guardian(s)	5 (Yes)
I provide effective support to our guardian(s)	5 (Yes)

Enter summarised commentary to support your score.

As HRD and Executive Lead for FTSU, I have undertaken the training at three levels for FTSU. I also attend events (national) to keep updated on this subject. am aware prior to me starting with the Trust that an open and transparent recruitment exercise was undertaken for the role of FTSU. A clear job description is in place and allocated time of x3 days per week is in place.

As Executive lead and line manager for the FTSU Guardian we met every month and keep in contact regularly to discuss any concerns/cases to ensure that they are being dealt with. Through these informal and formal arrangements, I believe that I provide the support required to the FTSU guardian. Also, as part of the Trust's approach to its culture transformation, I have ensured that FTSU is an integral part of what we do.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Need to identify a new Executive Lead for FTSU from 1/1/2023 as People Director leaves the organisation in Dec 2022

2 Need to consider how wider Board can demonstrate commitment to FTSU principles ie through training completion

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up	3
I effectively monitor progress in board-level engagement with the speaking-up agenda	4
I challenge the board to develop and improve its speaking-up arrangements	4
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am involved in overseeing investigations that relate to the board	5
I provide effective support to our guardian(s)	5
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 All board members to continue to call out behaviours that hinder speaking up especially at senior leadership level	
2 All board members to continue to role model the values of the organisation and call out any poor behaviours	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	4
We regularly and clearly articulate our vision for speaking up	3
We can evidence how we demonstrate that we welcome speaking up	3
We can evidence how we have communicated that we will not accept detriment	4
We are confident that we have clear processes for identifying and addressing detriment	4
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	3
We regular discuss speaking-up matters in detail	2

Enter summarised evidence to support your score. Comments included:

I believe that as a Trust we communicate FTSU and promote it via regular communications, promotion of the role of FTSU Guardian and support for FTSU month.

I still believe that we have some work to do on being clear about our process for dealing with FTSU complaints and separating out those that we know our managers and leaders should be dealing with (and for us to satisfy ourselves that they have been dealt with), and those that may need further intervention. I still think there is a perception (that we have tried hard to address) that FTSU is a complaint against a manager (which is some cases it is), and we need to continue to strive towards selling this as a good think, but also promoting the role of the manager/leader and how they can and should be dealing with issues and concerns raised by staff.

FTSU should be the safety net when other avenues have failed, but we should encourage staff, and support managers, for issues to be raised and addressed with managers.
Access to current role-holder to raise any thoughts or concerns
Board minutes

Operational Group notes and divisional reports
Sometimes a sense of speaking up outside the management chain is seen as something that is undesirable but think this has improved recently.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

1 Setting out a clear process for how FTSU issues will be dealt with.

Culture, values and behaviours to be led from the top

Specific Board development session to get all Board members to agree a vision for Speaking Up and to commit to it

More discussion at Board level on what more could be done to encourage a culture of speaking up as a matter of course

2 Continuing to promote the role of leaders and ensuring that leaders have the right skills

Ensure leaders listen and welcome those who speak up and to instil the values and behaviours of the organisation (through values-based leadership programme)

Statements for the person responsible for organisational development	**Score 1–5 or yes/no**
I am knowledgeable about Freedom to Speak Up	4
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	4
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	3
We support our guardian(s) to make effective links with our staff networks	4
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	4

Enter summarised evidence to support your score.
As above FTSU is an integral part of our Culture Transformation work and Just and Learning Culture approach. The FTSU Guardian forms part of the Culture Transformation Working Group and staff networks.
FTSU Month
Quarterly and Annual FTSU reports
FTSUG attends meetings with CEO, DOP, Vice Chair, Trust Chair, access to buddy calls and attendance at Patient Safety champion meetings, trust inductions etc
We collect positive evidence of the effective working of the Guardian role

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Ensure that we identify FTSU data and streamline with other data to identify themes and trends through cultural transformation board
2 Need to fully embed our Culture Transformation Programme Organisational culture is improving – the learning culture is progressing through quality improvement conference and consultant conference. Possibly room for improvement

Statements about how much time the guardian(s) has to carry out their role	**Score 1–5 or yes/no**
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	4
We have reviewed the ringfenced time our Guardian has in light of any significant events	4
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	4
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	4
Enter summarised evidence to support your score. The quarterly and annual report provides the intelligence. FTSU Guardian has been asked at Board if there are any concerns.	

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Review time allocated to ensure it is sufficient and comparable to similar Trusts
Consider how the FTSUG role has developed since its creation and whether at affects the amount of time required to do the role adequately (through regular 1:1s with Exec Lead for FTSU) Ensure experience sharing continues between FTSUGs at both HUTH and NLAG

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	3*
We can evidence that our staff know how to find the speaking-up policy	3

Enter summarised evidence to support your score.

*New policy will be signed off in December 2022 through TMB
Need to personally sense check in a live environment – continue to analyse staff survey result
The annual FTSU report details the number of those who have spoken up which has increased, so it appears that staff are aware.
There is always room for continuous improvement. Liz has also spoken at SLC about FTSU, so would hope this would be disseminated through Senior / Middle Managers to all staff.
The Guardian's details are available in lots of places and more people are speaking up, but I don't know how we could evidence that staff know where to find the policy.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Update and Communicate new policy to staff

2 Find a way to test whether staff can find the policy

3. Continue to analyse staff survey results for FTSU

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	4
We have an annual plan to raise the profile of Freedom to Speak Up	4
We tell positive stories about speaking up and the changes it can bring	4
We measure the effectiveness of our communications strategy for Freedom to Speak Up	3

Enter summarised evidence to support your score.

I think we engage in comms to test the effectiveness of our strategy, but not entirely sure how we measure it.
FTSU quarterly and annual report to Trust Board in July 2022.
Hub FTSU month.
There is lots of communication about the role of the Guardian and success stories are published to inspire others to speak up.
I know we review progress, but am not sure about a plan to raise the FTSU profile or whether there are measures in place on the effectiveness of the communications strategy.
We use FTSU in our culture transformation approach and through Monday messages to our staff. Liz is well known across the Trust and we use FTSU month in October to promote.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 An annual Comms plan should be developed.
2 Develop ways of measuring the effectiveness of the communications strategy for FTSU of they are not in place already.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	3
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4
Our HR and OD teams measure the impact of speaking-up training	2
Enter summarised evidence to support your score. We haven't as yet mandated FTSU training but we do actively encourage this at induction and through other opportunities, This is because we are trying to focus mandated training for training already in place. Due to operational pressures we are trying to limit further mandated training. We are trying to promote through induction but this probably needs regularly reviewed. Our Guardian does attend training and networking events FTSU is included in induction training at organisational level, but I am not sure about whether it is consistently included in local team-based inductions.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Decision to be made on if the NGO and HEE mandated training will form part of mandatory training	
2 Ensure FTSU information on local induction check list	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	3
All managers and senior leaders have received training on Freedom to Speak Up	3
We have enabled managers to respond to speaking-up matters in a timely way	3
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	2
Enter summarised evidence to support your score. We have developed guidance for managers on FTSU and a recent session run by the FTSU Guardian attracted a number of leaders and managers. However, perhaps still a perception that FTSU is a bad complaint and our current processes may not enable managers to feel empowered (with all cases being reported to the CEO). Managers are aware of this and may be concerned. As outlined above perhaps a review of how we process FTSU complaints and how we categorise them may assist There is evidence that managers are not adapting or learning when staff speak up. I think there is evidence that managers are encouraged to view speaking up as a learning opportunity from the cases held and the actions taken as a result. I think managers are learning what a healthy speaking up culture looks like, but have no evidence that they are adapting their environments to ensure a safe speaking-up culture The organisation is under a lot of pressure, so it is possible that responses may not be as quick as we would like, despite lots of support from our FTSU Guardian.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Further work to be done on how we can encourage managers to see speaking up as something to be embraced and not feared and an opportunity for improvement and greater staff morale. Further training is needed. Enabling reflective time and coaching for our managers Confirm that all managers and senior leaders have been trained on values-based leadership through leadership development	
2 Targeted support through Cultural Transformation work Further work at development sessions with the Board through the culture transformation programme is needed	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	4
We use triangulated data to inform our overall cultural and safety improvement programmes	4
Enter summarised evidence to support your score. Our FTSU is given a free range and undertakes walk outs across the Trust with the NED lead. As part of our cultural work we are gathering information to triangulate concerns.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about learning for improvement	**Score 1–5 or yes/no**
We regularly identify good practice from others – for example, through self-assessment or gap analysis	3
We use this information to add to our Freedom to Speak Up improvement plan	4
We share the good practice we have generated both internally and externally to enable others to learn	4
Enter summarised evidence to support your score. We identify any learning from national gap analysis and our FTSU responds in a timely way. Perhaps further learning can be shared through the FTSU reports submitted to the Workforce Committee and Board	

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Continue to feed case studies into organisation as appropriate

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5
Enter summarised evidence to support your score. Fair and open Recruitment process, our Guardian has received the relevant training. Board disclosures The Guardian has received training and is registered with the National Guardian Office.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	5
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
Our guardian(s) has access to a confidential source of emotional support or supervision	5

There is an effective plan in place to cover the guardian's absence	2*
Our guardian(s) provides data quarterly to the National Guardian's Office	4
Enter summarised evidence to support your score. Our Guardian has the relevant support through supervision and line management. Perhaps to review at some point cover arrangements to ensure continuity Detailed at Board I know that the Guardian receives support from a lead FTSU NED and has access to the CEO, but do not know what further support is in place. The Board sees evidence of the data submitted to the NGO in the quarterly progress reports we receive from the Guardian.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Create an effective plan to cover guardian's absence – plan now develop protocol shared and signed off	
2 Confirm all support available to the FTSUG and consider how that might be improved further	

Statements about our speaking up process	**Score 1–5 or yes/no**
Our speaking-up case-handling procedures are documented	5
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	3
We are assured that confidentiality is maintained effectively	5

We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	5
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	4

Enter summarised evidence to support your score.

All FTSU cases are dealt with in a timely way and followed up and documented and reported as appropriate. There is a follow up process to keep individuals updated.
As above perhaps a review of our processes in this area would be useful.
There have been no suggestions from anyone that anything raised has resulted in concerns about confidentiality being maintained.
I have not seen any evidence that I recall on timeliness of case resolution or on whether people have a consistently positive experience when speaking up within teams/divisions.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1.Seek further assurance on level of engagement with managers and other stakeholders on the role they play in handling cases through the leader programme, the timeliness of case resolution and the experience of those speaking up within teams or divisions.

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	2
We know who isn't speaking up and why	2
We are confident that our Freedom to Speak Up champions are clear on their role	2
We have evaluated the impact of actions taken to reduce barriers?	2
Enter summarised evidence to support your score. This is probably the work that needs most attention and is about encouraging staff at all levels across the organisation to speak up through the relevant processes and leaders and is linked to our culture work. Data exists where the process isn't being utilised. Correlation should take place between areas who score low on the requisite parts of the Friends and Family tests to see if the service is utilised. There should be active interrogation of the turnover data, which I understand there is and if possible inclusion of the FTSUG role in any leaver surveys. I think this is a gap area for the Trust, as I am not aware that attempts have been made to identify the barriers to people speaking up and taken steps to evaluate the impact of actions taken to reduce barriers. Whilst we record data on who is speaking up, I do not know if we question areas where no-one is speaking up. This would seem to be a useful idea.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Further evaluation required Further work to be carried out on identifying barriers to speaking up and then mapping clear actions to improve this Identify barriers to Speaking Up, actions that could be taken to remove them and evaluate impact of actions once taken	

Identify areas where no-one is speaking up and look for patterns, triangulate data from various sources and take steps to understand why people are not speaking up in those areas.
2 Clarity on what is the role and structure is for the FTSU champions - looking to develop cultural champions with FTSU included

Statements about detriment	**Score 1–5 or yes/no**
We have carried out work to understand what detriment for speaking up looks and feels like	3
We monitor whether workers feel they have suffered detriment after they have spoken up	4
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	4
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	4
Enter summarised evidence to support your score. We have not had any cases of this nature but I am confident that this would be dealt with swiftly and appropriate if it did arise. Review at Board Found in the FTSU report to Board The Guardian does follow up with people who have spoken up to get feedback on their experience. If allegations of detriment were raised, I am confident they would be investigated, but due to the confidential nature of those allegations, I would not expect to know whether they have occurred or how they were progressed.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
Continue to encourage through FTSUG to ask colleagues if they feel they suffered detriment	

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	5
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	5
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	5
Our improvement plan is up to date and on track	5
Enter summarised evidence to support your score. Strategy in place, annual review of improvement and objectives ,will be further strengthened through this self-assessment tool	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	3
Our plan follows a recognised ‘plan, do, study, act’ or other quality improvement approach	2
Our speaking-up arrangements have been evaluated within the last two years	3*
Enter summarised evidence to support your score. This probably needs some focus which could be identified as part of our improvement plan around evaluation. Some data is available	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 A plan to be put in place to measure whether there is an improvement in how safe and confident people are to speak up engage with QI to evaluate Evaluated externally 3 years ago will need to include 23/24 audit calendar	
2 FTSU information will be part of cultural matrix	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	5
We have we evaluated the content of our guardian report against the suggestions in the guide	5
Our guardian(s) provides us with a report in person at least twice a year	4
We receive a variety of assurance that relates to speaking up	4
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3
Enter summarised evidence to support your score. Reports are submitted to the Workforce Committee on a quarterly basis and to board every six months with a follow up annual plan. FTSU also forms part of Board Development Days	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Need to ensure that board programme allows for FTSUG present as a minimum twice a year	

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1. Board development session to get all Board members to agree a vision for Speaking Up (including role modelling values of the organisation) and to commit to it.	June 2023	HRD/Vice Chair
2 Discussion at Board level on what more could be done to encourage a culture of speaking up as a matter of course	June 2023	HRD/Vice Chair
3.Ensure leaders listen and welcome those who speak up and to instil the values and behaviours of the organisation (through values-based leadership programme) – Review FTSU input after 12 months delivery	January 2024	OD/FTSUG
4. Ensure that we identify FTSU data and streamline with other data to identify themes and trends through cultural transformation board- review in 6 months	June 2023	HRD/CIO
5. Update and Communicate new policy to staff	March 2023	HRD
6 Develop ways of measuring the effectiveness of the communications strategy for FTSU	June 2023	FTSUG/Comms
7 Ensure FTSU information on local induction check list	March 2023	FTSUG/People Directorate
8 Further work needed on how we can encourage managers including targeted support through cultural transformation work to see speaking up as something to be embraced and not feared and an opportunity for improvement and greater staff morale.	October 2023	OD/HRD

Development areas to address in the next 12–24 months	Target date	Action owner
1 Identify barriers to Speaking Up, actions that could be taken to remove them and evaluate impact of actions once taken	October 2023	FTSUG/HRD/OD
2 Clarity on what is the role and structure is for the FTSU champions - looking to develop cultural champions with FTSU included as part of their remit	October 2023	People Directorate
3 Continue to encourage through FTSUG to ask colleagues if they feel they suffered detriment – may need to define what detriment looks like for colleagues	January 2024	FTSUG
4 Work with QI to identify how to measure whether there is an improvement in how safe and confident people are to speak up engage with QI to evaluate	January 2024	FTSU/HRD/QI team
5 Board to commit that the board programme allows for FTSUG present as a minimum twice a year	January 2024	Vice Chair
6 Evaluated externally 3 years ago - will need to include FTSU in 23/24 audit calendar	March 2024	FTSUG
7		
8		

Stage 3: 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
1 Strategy in place, annual review of improvement and objectives, will be further strengthened through this self-assessment tool	Achieved	HRD
2 Confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	Actioned	HRD
3 Confident that the FTSUG reports provide assurance required	Assured	FTSUG
4 FTSU data no longer viewed in isolation – and will be included in the new culture matrix	Actioned	HRD/CIO
5		
6		
7		
8		

NLG(22)218

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	06 December 2022	
Director Lead	Christine Brereton, Director of People	
Contact Officer/Author	Liz Houchin, Freedom To Speak Up (FTSU) Guardian	
Title of the Report	**Freedom To Speak Up (FTSU) Guardian - Q2 Report 2022-23**	
Purpose of the Report and Executive Summary (to include recommendations)	Report is the Q2 report and gives an update from last board, an overview of number of concerns raised, national and regional updates and the proactive work undertaken by the Trust's FTSU Guardian, and future plans for FTSU. It is for approval and assurance	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Workforce Committee
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Q2– July – Sept 2022

Liz Houchin
2nd November 2022

Contents

1. Executive Summary

This paper provides an update regarding NLaG activity for Q2 2022-23 (which covers the period July–September 2022). Within this paper the results of the National Guardians Office publications are presented alongside NLaG information to provide national and regional comparison and context.

2. Strategic Objectives, Strategic Plan and Trust Priorities

This paper satisfies the Trust Strategic Objective of 'Being a good employer' and is aligned to the Trust priorities of: Leadership and Culture, Workforce and Quality and Safety.

3. Introduction / Background

The paper is presented in a structured format to ensure compliance with the ''Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts'' published by the National Freedom to Speak Up Guardians Office and NHS Improvement. The presentation of this information is structured in such a way that enables the FTSU Guardian to describe arrangements by which Trust staff may raise any issues, in confidence, concerning a range of different matters and to enable the Board to be assured that arrangements are in place for the proportionate and independent investigation of such matters and that appropriate follow-up action is taken.

4. Assessment of FTSU Concerns Raised

4.1 In Q2 2022-23 the number of concerns received were 50, 27 of those were closed on the same day after giving advice or signposting to other services:

- 2 concerns were raised anonymously in Q2.
- 10 concerns involved an element of patient safety (12 month rolling average). This puts the Trust in the mid-quartile nationally, the peer figure being 22 and the national median 23 (figures according to Model Hospital data)
- 7 concerns involved an element of bullying and harassment (12 month rolling average) which puts the Trust in the mid-quartile nationally, the peer figure being 13 and the national median being 22.

4.2 The Q2 figure of 50 is higher than Q2 in 2021-22 when 40 concerns were raised. In Q1 2022-23 35 concerns were raised.

4.3 The main themes raised were around behaviours, process, patient safety and worker safety.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and the majority of concerns were managed and

closed within 10 weeks. Any outstanding concerns are discussed monthly with the DOP /CEO for awareness and support if required.

4.5 FTSU Guardian continues to produce quarterly reports for all divisions to ensure that the FTSU information is used to triangulate with other data i.e., 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.

Q1. 2022-2023 (April-June 2022)			**Q2. 2022-2023 (July-September 2022)**
Concerns		**35**	**50**
Themes	Behaviour / relationships	13	20
	Bullying & Harassment	7	3
	Culture	0	0
	Leadership	1	1
	Patient Safety	10	10
	Process/Systems	10	18
	Personal Grievance	0	1
	Worker Safety	9	10
How Raised	Openly	15	10
	Confidentially	17	38
	Anonymously	3	2
Perceived detriment		0	1

NB - Please note some concerns may have more than 1 element.

Report Breakdown by Division and Role

Q1.2022-2023 (April – June 2022)			Q2. 2022-2023 (July – September 2022)		
Role	**Division**	**Number**	**Role**	**Division**	**Number**
Doctor/ Dentist	1 x Medicine 2 x S&CC	3	Doctor/ Dentist	1x Medicine 1 x S&CC	2
Nurse/ Midwife	1 x Medicine 1 x W&C 5 x S&CC 1 x C&T	8	Nurse/ Midwife	4 x Medicine 2 x S&CC 1 x C&T 8 x W&C 1 x Chief Nurse	16
HCA	2 x Medicine 1 x Bank	3	HCA	Medicine	1
Admin	3 x COO 1 x Corporate 2 x S&CC 1 x Digital	7	Admin	1 x Medicine 6 x S&CC 5 x C&T 5 x CIO	17
AHP	3 x C&T 1 x Medicine 2 x S&CC	6	AHP	1 x Medicine 1 x S&CC 3 x C&T	5
Other	1 x E&F 2 x C&T 3 x COO	6	Other	2 x E&F 1 x CIO 1 x S&CC 1 x C&T 1 x Medical Director 3 x COO	9

4.6 FTSUG Feedback /Evaluations received:

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

Quarter 2022-23	Feedback received	Would you speak up again? Yes
Q1	7	7
Q2	12	12
Q3		
Q4		

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

- ***Thank you for ensuring these issues were heard, I am pleased with the outcome.***
- ***I was anxious about raising my concern and the possible negative impact this may have on my working relationships with colleagues, but Liz reassured me it would be anonymous. She talked me through the process and kept me up to date with its progress.***
- ***The process is easy, and the response is very informative and quick. I won't hesitate to contact FTSU 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 FTSUG was contacted by a colleague who had recently started working in the Trust. At a Pre-Employment Occupational Health assessment, it was identified that some adaptations were needed to support the colleague who has a long-term health condition. The colleague had been in post for 3 months and the equipment had not been ordered, FTSUG contacted management team and equipment was ordered. Staff member was happy with the outcome but wanted to ensure that there was organisational learning as the impact of not having the equipment had a negative effect on their wellbeing. Learning from this concern includes looking at the recruitment process (when someone highlights that they require equipment to ensure that managers know and can order equipment in advance, so it is here for the employee's first day), looking at centralising the budget for equipment and ensuring that access to work fund is utilised.

5.0 Regional and National Information and Data

5.1 National update

The National Guardian's Office reported 20,362 cases were brought to Guardians in 2021-22 (on a par with previous year). 5,312 cases were recorded by the NGO in Q1 which is an 8.9% increase compared to the same period last year. The increase may be due to the national issue of increasing staff pressures.

The NGO have published a new national Freedom To Speak Up policy which the Guardian will be looking at publicising in the near future.

Q2 data for 2022-23 has been submitted to the NGO by the Guardian.

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. Recent discussions included whether organisations are mandating the HEE/NGO training, the new Guardian training and how the NGO supports Guardians. There was also a presentation about Critical Incident Staff Support pathway and ensuring that Guardians are aware of the psychological support available for staff across the region.

6.0 Proactive work of the FTSUG during Q2

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at Health & Wellbeing Steering Group
- Attendance at Cultural Transformation Launch
- Presented at Doctors Induction Day and International Nurses Induction
- Walk Rounds at DPOW with a NED
- Attendance at all network meetings

6.1 Future Plans

Work to define the future work of combined Champions to include FTSU and Health and Wellbeing is ongoing by the People Directorate
Continue to be a core member of the Cultural Transformation Working Group
Continue to raise profile of the Guardian

7.0 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 objective of being a good employer.

8.0 Recommendations

The Trust Board is asked to:

a) Note the report for assurance
b) Approve the report

Compiled By: Liz Houchin,
Date: 2nd November 2022

NLG(22)219

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	06 December 2022	
Director Lead	Susan Liburd, Non-Executive Director and Chair of Workforce Committee	
Contact Officer/Author	Susan Liburd, Non-Executive Director and Chair of Workforce Committee	
Title of the Report	**Workforce Committee Highlight Report and Board Challenge**	
Purpose of the Report and Executive Summary (to include recommendations)	The Committee recommended highlighting the following matters to the Board, namely: 1. Assuring Undergraduate Medical Education Monitoring and the need for Board level assurance. 2. New areas of Committee reporting: • Workforce Profile and Apprenticeship Levy utilisation. • Industrial Action update on current position. 3. Acknowledging People Directorate recruitment strategy success. 4. Approving: • The Workforce Committee TOR for Board approval. • The Freedom to Speak Up Quarter 2 Report.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
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1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
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4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	06 December 2022
Report From:	Susan Liburd, Non-Executive Director, and Chair of Workforce Committee

Highlight Report: Workforce Committee – 29 November 2022

Introduction
The aim of this report is to provide an update and prompt discussions and scrutiny of the work of the Workforce Committee and Board Assurance.

1. Undergraduate Medical Education

- Undergraduate Medical Education in NLaG is subject to an annual monitoring visit from both Hull York Medical School (HYMS) and Sheffield Medical School. NLaG is required to ensure Board level governance arrangements are in place.
- In June concerns were raised about NLaG Board level oversight, citing we were an outlier compared with other NHS providers medical educational governance structures.
- Undergraduate medical education is now a 6monthly standing agenda item on the Workforce Committee with appropriate escalation and reporting mechanisms to Board in place to provide the necessary Board level oversight and governance. These actions will meet the assurance requirements of NLaG, the Medical School's, and GMC.

2. Workforce Profile Annual Report

- Workforce committee welcomed this new report.
- The Trust has a workforce of 6,892 staff (5,786.21 full time equivalent) as at 31/10/2022. This is a 2% increase in the number of staff employed in NLaG at the same period last year.
- The largest staff group is Nursing and Midwifery (25.9% of the total workforce). The Trust's biggest age group is between 51 and 55 years and is predominately made up of Nursing, and Midwifery staff. There is a disruptive early retirement departure risk with this group. Work is being undertaken to mitigate this risk for example a new retirement policy is in place facilitating retire and return. Committee will carry out a deep dive in Q4.

3. Apprenticeship Levy Annual Report

- Workforce Committee welcomed receipt of a new report updating Apprenticeship Levy activity and plans to further utilise the levy to meet staff development plans and reduce levy underspend.
- Plans to better utilise the levy include promoting wider opportunities for staff to gain a qualification and career pathways in areas such as administration, management, nursing, or technology.
- NLaG non allocated levy spend is used to support other health organisations within the region such as GP Practices to access apprenticeships.

4. Recruitment Strategy

- Workforce Committee commended the focused effort on recruitment by the People Directorate and success in improving workforce vacancies.
- Notable areas of success where targets had been exceeded included Healthcare Support Workers, Newly Qualified and International Nurses.

5. Industrial Action

The Workforce Committee noted:

- The RCN has balloted its members. The threshold for strike action was not met at NLaG.
- The unions: UNISON, The Chartered Society of Physiotherapy and BMA Junior

Doctors have entered a trade union dispute and will be balloting members in December and January for a vote on whether to take industrial action.
- NLaG contingency planning is being undertaken.

6. Items for Committee Ratification & Assurance
- In line with the governance annual review for Board Committees, the Workforce Committee terms of reference has been reviewed and ratified.
- Workforce Committee approved the Freedom to Speak Up Quarter 2 Report.

Confirm or Challenge of the Board Assurance Framework:

No changes were recommended for the Board Assurance Framework.

Action Required by the Trust Board:

The Board is asked to receive and note the content of this highlight report.

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	6 December 2022
Director Lead	Sue Liburd, Chair of Workforce Committee
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Workforce Committee – Terms of Reference (TOR)**
Purpose of the Report and Executive Summary (to include recommendations)	The Workforce Committee at its meeting on 29 November 2022 reviewed its Terms of Reference (see Appendix A). Amendments are as follows: i) Section 2.1: NHS People Plan added to the first bullet point, Freedom to Speak Up wording written in full in the fifth bullet point. ii) Section 4.2.1: Reporting Group minutes must be submitted to the Committee. The wording removed in this section is: A summary report prepared by the Chair of that group outlining the key issues discussed at the meeting and those issues that need to be brought to the attention of this Committee. iii) Section 4.2.2: List of Reporting Groups added: Health and Wellbeing Steering Group, Culture Transformation Board and Working Group, Equality and Diversity Steering Group, Workforce Systems Steering Group and Portfolio Governance Boards. iv) Section 5.1.1: Culture Transformation programme and People Agenda wording added. v) Section 5.1.9: to be removed. The wording removed in this section is: Receive the minutes of the appropriate forums which monitor the delivery of the trusts Equality & Diversity Action Plan. vi) Section 6.2: Executive Director in Attendance, reworded to Executive Director / or deputy. Chief Operating Officer and Chief Nurse / or deputies have been included as those in attendance at this Committee. vii) Section 7.4.2 to be removed. The wording removed in this section is: Executive Directors who are unable to attend will arrange for the attendance of an appointed deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend. Formal deputies appointed can attend up to 25% of all meetings. viii) Section 7.4.3 to be removed. The wording in this section to be removed is: Joint Trust roles, where applicable, the attendance required is 50% of Committee meetings with appointed deputies covering the remainder of meetings.

	ix) Section 7.5.2 to be removed as now covered in Section 6.2. Wording to be removed is: A formally appointed deputy of the Director of People from their Senior Management Team will be counted towards quoracy. **Recommendation:** The Trust Board is recommended to approve the Workforce Committee Terms of Reference.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Workforce Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
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Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Corporate Governance

WORKFORCE COMMITTEE

Membership and Terms of Reference

Reference:	DCT093
Version:	1.3
This version issued:	
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	06/12/22
Approving body:	Trust Board
Date for review:	November, 2023
Owner:	Helen Harris, Director of Corporate Governance
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Helen Harris, Director of Corporate Governance

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.

1.0 Constitution

The Trust has established the Workforce Committee, as a formal sub-committee of the Trust Board. This Committee is responsible for oversight, challenge and assurance, on behalf of the Trust Board, in respect of Trust strategies, plans and performance against key operational targets.

2.0 Purpose

2.1 The Committee's oversight remit will extend to:

- Implementation of the NHS People Plan, Trust People Strategy along with its priorities and sub-strategies;
- Resource and budget requirements for the implementation of the People Strategy;
- Risk Management of risks associated with the People Strategy;
- Performance of the People Directorate and related metrics of the Trust; and
- Monitoring, assuring and reporting to the Trust Board regulatory requirements concerning Workforce e.g. Freedom to Speak Up (FTSU), and Equality and Diversity reporting

2.2 The Committee will report the outcome of each meeting to the Trust Board, raise any concerns and make recommendations for action to the Trust Board across this remit.

2.3 The specific objectives of the Workforce Committee are to ensure risks pertaining to the strategy and transactions of workforce and organisational development are identified and managed and conform with the following:

- To provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability;
- To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities;
- To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential;
- To provide support and opportunities for staff to maintain their health, wellbeing and safety;
- To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through

local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families;

- To have a process for staff to raise an internal grievance;
- To encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure; and
- To promote the delivery of quality education by and for all staff.

3.0 Authority

3.1 The Workforce Committee is authorised by the Trust Board:

3.1.1 To investigate any activity within its terms of reference and produce an annual work program.

3.1.2 To approve or ratify (as appropriate) those policies and procedures for which it has responsibility as listed in the 'Policy Schedule'.

3.1.3 To promote a learning organisation and culture, which is open and transparent.

3.1.4 To establish and approve the terms of reference of such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference.

3.2 The Committee is only able to recommend the commitment of financial resources in respect of matters identified in these terms of reference and as set out in the Scheme of Delegation and Standing Financial Instructions.

3.3 The Chief Financial Officer must be informed of any recommendation requiring use of resources. Any other matters requiring a decision on the use of resources are to be referred to the Trust Board and/or the Chief Financial Officer.

4.0 Accountability & Reporting Arrangements

4.1 Key Arrangements

4.1.1 The Committee, appointed under and subject to the Standing Orders of the Trust, is a sub-committee of the Trust Board, and will submit copies of its minutes for inclusion on the Trust Board agenda. The Trust Board will also receive details of the outcome of the annual evaluation of performance of the Committee.

4.1.2 The Committee will ensure that significant issues are escalated to the Trust Board via monthly 'highlight' reports with recommendations for action where appropriate.

4.1.3 Executive and Non-Executive/Associate Non-Executive Committee members will be expected to ensure appropriate cross over with the work of other Trust Board sub-committees, to avoid adoption of incompatible strategies or plans, and eliminate duplication of workload.

4.1.4 Where relevant, the Committee will seek assurance on relevant matters directly from operational staff, requiring attendance at meetings as required.

4.1.5 The Committee will agree an Annual Work Programme/Cycle of Business (Appendix A), which will be reviewed at each Annual Evaluation of the Committee, or as necessary.

4.1.6 To produce an annual report for the Board of Directors setting out:

- the role and the main responsibilities of the committee
- membership of the committee
- number of meetings and attendance
- a description of the main activities during the year.

4.2 Reporting Groups

4.2.1 Reporting groups will be required to submit the following information to the Committee:

- Their terms or reference for formal approval and review
- The minutes of their meetings must be submitted to this Committee.
- To produce those assurance and performance management reports listed in the individual group's annual work programmes which have been agreed with, and are required by, this Committee
- An annual report setting out the progress they have made and future development and
- Any report or briefing requested by this Committee.

4.2.2 A number of operational groups will support the work of the Workforce Committee by providing around a range of activities related to the remit of the group by the provision of periodic reports and action plans. The groups are:

- Health and Wellbeing Steering Group
- Culture Transformation Board and Culture Transformation Working Group
- Equality and Diversity Steering Group
- Workforce Systems Steering Group
- Portfolio Governance Boards (PGB)

5.0 Responsibilities of the Committee

5.1 On behalf of the Trust Board, the Committee will:

5.1.1 Influence and monitor the development of the People Strategy and Culture work within the Trust incorporating the Trust Vision and Values, Engagement, Culture Transformation programme and any National, Regional or Local People Agenda

5.1.2 Act to provide assurance to the Trust Board that agreed strategies and programmes of work, including performance management of operational teams, are clearly scoped, appropriately resourced and delivered in line with best practice and against the NHS Constitution's Staff Pledge.[1]

5.1.3 Provide assurance, raise concerns (if appropriate) and make recommendations to the Board of Directors in respect of:

5.1.4 The development and ongoing review of an effective People Strategy that is aligned with the Trust's strategic vision and values, making appropriate recommendations to the Board for approval. Review progress against agreed action plans and trajectories to achieve locally determined or nationally set / mandated standards and targets including:

- Monitor Trust performance and data quality on national and local initiatives against Workforce Key Performance Indicators (KPIs) and other indicators/standards
- Staff survey results (local and national)
- Attendance levels
- Demographic makeup of the organisation
- Turnover
- Occupational health data
- Recruitment
- Annual Workforce plan with the involvement of multidisciplinary teams
- Equality and Diversity

5.1.5 Monitor educational, training, learning activities and recruitment to ensure that it complies with required legal and mandated standards, the expectations of the Trust and supports Service development/transformation and evidence based practice.

[1] The NHS Constitution for England - GOV.UK (www.gov.uk)

5.1.6 Consider the control and mitigation of workforce-related risks and provide assurance to the Board that such risks are being effectively controlled and managed via active use of the Board Assurance Framework (BAF).

5.1.7 To review the relevant sections of the Board Assurance Framework on a quarterly basis, giving consideration to the assurance provided, whether the key elements are appropriate in light of any concerns about which the Committee may be aware, and whether the underpinning risks provide sufficient assurance that the strategic risks is being appropriately managed.

5.1.8 Ensure that statutory workforce requirements and reports are submitted in a timely manner to support effective and safe management of services.

5.1.9 Support the development of emerging innovative roles.

5.1.10 Understand the workforce implications of service transformation within the Trust.

5.1.11 Ensure high level risks and mitigation plans are appropriately highlighted to the Trust Board with clear articulation of the actions required at board level.

6.0 Membership

6.1 Core Membership

6.1.1 The Committee will comprise three Non-Executive Directors or Associate Non-Executive Directors.

6.1.2 Associate Non-Executive Directors to be included as core/voting members of Committee and to be counted towards quoracy and can be counted towards voting rights (where applicable).

6.2 Executive Director in Attendance:

- Director of People / or deputy
- Chief Operating Officer / or deputy
- Chief Nurse / or deputy

6.3 Other Persons Attending Meetings

6.3.1 Other persons will attend as agenda items dictate or where a pre-existing or externally driven reporting requirement exists.

6.3.2 Other Non-Executive Directors / Associate Non-Executive Directors and Executive Directors can attend as desired but will not form part of the permanent membership of this committee.

6.3.3 The Chief Executive and Chair have a right of attendance and speaking rights at all meetings of the Committee and may be included in the quoracy subject to agreement by the Chair.

6.3.4 An invitation to join the committee as an attendee will be extended to a Governor to be identified by the Lead Governor.

6.3.5 Executive Directors may on occasion invite other senior officers to attend the Committee, with the approval of the Committee Chair, to present specific items, or for developmental purposes.

6.3.6 On a rotational basis Divisional Management Teams will be invited to the Committee to be held accountable for, and provide assurance against, delivery of the workforce agenda.

6.3.7 The Director of Corporate Governance may be in attendance at meetings as the agenda dictates.

7.0 Procedural Issues

7.1 Frequency of Meetings

Meetings will normally take place every other month.

7.2 Chair

One of the Non-Executive Director members of the Committee will be appointed as Chair. One of the other Non-Executive Director/Associate Non-Executive Director representatives shall deputise in his/her absence.

7.3 Secretary

The Director of People's Executive Personal Assistant will act as Secretary to the Committee, preparing agenda papers in conjunction with the Chair, and Director of People.

7.4 Attendance

7.4.1 Attendance is a minimum of 75% of all committee meetings.

7.5 Quorum

7.5.1 The committee will be deemed to be quorate when there are three members, two of whom will be Non-Executive Directors/Associate Non-Executive Directors and one will be the Director of People (or their deputy).

7.5.2 A quorum must be maintained at all meetings.

7.6 Administration and Minutes of Meetings

7.6.1 Minutes of meetings will be circulated with the agenda papers to all members well in advance of each meeting but no less than seven calendar days before each meeting. In addition to the circulation of minutes, the 'action log' 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 timescale.

7.6.2 Agenda items for consideration to be submitted 12 calendar days before the meeting.

7.6.3 Submission of papers to members should take place seven calendar days before the meeting. Late papers may be submitted at the discretion of the Chair.

7.6.4 Minutes of meetings of the Workforce Committee will also be submitted to the Audit, Risk and Governance Committee and the Trust Board.

7.6.5 The Director of People's Executive Personal Assistant will maintain a record of attendance which must be presented at each committee meeting and included in the annual evaluation exercise.

7.7 Decision Making

7.7.1 Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.

7.7.2 Where this is not possible then the chair of the meeting will ask for members to vote using a show of hands, all such votes will be compliant with the current Standing Financial Instructions (SFIs) and Scheme of Delegation of the Northern Lincolnshire & Goole NHS Foundation Trust.

7.7.3 In the event of a formal vote the chair will clarify what members are being asked to vote on – the 'motion'. Subject to meeting being quorate a simple majority of members present will prevail. In the event of a tied vote, the chair of the meeting may have a second and deciding vote.

7.7.4 Only the members of the Committee present at the meeting will be eligible to vote. Members not present and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

7.7.5 The Trust's Standing Orders and SFIs apply to the operation of this Committee.

7.7.6 Decisions which are outside of the Scheme of Delegation will be escalated to the Trust Board with the findings and recommendations of the Sub Committee for action at board level.

7.8 Monitoring Compliance & Effectiveness

7.8.1 In accordance with the requirements of good governance and in order to ensure its ongoing effectiveness, the Workforce Committee will undertake an annual evaluation of its performance and attendance levels.

7.8.2 A performance evaluation tool, which reflects the requirements outlined within this Terms of Reference, has been developed for this purpose. As part of this evaluation, the committee will formally review the:

- Performance against core duties
- Completion of the actions outlined in the action log
- Effectiveness of the Annual Work Programme

7.8.3 Where gaps in compliance are identified arising from this evaluation, an action plan will be developed, and implementation will be monitored by the Committee.

7.8.4 The results from the annual evaluation exercise, including any agreed actions, will be reported to the Trust Board.

7.9 Review

The terms of Reference will be reviewed every year, with recommendations on changes submitted to the Trust Board for approval.

8.0 Equality Act (2010)

8.1 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.

8.2 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.

8.3 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.

8.4 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).

Appendix A

Northern Lincolnshire and Goole NHS Foundation Trust

Committee Name

Committee Workplan Template

Item of Business	Committee Oversight	BAF Requirement	Reference to TOR	Trust Priority	Delivery Method	Frequency	Lead	20xx									20xx		
								Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
SECTION HEADING																			
SECTION HEADING																			

NLG(22)220

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6 December 2022	
Director Lead	Lee Bond, Chief Financial Officer	
Contact Officer/Author	Brian Shipley, Deputy Director of Finance	
Title of the Report	**Finance Report – M07**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights the reported financial position of Month 07 of the 2022/23 reporting period. The Trust Board are asked to note: • The Finance Report, Month 07 • The £3.55m year-to-date deficit	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: F&P Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Contained within the report.	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	☐ Information ✓ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Finance Update Report 2022/23: Month 7

1. Report Outline:

This report covers the Trust's financial performance for the 2022/23 financial year against the Trust's financial plan. It covers the following areas:

- Financial Position Overview;
- Forecast;
- COVID-19 Expenditure;
- Temporary Staffing Analysis;
- Savings Programme;
- Elective Recovery Funding;
- Capital;
- Balance Sheet, Cash and Working Capital;
- Underlying Financial Position;
- Conclusion

2. Financial Position Overview:

	M7 £m
Current month Actual I&E Surplus/(Deficit)	**0.46**
Current month Planned I&E Surplus/(Deficit)	**0.19**
Current month Variance I&E Surplus/(Deficit)	**0.27**
YTD Actual I&E Surplus/(Deficit)	**(3.55)**
YTD Planned I&E Account Surplus/(Deficit)	**1.08**
YTD Variance from Plan – I&E Surplus/(Deficit)	**(4.63)**

The Trust had a £0.46m surplus in October, £0.27m better than plan. However, the in month position was supported through release of £1.59m of non recurrent technical reserves. The Trust now has a £3.55m year-to-date deficit, £4.63m worse than plan.

The Trust is formally forecasting a balanced financial position but is highlighting a deficit risk of **£8.5m**. This is predominantly driven through increased usage of temporary staffing, escalation beds and pay award pressures.

Loss of Elective Recovery funding and non-achievement of CQUIN income are further risks but at this stage not included within the headline forecast deficit risk of £8.5m.

The current month and year to date Income and Expenditure Summary is included in Appendix 1

Key Variances from Plan

Income - £0.93m Favourable in month, £5.01m favourable YTD

• Clinical income was £0.37m above plan in month, £3.53m YTD, mainly due £4.14m pay award funding. Injury recovery income is £0.34m above plan year to date. The Trust received non-recurrent bed capacity funding of £0.22m in month offsetting nurse overspends driven through escalation beds. These favourable variances are partly offset by the shortfall on the Lincs ICB Contract, which totalled £0.7m under plan YTD and adverse high cost drugs were £0.62m under plan due to low activity. In addition to this there are £0.6m drug challenges year-to-date, due to prior approval processes not being followed. CDF drugs however are £0.28m above plan. The Trust is also continuing to over-perform on CCG pathology contracts, but these are block-funded, driving pressures in non pay consumable costs. The transfer of Neurology services reduced NHS clinical income by £0.35m YTD but this is now reported under Non-patient care contract income from HUTH under provider to provider income.

• Elective Recovery Funding was again recognised as fully achieved, per system requirements (except the Lincs ICB misalignment). The Trust did not achieve the 104% activity target for October, but performance has improved to 99% in month and now sits at 95% year to date. However, core activity is supported by IS capacity of 3% both in month and year to date. £3.38m of Elective Recovery Funding received year to date would have been at risk if penalties had been enforced. Late activity reporting is causing some adverse impact to activity performance. The value of this missed activity is around £30k a month.

• CQUIN income was also recognised as achieved, however there remains a risk of £0.7m CQUIN clawback year-to-date.

• Covid outside envelope income is £0.52m below plan year-to-date due to lower testing costs than expected in the plan.

• Education income is £0.4m above plan due to increased funding for lead employer payments and additional GP VTS Dr's with offsetting expenditure. Other income mainly consisted of several minor favourable variances, including Donated Asset income (£0.15m), Charitable Donations £384k (offset by expenditure), R&D income (£0.09m) and accommodation income (£0.04m).

• Non-patient care and contracts agreements is £0.95m above plan. £0.35m relating to Neurology as per above. £0.43 for Grange Beds and £0.36m for Migrant Support Workers are offset with corresponding expenditure.

Pay - £0.71m adverse in month, £10.05m adverse year to date

• The impact of the pay award accounts for £0.78m in month and £5.48m YTD across all staff Groups. This is only partly offset by additional funding received of £0.59m in month and £4.14m YTD resulting in a net pressure of £1.34m.

• Medical staff was £1.01m overspent in month and £7.58m YTD. £0.12m in month and £0.85m YTD was due to the pay award (before additional funding support as above). Increased Non-Elective and Emergency activity continues to drive pressures across Medicine Acute Care and ED (£0.17m in month and £1.01m YTD overspend). Non-delivery of CIP, mostly recruitment, caused a £0.14m overspend in month, £1.03m overspend YTD. Premium pay covering sickness and vacancies caused £0.48m overspends in month and £3.73m YTD across several Specialities (Stroke, Geriatrics, Gastro, Goole Medicine, Orthopaedics and Ophthalmology). £1.38m of Waiting List payments for additional capacity are partially offset by slippage on planned Independent Sector contracts.

• Nursing was £0.77m overspent in month and £2.02m overspent YTD. £0.32m in month and £2.24m YTD was due to the pay award (before additional funding support as above). £0.19m in month and £1.84m YTD vacancy underspends across Maternity, Community District Nursing, ACP's and NICU obscure cost pressures that would otherwise amount to £0.14m in month and £1.36m YTD from at least 30 additional escalation beds (per Strep) driven by increased Non Elective activity with circa 10,600 additional bed days than the equivalent period in 21/22. The escalation beds costs in month are offset by non-recurrent bed capacity funding but should also be reducing via recent investment in community schemes. Other overspends includes additional duties in SGH ED and SDEC agency premiums (£0.04m in month and £0.4m YTD). Non-delivery of CIP, mostly recruitment, caused a £0.09m overspend in month and £0.42 YTD.

• Scientific was £0.39m overspent year-to-date. £0.95m due to pay awards impact (before additional funding support as above), partly offset by vacancies across Community and Therapy, Blood Sciences and Pharmacy.

• Other Pay was £1.03m underspent in month and £0.06m overspent YTD. £0.21m in month and £1.44m YTD was due to the pay award (before additional funding support as above). This is obscured by the release of £1.14m of non recurrent technical reserves and CIP over deliver within Corporate functions of £0.82m. Approximately £0.2m Medical Support Worker overspends were offset by income.

Non Pay - £0.04m adverse in month, £0.14m adverse year to date

• Clinical non pay was £0.45m overspent in month £1.70m YTD.

High Cost Drug pressures of £0.75m YTD would otherwise be offset by additional income under previous PBR rules. However, the Trust would not have been able to recover in full due to the challenges received of £0.60 as per above. Pathology overspends of £0.09m in month and £0.37m YTD are driven by CCG over-performance with no corresponding income due to block arrangements. Change of supplier and increased activity drive Diabetic Insulin Pump overspends of £0.08m in

month and £0.30m YTD which would otherwise be funded under PBR as high cost excluded devices.

• Other non -pay was £0.41m underspent in month and £1.84m underspent YTD. Underspends in planned IS activity of £0.36m in month and £2.21m YTD partly offset additional WLI payments outlined above. Donations expenditure of £0.22m is offset by additional income. Cost pressures in Employment Checks £0.16m YTD, Postage £0.11m and Travel and fuel of £0.14m are supported through £0.44m of non recurrent technical reserve release support the position.

Post EBITDA - £0.16m favourable in month, £0.81 favourable YTD

• This is mainly due to a high cash balances resulting in interest received, and a reduced PDC charge.

Reserves

The position is supported through slippage on centrally held unallocated reserves of £0.95m as below:

£000's	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance
Investment Reserves				
2022/23 SDF NL	269	130	-	**130**
ED / UCS Expansion	941	684	-	**684**
Nursing Apprenticeships	323	188	-	**188**
Overseas Recruitment	216	(34)	-	**(34)**
HOBS Beds	(377)	(108)	-	**(108)**
End of Life (Acute)	(149)	(87)	-	**(87)**
Winter Ward	1,000	0	-	**0**
Bed & Capacity Funding	1,094	14	-	**14**
Leadership Development	150	0	-	**0**
Cancer Alliance	245	149	-	**149**
Total Investment Reserve	**3,711**	**937**	**-**	**937**
Inflation Reserves				
Pay Inflation	(2,366)	(1,380)	-	**(1,380)**
Non Pay Inflation	946	420	-	**420**
Digital Aspirant	298	166	-	**166**
Total Inflation Reserve	**(1,122)**	**(794)**	**0**	**(794)**
COVID-19	**2,570**	**959**		**959**
ERF	**2,874**	**(150)**		**(150)**
TOTAL	**8,032**	**952**	**-**	**952**

Individual Division/Directorate Budgetary Performance at Month 7

Performance is displayed in the following table:

BUDGETARY PERFORMANCE

	Annual Budget (£000s)	YTD Budget (£000s)	YTD Actual (£000s)	Variance (£000s)
Operations Directorate	(39.0)	(22.9)	(23.2)	(0.3)
Family Services	(47.3)	(27.6)	(27.0)	0.6
Surgery & Critical Care	(119.2)	(71.0)	(75.4)	(4.4)
Medicine	(119.9)	(71.0)	(74.5)	(3.5)
Therapy & Community Services	(35.6)	(21.0)	(20.5)	0.5
Sub Total – Operations	**(361.0)**	**(213.5)**	**(220.7)**	**(7.2)**
Trust Management	(1.5)	(0.9)	(0.9)	0.0
Medical Director's Office	(22.8)	(13.4)	(13.2)	0.3
Chief Nurses Office	(5.2)	(3.0)	(2.9)	0.1
Finance	(5.0)	(2.9)	(2.7)	0.2
People & Organisational Effectiveness	(5.2)	(3.1)	(3.1)	0.1
Estates & Facilities	(33.1)	(19.0)	(19.1)	(0.1)
Strategic Development	(1.3)	(0.7)	(0.7)	0.1
Digital Services	(10.7)	(6.3)	(6.2)	0.1
Central & Capital Charges	(15.5)	(8.2)	(5.5)	2.8
Central Income	468.2	272.6	271.1	(1.5)
Trust Reserves	(8.0)	(1.0)	0.0	1.0
Sub Total – Corporate Directorates	**359.7**	**213.9**	**216.9**	**3.1**
Trust Total	**(1.3)**	**0.3**	**(3.8)**	**(4.1)**
Excluded Items	**1.3**	**0.8**	**0.2**	**(0.5)**
TOTAL	**(0.0)**	**1.1**	**(3.5)**	**(4.6)**

3. Full Year Forecast:

The Trust is currently £4.63m behind plan at the end of month 7 and is supported in month from release of additional technical reserves of £1.59m. If no mitigating actions are taken, forecast assessments project a potential £8.53m end of year deficit risk.

The main drivers of the forecast deficit consist of:

	M6 £m	M7 £m	Change £m
Clinical Income (Lincs CCG)	(1.6)	(1.6)	0.0
Other Income	1.7	1.3	(0.4)
Pay Award Funding Shortfall	(2.3)	(2.3)	0.0
Medical Staffing	(10.4)	(10.6)	(0.2)
Nursing – Escalation Beds	(1.3)	(1.3)	(0.0)
Other Nursing	1.6	1.5	(0.1)
Other Pay	(0.1)	0.0	0.2
Drugs & Clinical Supplies & Other Non-Pay	(1.9)	(2.5)	(0.5)
IS Capacity Slippage	3.5	4.1	0.7
Post EBITDA Slippage	1.1	1.1	(0.0)
Technical Reserve Release	0.0	1.6	1.6
CIP Non-Delivery (excl Technical)	(0.0)	(0.1)	(0.1)
Forecast Deficit	**(9.6)**	**(8.5)**	**1.1**

The forecast deficit risk position has been further refined in month to £8.53m. An in-month improvement of £1.1m predominantly driven through release of technical reserves in month of £1.6m. The forecast deficit position currently assumes no clawback of Elective Recovery funding in H2, nor for CQUIN income penalties.

The Trust is continuing to assess the potential mitigating actions it could take to minimise the above deficit risk. Actions taken to date consist of:

- Discussions with the ICB in holding back ERF for outside providers to mitigate the Lincs CCG misalignment or alternatively through Non-Elective and Pathology over-performance. **Estimated impact - £1.55m.**

  Financial Risk – Low **Operational Risk – Low**

- The Pay Award risk is derived from the full year funding assumption based on the H1 payment received replicated for H2. The ICB is currently assessing the overall impact of the Pay Award to determine if additional funding is potentially available. **Estimated Impact - £0.5m.**

  Financial Risk – Medium **Operational Risk – Low**

- The Trust has incurred costs of circa £50k per month for the continuation of Orthopaedic Hot Clinics in H1 of 22/23. Whilst this activity contributes to Orthopaedic ERF activity, the overall ERF performance of Orthopaedics has been at an average 92% of 19/20 levels during H1 (with the Hot Clinics only in place for Q4 of 19/20). Previously the majority of the activity would have been undertaken via the ED departments. ED and UCS establishment capacity have been modelled to include this workload. **Estimated Impact - £0.25m**

  Financial Risk – Low **Operational Risk – Medium**

- The Trust has received additional CPD funding from Health Education England. Operational pressures have restricted limit use of this funding with limited plans in place to utilise this funding in year. There is a potential for HEE to clawback this funding if not fully utilised, however, this has not been enacted in previous years. **Estimated Impact - £0.60m**

  Financial Risk – Low **Operational Risk – Low**

- The Trust has initiated schemes aimed at reducing its Tier 3 suppliers by increasing its T1 price to entice greater fill. **Estimated Impact - £0.12m**

  Financial Risk – Medium **Operational Risk – High**

The above actions result in a residual deficit risk of £5.4m. The Trust has assessed its residual technical reserves in order to cover this residual risk, however £1.8m already assumed in the plan for Annual Leave provision release is still at risk if closing annual leave balances are not as envisaged.

Forecast Run Rate Deficit with Mitigations

	AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09	AP10	AP11	AP12	TOTAL
Actual Surplus / Deficit	(109)	(549)	(599)	(1,175)	(155)	(1,421)	458						(3,551)
Forecast Surplus / Deficit								(728)	(1,068)	(1,268)	(1,018)	(895)	(4,977)
Headline Surplus (Deficit) pre-mitigation	**(109)**	**(549)**	**(599)**	**(1,175)**	**(155)**	**(1,421)**	**458**	**(728)**	**(1,068)**	**(1,268)**	**(1,018)**	**(895)**	**(8,528)**
Lincolnshire ERF/Growth Alignment Income								310	310	310	310	310	1,550
Pay Award / Depreciation Support Estimate								100	100	100	100	100	500
HEE CPD Income Slippage												600	600
Cease Orthopaedic Hot Clinics								50	50	50	50	50	250
Tier 3 Agency Control								11	25	25	25	25	112
Other Discretionary Controls								22	22	22	22	22	108
Additional Technical Reserve Release								1,082	1,082	1,082	1,082	1,082	5,408
Total Mitigations	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,574**	**1,588**	**1,588**	**1,588**	**2,188**	**8,528**
Forecast Surplus (Deficit)	**(109)**	**(549)**	**(599)**	**(1,175)**	**(155)**	**(1,421)**	**458**	**846**	**520**	**320**	**570**	**1,293**	**(0)**

Whilst the technical release is forecast to cover the residual in year deficit, it is non recurrent and removes all remaining technical reserves held by the Trust. It is therefore imperative the Trust looks to reduce its exit run rate over the remaining months of the year to mitigate any potential further risks in year and as it enters 2023/24.

4. COVID-19 Expenditure:

The Trust included in its financial plan an assumption of £9.1m for specific Covid-19 expenditure after a top slice of funding of £3.6m was applied for additional savings delivery requirements and consists of the following:

Covid Expenditure	Final Plan £m
Ward / Bed Changes (Chief Nurse Review)	5.1
Swabbing Centres	0.6
Patient Facilitators / Liaison Staff	0.4
Decontamination	0.3
CMDU	0.2
Redroom Canopies	0.1
Other	0.8
Inside Envelope Forecast	**7.4**
Testing	1.5
Vaccinations	0.2
Outside Envelope Forecast	**1.7**
TOTAL	**9.1**

The £5.1m has been allocated to rebase the Ward Establishments in line with the Chief Nurse Review and is now monitored as business as usual, leaving a residual budget of £4.0m to cover other COVID19 specific expenditure.

The year-to-date non-ward covid-19 expenditure was as follows:

		M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Total
Outside envelope (testing)		115	51	51	49	44	63	51						425
CMDU		0	6	19	19	8	10	17						79
Patient Facilitators		7	4	4	0	0	1							17
Decontamination		12	6	11	10	5		8						53
Redroom canopies		26	12	4	4	5	41	0						92
Swabbing centre		32	33	23	0	0	5							92
Backfill of isolation & sickness		147	73	75	93	70	41	16						517
TOTAL		**340**	**185**	**188**	**176**	**132**	**161**	**92**						1,274

The year-to-date covid-19 expenditure including Ward Nursing costs by NHSE&I category, was as follows:

Expenditure Category	Year-to-date 21-22		
	Pay (£k)	Non-pay (£k)	Total (£k)
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	2,469	0	2,469
Existing workforce additional shifts to meet increased demand	3	0	3
Backfill for higher sickness absence	528	0	528
Decontamination	0	145	145
After care and support costs (community, mental health, primary care)	0	19	19
COVID Medicine Delivery Unit (CMDU) service	79	0	79
COVID-19 virus testing - rt-PCR virus testing	96	14	110
COVID-19 virus testing - Rapid / point of care testing - locally procured reagents costs	217	149	366
Total COVID-19 Expenditure	3,392	326	3,718
Total Trust Operating Expenditure (including COVID-19 expenditure and all other operating expenditure)	170,705	70,011	240,716
COVID-19 % of Total Trust Operating Expenditure	2.0%	0.5%	1.5%

The year-to-date COVID-19 specific expenditure incurred was £3.72m. The inside envelope costs were £0.49m below plan YTD. The Trust must look to minimise all inside envelope costs where possible, as the Covid income is expected to be non-recurrent.

There has also been £0.03m vaccination costs year-to-date. NHSE&I now require this to be reported separately from other Covid expenditure, as it attracts its own NHSE&I funding.

5. Temporary Staffing Analysis:

As at Month 7, the Trust has spent £38.7m on agency, bank and locum variable pay, £2.83m more than the corresponding year-to-date period in 2021-22. Whilst COVID-19 specific expenditure has reduced as planned, Non-COVID expenditure has increased.

	2021/22			2022/23			Variance		
Subjective Sub catergory	Non-COVID £000	COVID £000	Total £000	Non-COVID £000	COVID £000	Total £000	Non-COVID £000	COVID £000	Total £000
Admin & Clerical Staff	858	230	1,088	1,510	7	1,517	(652)	224	(429)
Medical Staff	15,517	2,022	17,538	18,659	287	18,946	(3,142)	1,734	(1,408)
Nursing Staff	11,530	3,069	14,599	15,061	240	15,301	(3,531)	2,829	(702)
Other Staff	2		2	2		2	(0)	0	(0)
Scientific, Therapeutic & Technical Staff	1,111	36	1,147	1,546	0	1,546	(435)	36	(399)
Support Staff	1,165	285	1,450	1,317	23	1,340	(152)	262	110
Grand Total	**30,182**	**5,642**	**35,824**	**38,095**	**557**	**38,652**	**(7,912)**	**5,085**	**(2,828)**

		2021/22			2022/23			Variance		
Type	Subjective Sub catergory	Non-COVID £000	COVID £000	Total £000	Non-COVID £000	COVID £000	Total £000	Non-COVID £000	COVID £000	Total £000
Agency	Admin & Clerical Staff	24		24	282		282	(258)	0	(258)
	Medical Staff	6,971	1,006	7,978	7,343	31	7,374	(372)	975	603
	Nursing Staff	5,882	1,561	7,443	8,159	114	8,273	(2,277)	1,447	(830)
	Other Staff	2		2	2		2	(0)	0	(0)
	Scientific, Therapeutic & Technical Staff	857		857	1,021		1,021	(164)	0	(164)
	Support Staff	0		0	-		-	0	0	0
Agency Total		**13,736**	**2,568**	**16,303**	**16,807**	**145**	**16,952**	**(3,071)**	**2,423**	**(649)**
Bank / Locum	Admin & Clerical Staff	834	230	1,064	1,228	7	1,235	(395)	224	(171)
	Medical Staff	8,546	1,015	9,561	11,315	256	11,571	(2,770)	759	(2,011)
	Nursing Staff	5,648	1,508	7,156	6,902	126	7,028	(1,254)	1,382	128
	Other Staff	-		-	-		-	0	0	0
	Scientific, Therapeutic & Technical Staff	254	36	290	525	0	525	(271)	36	(235)
	Support Staff	1,165	285	1,450	1,317	23	1,340	(152)	262	110
Bank / Locum Total		**16,447**	**3,074**	**19,521**	**21,288**	**412**	**21,700**	**(4,841)**	**2,662**	**(2,179)**
Grand Total		**30,182**	**5,642**	**35,824**	**38,095**	**557**	**38,652**	**(7,912)**	**5,085**	**(2,828)**

In addition, premium additional sessions payments have increased:

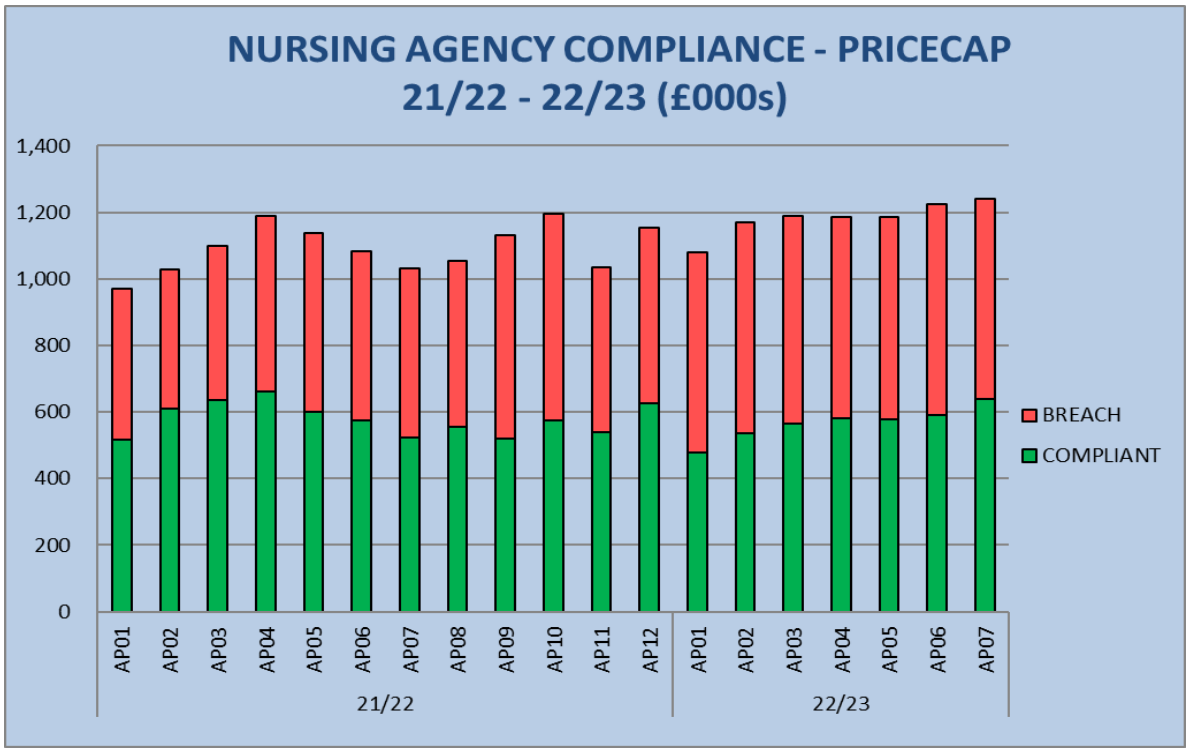
Division	2021/22 £000	2022/23 £000	Variance £000
Family Services	237	247	(11)
Medicine	534	408	126
Surgery & Critical Care	2,046	2,511	(464)
Total	**2,816**	**3,166**	**(349)**

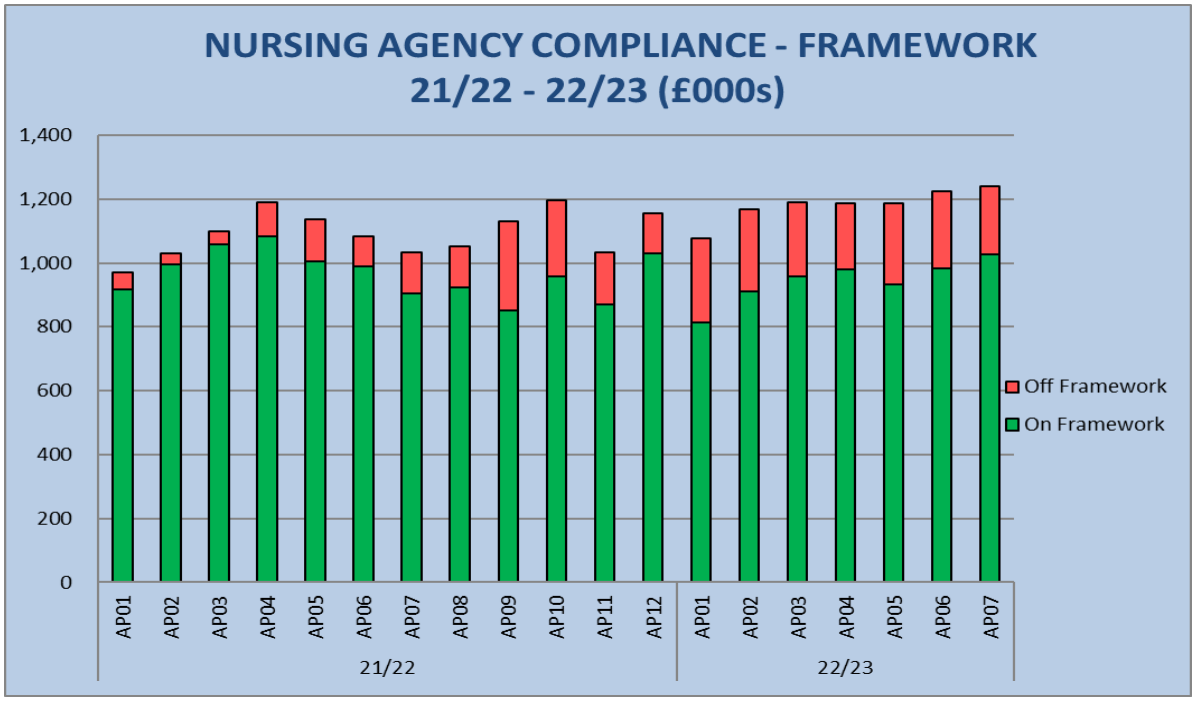
NHSI recently announced targeted reductions of agency spend through the re-introduction of agency ceilings. The Trust has a 10% reduction required on its 2021/22 agency spend. The current forecast is £2.8m adrift of the ceiling.

	£m
2022/23 Agency Ceiling	26.1
2022/23 Forecast Agency Spend	28.9
Variance to Ceiling	**(2.8)**

Nursing

Overall agency usage is higher than the equivalent year-to-date period in 21-22, despite success in recruitment, the proportion of price-cap breaches and off-framework usage have increased in 2022-23.





To assess the full nursing spend position, rather than just the variable pay increases, the table below demonstrates the full year on year change both in terms of budget and actual spend.

	21-22				22-23			Variance 21-22 vs 22-23	
	Budget £k	Actual £k	Variance £k		Budget £k	Actual £k	Variance £k	Budget £k	Actual £k
Substantive	61,951	53,636	8,315	Substantive	70,684	57,221	13,464	8,734	3,585
Bank	4,186	7,156	(2,970)	Bank	615	7,028	(6,413)	(3,571)	(128)
Agency	1,851	7,443	(5,593)	Agency	1,609	8,273	(6,664)	(242)	830
Total	67,987	68,235	(248)	Total	72,908	72,521	386	4,920	4,286

	21-22				22-23			Variance 21-22 vs 22-23	
	Budget £k	Actual £k	Variance £k		Budget £k	Actual £k	Variance £k	Budget £k	Actual £k
Chief Nurses Office	1,995	1,878	117	Chief Nurses Office	2,033	1,973	60	38	95
Digital Services	21	10	11	Digital Services	21	22	(1)	0	12
Medical Directors Office	30	32	(2)	Medical Directors Office	53	49	4	23	17
People Directorate	512	491	21	People Directorate	367	369	(2)	(146)	(122)
Family, Community + Therapy Services	19,427	18,587	839	Family, Community + Therapy Services	22,100	20,489	1,611	4,041	1,981
Medicine	27,943	28,729	(786)	Medicine	29,317	30,397	(1,081)	9,890	11,810
Surgery + Critical Care + CSS	18,059	18,508	(449)	Surgery + Critical Care + CSS	19,017	19,222	(206)	(8,926)	(9,506)
Total	67,987	68,235	(248)	Total	72,908	72,521	386	4,920	4,286

Nursing was £0.39m underspent year-to-date, (excluding the impact of the pay awards, reserves and any technical adjustments held centrally). Vacancy underspends across Maternity, Community District Nursing and NICU support cost pressures from additional escalation beds, ED and SDEC agency premiums, and some non-delivery of CIP.

The Trust has initiated schemes to migrate supply away from Tier 2 and 3 suppliers. The average hourly rate of Tier 3 is double that of its Tier 1 suppliers and is being used in non specialist general ward areas.

Average Hourly Rate by Tier

Row Labels	Sum of Booked Hours	Sum of Total cost	Average Hrly Rate
T1	101,012	3,961,667	39.22
T2	58,174	2,643,305	45.44
T3 O/F	20,692	1,668,271	80.62
Grand Total	**179,878**	**8,273,243**	

The Trust introduced diversionary schemes to migrate supply from Tier 2/3 suppliers from October. Whilst overall demand has increased to the highest month yet, early signs are positive of some migration occurring.

Sum of Booked Hours	Column Labels							
Row Labels	AP01	AP02	AP03	AP04	AP05	AP06	AP07	Grand Total
T1	12,251	13,662	14,397	14,842	14,764	15,015	16,082	101,012
T2	7,404	8,332	8,501	8,837	7,779	8,734	8,586	58,174
T3 O/F	2,895	3,289	2,736	2,639	3,100	3,104	2,929	20,692
Grand Total	**22,549**	**25,283**	**25,634**	**26,318**	**25,643**	**26,853**	**27,598**	**179,878**

Tier usage by Area

Sum of Booked Hours	Tier			
Ward2	T1	T2	T3 O/F	Grand Total
Non Specialist	72,296	38,954	11,917	123,167
ED	17,601	17,090	6,223	40,913
ICU	3,747	1,545	2,552	7,845
Theatres	6,734	586		7,320
Day 1 Reporting Estimate	633			633
Grand Total	**101,012**	**58,174**	**20,692**	**179,878**

Tier usage by Site

Sum of Booked Hours	Column Labels			
Row Labels	T1	T2	T3 O/F	Grand Total
DPOW	26,973	30,255	10,369	67,597
SGH	64,920	26,236	9,662	100,818
GDH	9,119	1,684	660	11,463
Grand Total	**101,012**	**58,174**	**20,692**	**179,878**

Tier usage by Division

Sum of Booked Hours	Column Lal			
Row Labels	T1	T2	T3 O/F	Grand Total
Family, Community + Therapy	3,516	2,220	4,361	10,098
Medicine	75,084	44,499	12,168	131,752
Surgery + Critical Care	22,411	11,454	4,163	38,029
Grand Total	**101,012**	**58,174**	**20,692**	**179,878**

Top 10 Ward / Department usage by Tier

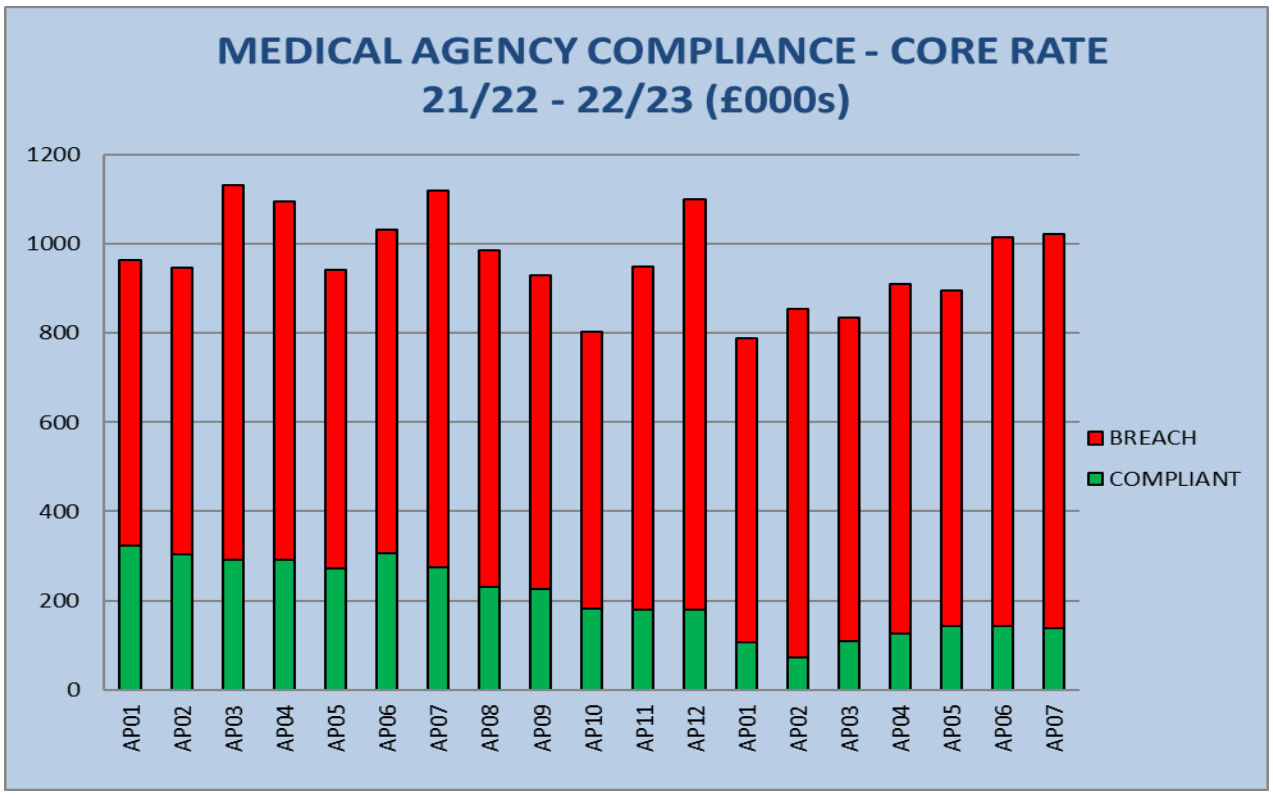
Sum of Booked Hours	Column Lal			
Row Labels	T1	T2	T3 O/F	Grand Total
Emergency Centre SGH	14,478	7,714	2,630	24,821
ECC DPoW	3,123	9,376	3,593	16,092
AAU Yellow B IAAU SGH	9,336	927	322	10,586
B2 Yellow A IAAU DPoW	4,206	3,075	1,228	8,509
Ward 28 SGH	4,105	2,603	338	7,046
Ward 17 SGH	5,162	1,555	160	6,877
C3 Short Stay DPoW	2,372	3,693	582	6,646
Ward 24 new SGH	4,851	1,499	209	6,558
Ward 23 new SGH	3,893	1,435	211	5,539
Ward 22 SGH	3,685	1,327	272	5,283
Grand Total	**55,211**	**33,203**	**9,544**	**97,957**

Top 10 usage by Supplier

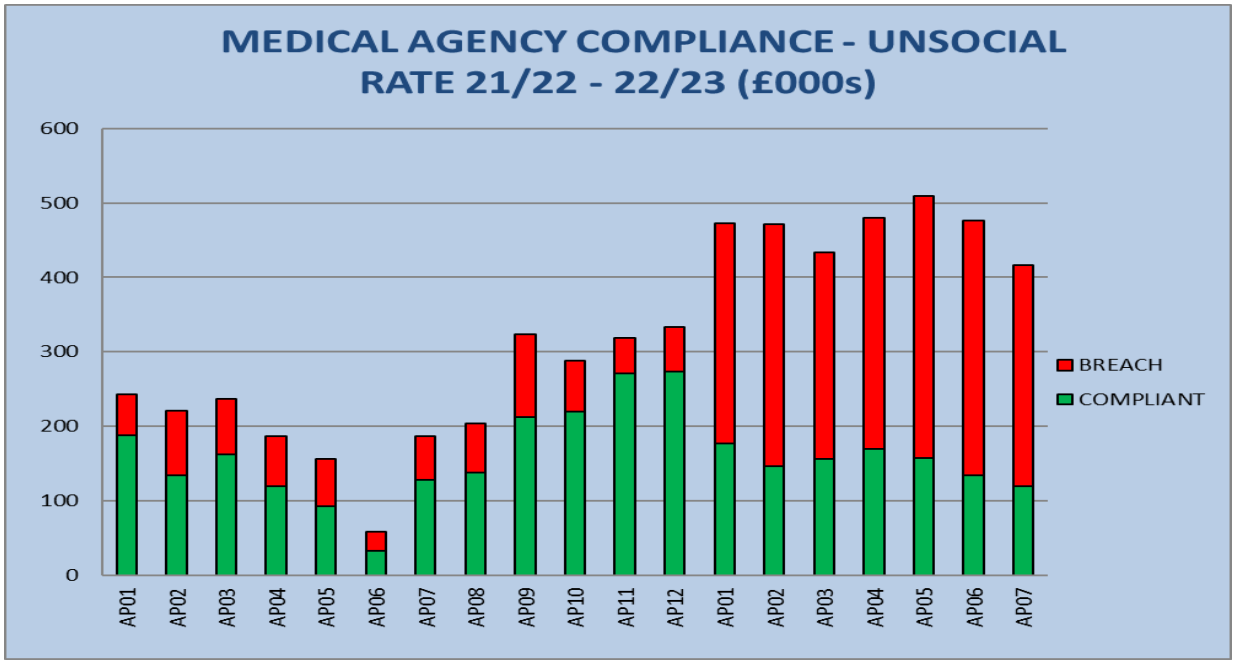
Sum of Booked Hours	Column Lal			
Row Labels	T1	T2	T3 O/F	Grand Total
Altrix T1	30,915			30,915
TFS T1	23,585			23,585
Coyle T2		16,324		16,324
Thornbury T3 O/F			16,246	16,246
Arcadia T1	15,261			15,261
NextStep T2		12,719		12,719
Urge Nur T2		10,681		10,681
NLG T1	10,538			10,538
Daytime T2		3,896		3,896
Clinical 24 T2		3,567		3,567
Grand Total	**80,300**	**47,187**	**16,246**	**143,733**

Medical Staffing

Medical staffing is still the leading cause of temporary staffing spend. Also, the Trust continues to see a very low proportion of compliant core hourly rates.



Unsocial hour rates had shown a downward trend in total usage, but this has significantly reversed since October 2021, and compliance has also deteriorated since March 2022.



The table below demonstrates the full year on year change both in terms of budget and actual medical staffing spend year-to-date. Cost pressures remain, predominantly but not exclusively within Medicine and Surgery, and are driven by an increased vacancy position, over-established and unfunded cost pressures and non-delivery of CIP, and some sickness and temporary staffing premiums. (Excluding the impact of the pay awards any technical adjustments held centrally).

	21-22				22-23			Variance 21-22 vs 22-23	
	Budget £k	Actual £k	Variance £k		Budget £k	Actual £k	Variance £k	Budget £k	Actual £k
Substantive	43,700	35,443	8,257	Substantive	47,780	39,500	8,281	4,080	4,056
Locum/bank	4,510	9,561	(5,051)	Locum/bank	4,632	11,571	(6,939)	123	2,011
Agency	3,116	7,978	(4,861)	Agency	2,166	7,374	(5,209)	(951)	(603)
Total	51,326	52,982	(1,656)	Total	54,578	58,445	(3,867)	3,252	5,464

	21-22				22-23			Variance 21-22 vs 22-23	
	Budget £k	Actual £k	Variance £k		Budget £k	Actual £k	Variance £k	Budget £k	Actual £k
Chief Nurses Office	14	13	1	Chief Nurses Office	21	14	7	7	1
Medical Directors Office	1,665	1,655	10	Medical Directors Office	2,175	2,114	61	511	459
Strategic Development	0	0	0	Strategic Development	18	18	0	18	18
Family, Community + Therapy Services	8,379	8,428	(49)	Family, Community + Therapy Services	9,407	9,647	(240)	1,028	1,219
Medicine	18,741	18,701	40	Medicine	19,318	20,457	(1,139)	578	1,756
Surgery + Critical Care + CSS	22,527	24,184	(1,657)	Surgery + Critical Care + CSS	23,639	26,195	(2,557)	1,112	2,011
Trust Management	51,326	52,982	(1,656)	Total	54,578	58,445	(3,867)	3,252	5,464

Model Hospital shows we are quartile 4 for agency spend as a percentage of total pay spend and one factor driving increasing temporary staffing spend is rate (pay cost per hour), particularly for agency which until July had been steadily rising since May 21. The increase in rate is most prevalent in Acute Medicine, Emergency Department and Breast. There has also been an increase in volume, but this has begun to subside since September so demand could be a factor influencing market price.

Average Medical Staff Agency rate

There are several temporary medical staff who cost approximately four times more than 1 WTE substantive consultant (see Table below). The first 16 of these are sourced via agency though Doctor 731 below is sourced via the internal bank.

Table 2 – High-cost temporary staff by cost and rate

Pseudonym	Department	Cost	Hours	Pay/ Hr
Doctor 1187	Acute Medicine	£257,968	2053	£117.17
Doctor 1193	Gdh Ophthalmology	£158,567	1221	£120.80
	Sgh Ophthalmology	£86,925	1333	£60.41
Doctor 755	Stroke	£207,545	1454	£133.88
Doctor 1666	Acute Medicine	£203,338	1592	£119.10
Doctor 950	Haematology	£198,779	2338	£78.55
Doctor 1742	Emergency Department	£188,223	1722	£107.50
Doctor 56	Emergency Department	£172,061	1396	£96.81
Doctor 1562	Sgh Urology	£169,508	1527	£103.69
Doctor 1293	Sgh Urology	£166,033	1500	£103.53
Doctor 616	Sgh Urology	£155,944	1873	£63.98
Doctor 610	Cellular Pathology	£142,170	1182	£111.21
Doctor 1192	Dpow Ent	£138,723	1806	£69.80
Doctor 1730	Acute Medicine	£135,019	1116	£113.13
Doctor 2171	Dpow Theatres	£131,904	1383	£86.29
Doctor 1281	Emergency Department	£130,951	1014	£120.02
Doctor 2139	Goole Medicine Services	£126,696	1409	£82.84
Doctor 731	Emergency Department	£124,479	1048	£118.81
Doctor 545	Sgh Ophthalmology	£118,206	1140	£80.49
Doctor 1935	Emergency Department	£112,264	989	£113.57
Doctor 750	Goole Medicine Services	£110,870	1233	£82.84
Doctor 2056	Dpow Ent	£97,600	1328	£67.29

Pseudonym	Department	Cost	Hours	Pay/ Hr
Doctor 190	Acute Medicine	£1,553	9	£172.58
Doctor 1552	Gdh Ophthalmology	£3,531	20	£172.57
Doctor 1725	Acute Medicine	£29,138	193	£149.57
	Respiratory	£4,437	36	£121.44
Doctor 1266	Emergency Department	£503	4	£143.81
Doctor 1262	Internal General Medicine	£70,646	480	£138.06
Doctor 1218	Gastroenterology	£50,704	345	£138.06
Doctor 1589	Sgh Ophthalmology	£23,990	163	£138.06
Doctor 963	Geriatric Medicine	£20,016	136	£138.06
Doctor 755	Stroke	£207,545	1454	£133.88
Doctor 1958	Emergency Department	£3,324	24	£132.31
Doctor 969	Gastroenterology	£83,408	590	£132.31
Doctor 464	Emergency Department	£3,018	23	£129.43
Doctor 1068	Gastroenterology	£47,624	351	£126.56
	Acute Medicine	£43,892	324	£126.56
Doctor 1625	Breast Surgery	£51,016	376	£126.56
Doctor 1969	Breast Surgery	£5,834	43	£126.56
Doctor 800	Acute Medicine	£1,560	12	£126.56
Doctor 693	Acute Medicine	£19,911	147	£126.56
Doctor 1127	Cardiology	£16,277	120	£126.56
Doctor 915	Cellular Pathology	£77,355	571	£126.37
Doctor 19	Acute Medicine	£7,951	60	£124.25
Doctor 93	Emergency Department	£3,001	24	£123.22
Doctor 1265	Emergency Department	£90,410	685	£122.87

6. Savings Programme:

2022/23 CIP DELIVERY AT 31ST OCTOBER 2022

At the end of October, the Trust had delivered £5.93m of savings against its core year to date plan of £6.40m, an under delivery of £468k. Expenditure on COVID was high in month meaning that the usual mitigation wasn't available. However further non-recurrent in-year support was provided through technical adjustments. As a result of these changes the year to date position for the full programme was £13.76m delivered against the plan of £12.46m.

CIP DELIVERY BY WORKSTREAM & DIVISION/DIRECTORATE

Table 1 Trust Summary CIP Delivery

	Annual	Current Month October 22				Year to Date at October 22				Forecast Year end		
Workstream	Plan £000s	Plan £000s	Actual £000s	Variance £000s	Risk RAG	Plan £000s	Actual £000s	Variance £000s	Risk RAG	Actual £000s	Variance £000s	Risk RAG
Clinical Workforce - Medical Staff	2,577	214.7	71.0	-144		1,503.1	477.1	-1,026		1,580.1	-997	
Clinical Workforce - Nursing and Midwifery	3,632	261.5	174.0	-88		1,493.5	1,073.0	-421		2,384.7	-1,247	
Digital Transformation	91	8.3	6.2	-2		49.7	43.5	-6		84.1	-7	
Estates & Facilities	679	50.3	50.1	-0		427.5	521.3	94		716.7	38	
Non-Pay and Procurement	2,219	205.3	113.0	-92		1,192.5	1,141.0	-51		1,936.1	-283	
Income	557	46.8	27.6	-19		323.1	229.8	-93		407.2	-150	
Grip & Control	10	0.8	0.0	-1		5.7	0.0	-6		0.0	-10	
Unidentified	14	1.1	0.0	-1		7.9	0.0	-8		0.0	-14	
TOTAL CORE PROGRAMME	**12,000**	**962**	**813**	**149**		**6,396**	**5,928**	**468**		**10,838**	**1,162**	
COVID Expenditure Reduction	3,600	300	33	-267		2,100	2,263	163		4,685	1,085	
System Stretch Efficiency Target NR	6,800	567	2,175	1,608		3,967	5,575	1,608		8,408	1,608	
TRUST TOTAL EFFICIENCY PLAN	**22,400**	**1,829**	**3,021**	**1,192**		**12,463**	**13,766**	**1,303**		**23,932**	**1,532**	

	Current Month October 22				Year to Date at October 22				Forecast Year end			
Workstream	Plan £000s	Recurrent £000s	Non rec £000s	Variance £000s	Plan £000s	Recurrent £000s	Non rec £000s	Variance £000s	Plan £000s	Recurrent £000s	Non rec £000s	Variance £000s
Medicine	345	128	-1	-218	2,120	921	5	-1,193	4,503	2,464	13	-2,026
Surgery & Critical Care	265	215	0	-51	1,546	1,271	45	-230	3,045	2,921	45	-78
Family Services	49	39	0	-9	368	312	0	-56	611	536	0	-75
Community & Therapy Services	62	39	51	28	384	254	162	32	656	460	287	92
COO'S Directorate	91	18	87	15	614	123	504	13	1,065	256	801	-8
Total Operations	**811**	**440**	**136**	**-236**	**5,032**	**2,881**	**717**	**-1,434**	**9,880**	**6,638**	**1,146**	**-2,096**
Chief Executive's Office	18	0	0	-18	126	90	50	14	216	166	50	-0
Chief Nurse Directorate	4	3	10	10	70	22	187	139	89	37	197	146
Digital Services	7	2	6	1	225	15	242	31	258	25	264	31
Finance	10	10	37	37	71	71	232	232	122	122	328	328
Medical Director's Office	9	8	24	23	69	56	219	206	113	96	279	262
People & OE	11	3	27	19	76	24	189	138	130	40	285	196
Strategic Development	2	1	9	8	11	4	62	56	18	8	89	79
Total Corporate Directorates	**60**	**27**	**113**	**80**	**648**	**282**	**1,181**	**816**	**946**	**494**	**1,494**	**1,042**
Estates & Facilities	55	23	32	-0	463	195	361	94	739	310	467	38
Trust	36	9	34	6	254	75	235	56	435	131	159	-145
Total Core Programme	**962**	**499**	**314**	**149**	**6,396**	**3,434**	**2,494**	**468**	**12,000**	**7,572**	**3,266**	**1,162**
COVID Expenditure Reduction	300	33	0	-267	2,100	2,263	0	163	3,600	4,685	0	1,085
System Stretch Efficiency Target NR	567	0	2,175	1,608	3,967	0	5,575	1,608	6,800	0	8,408	1,608
Grand Total	**1,829**	**532**	**2,489**	**1,192**	**12,463**	**5,697**	**8,069**	**1,303**	**22,400**	**12,258**	**11,674**	**1,532**

The year to date position improved significantly due to the non-recurrent technical support. However, the core programme continues to decline slipping from a £274k shortfall at the end of September to £468k behind at the end of October. This is due to planned increases in nursing recruitment and pharmacy biosimilars which haven't been matched by increased CIP delivery.

Nursing savings in the first six months have largely been through sickness reductions in Medicine, cessation of the bank incentive scheme and the full year effects of last year recruitment with only £67k of in-year recruitment savings reported in Surgery.

The profiling of nursing recruitment savings increases substantially in the second half of the year with NQN appointments and the overseas recruitments coming out of their supernumery period. The forecast position, although below original plan, contributes to overall achievement of the CIP programme. Nursing, along with medical recruitment savings, are dependent on timely on-boarding along with retention of existing staffing and the replacement of agency.

A biosimilar switch for Lucentis was initially planned to commence from October but this has been put back, initially, to December. The switch is still expected to be made delivering £244k of savings however this is extremely risky until it has been agreed with the medical body and plans put firmly in place to deliver.

Corporate and AHP vacancies continue to provide non-recurrent support to the challenged areas of the programme.

Any residual shortfall on the core programme in previous months has been more than covered by an over delivery on COVID expenditure reductions. In October this expenditure increased, and the relief wasn't available although it is expected to be back on track for the remainder of the financial year. Further non-recurrent support has been provided through some technical schemes such as rebates and VAT reclaims. These are anticipated to be about £1.1m.

Despite the in-month challenges the forecast position has improved and is now expected to be £23.93m. This is almost entirely due to the non-recurrent technical schemes. However, increased optimism on nursing recruitment and Corporate and AHP vacancies has slightly improved the core programme forecast.

Risks

With the Trust finding achievement of its activity targets challenging. Improved productivity through its theatre and outpatient initiatives is highly unlikely to provide cash releasing efficiencies but instead enable delivery of additional activity.

The main cost driver for financial efficiency is pay and specifically agency costs. Delivery of the cost improvement programme in full will be dependent on the ability of the organisation to drive down its pay bill and this is therefore the principal risk.

The risks identified to date are:

i. £3.3m of the programme is dependent on new recruitment. Review of the current pipelines is a continuous process, but current numbers suggest that the Medicine Division still face a significant challenge.

ii. The next biggest driver of agency spend is sickness presenting an opportunity of £691k in nursing. Savings assumed have been reduced to £345k. In-roads have been made on this scheme, but it will continue to be closely monitored as it is not delivering in full currently and any major resurgence of COVID could compromise this.

iii. A Lucentis biosimilar switched was originally planned from October. This hasn't happened and is now expected to be December, but it is anticipated to be a larger uptake than originally planned thus mitigating the slippage. Due to the uncertainty around the scheme and until there is more clarity no savings have been assumed. This will be reviewed on a month by month basis.

iv. Actions taken to support the reduction of agency rate did not realise benefits due to increased demand for agency staff. The workforce resource centre is currently trying to progress a reduction to nursing rate, along with other schemes to reduce cancellations; address hours owed and planned leave and the development of a local medical bank.

v. With the pandemic, OPEL 4 and the planning cycle, and more recently the delivery of activity, focus on CIP has been variable across the areas. To support delivery full engagement is required however, any resurgence of COVID could seriously compromise this.

vi. Corporate and AHP vacancies have all over delivered in previous years and this year so far. However, this has been non-recurrently and will impact the Trust going forward if at least some of this delivery is not made recurrent.

The full CIP report is provided separately in Appendix 2.

7. Elective Recovery Funding & Other Activity Performance

The Trust included £9.17m of Elective Recovery Funding to deliver the 104% activity requirement of 2019/20 baseline levels within its plan. This included £1.55m of associated growth funding from Lincolnshire ICB which has not been agreed.

Included within its plan is an allocation of £7.3m to cover additional capacity expenditure. The Trust has incurred £3.8m of additional expenditure in additional capacity but has not achieved the required activity targets. The Trust has accounted for receipt of the ERF funding included within the block contracts agreed with the ICS in line with ICS assumptions that no clawback will be action for H1 except for the mis-aligned Lincs ICB contract value. The Trust would otherwise have incurred potential penalties of £3.38m YTD. The additional bank holiday in year would equate to circa £0.5m of the YTD variance.

Estimated Year to date penalties by Division:

Division	£000's
Community and Therapies	11
Medicine	252
Surgery and Critical Care	2,350
Womens and Childrens	764
Total	**3,376**

Actual Expenditure vs Plan:

	In Month			YTD		
Expenditure	Plan	Actual	Variance	Plan	Actual	Variance
Internal Capacity	0.00	(0.32)	(0.32)	0.00	(1.65)	(1.65)
IS Capacity	(0.61)	(0.37)	0.24	(3.65)	(2.14)	1.51
Total	**(0.61)**	**(0.68)**	**(0.08)**	**(3.65)**	**(3.79)**	**(0.14)**

In month performance improved to 99% of 2019/20 levels but was still reliant on 3% of IS capacity. YTD performance now stands at 95% with 3% reliance on IS capacity. In year capacity has been reduced by the closure of 3 theatre's that were operational in 2019/20 impacting performance by circa 7%.

We have witnessed some recovery in Elective and Daycase activity following the introduction of Theatre HIT lists.

	Spells / Attendances						
POD	M01	M02	M03	M04	M05	M06	M07
Elective	345	400	353	399	417	426	487
Daycase	3,990	4,747	4,248	4,538	4,633	4,354	4,447
OPD New	6,529	7,509	6,947	6,388	6,643	7,224	6,718
OPD New Procedure	1,718	1,978	1,702	1,795	1,806	2,081	2,009
OPD Follow Up	10,364	11,827	11,552	10,633	11,277	11,768	12,072
OPD Follow Up Procedure	3,804	4,374	3,790	3,865	3,980	4,417	4,532
Total	**26,750**	**30,835**	**28,592**	**27,618**	**28,756**	**30,270**	**30,265**

Activity performance has improved since the Pandemic. However, the in year YTD position is still short against 2019/20 levels as follows:

	Spells / Attendances				
POD	19/20	20/21	21/22	22/23	Variance to 19/20
Elective	4,031	2,292	2,807	2,827	(1,204)
Daycase	31,835	18,674	28,930	30,957	(878)
OPD New	56,202	24,566	42,373	47,958	(8,244)
OPD New Procedure	16,306	6,765	13,129	13,089	(3,217)
OPD Follow Up	110,590	43,572	64,073	79,493	(31,097)
OPD Follow Up Procedure	31,715	15,494	25,227	28,762	(2,953)
Total	**250,679**	**111,363**	**176,539**	**203,086**	**(47,593)**

Performance vs 19/20 Baseline in Month:

		Community and Therapies	Medicine	Surgery and Critical Care	Womens and Childrens	Surgery Endoscopy	Trust Total
DAYCASE	CORE	90%	116%	96%	79%	106%	**101%**
	ISP						
	TOTAL	**90%**	**116%**	**96%**	**79%**	**106%**	**101%**
ELECTIVE	CORE		39%	99%	73%		**92%**
	ISP						
	TOTAL		**39%**	**99%**	**73%**		**92%**
OP FIRST ATTENDANCE	CORE		73%	113%	116%		**98%**
	ISP		35%	0%			**13%**
	TOTAL		**108%**	**113%**	**116%**		**111%**
OP F/UP ATTENDANCE	CORE		79%	89%	120%		**90%**
	ISP		11%	2%			**6%**
	TOTAL		**91%**	**91%**	**120%**		**96%**
OP FIRST PROCEDURE	CORE		116%	92%	113%	0%	**108%**
	ISP			0%			**0%**
	TOTAL		**116%**	**93%**	**113%**		**108%**
OP F/UP PROCEDURE	CORE		84%	113%	128%		**109%**
	ISP			8%			**5%**
	TOTAL		**84%**	**122%**	**128%**		**114%**
Total	CORE	**90%**	**87%**	**99%**	**95%**	**107%**	**96%**
	ISP		**10%**	**1%**			**3%**
	TOTAL	**90%**	**97%**	**100%**	**95%**	**107%**	**99%**

Performance vs 19/20 Baseline YTD:

		Community and Therapies	Medicine	Surgery and Critical Care	Womens and Childrens	Surgery Endoscopy	Trust Total
DAYCASE	CORE	78%	101%	93%	82%	103%	**96%**
	ISP						
	TOTAL	**78%**	**101%**	**93%**	**82%**	**103%**	**96%**
ELECTIVE	CORE		43%	90%	73%		**83%**
	ISP						
	TOTAL		**43%**	**90%**	**73%**		**83%**
OP FIRST ATTENDANCE	CORE		79%	117%	109%		**101%**
	ISP		41%	2%			**15%**
	TOTAL		**120%**	**119%**	**109%**		**116%**
OP F/UP ATTENDANCE	CORE		80%	91%	110%		**89%**
	ISP		14%	1%			**6%**
	TOTAL		**93%**	**92%**	**110%**		**96%**
OP FIRST PROCEDURE	CORE		78%	76%	103%	0%	**92%**
	ISP			6%			**3%**
	TOTAL		**78%**	**82%**	**103%**		**95%**
OP F/UP PROCEDURE	CORE		65%	104%	116%		**97%**
	ISP			5%			**3%**
	TOTAL		**65%**	**110%**	**116%**		**100%**
Total	CORE	**49%**	**84%**	**95%**	**91%**	**102%**	**92%**
	ISP		**11%**	**1%**			**3%**
	TOTAL	**49%**	**95%**	**96%**	**91%**	**102%**	**95%**

Specialty Performance vs 19/20 Baseline:

			Month						
Division	**SpecCode**	**Spec Description**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Surgery and Critical Care	100	General Surgery	83%	81%	77%	81%	87%	78%	79%
	101	Urology	101%	100%	90%	100%	103%	107%	108%
	104	Colorectal Surgery	94%	101%	130%	121%	110%	108%	140%
	106	Upper Gastrointestinal Surgery	55%	63%	49%	52%	49%	63%	66%
	110	Trauma & Orthopaedics	91%	111%	98%	90%	90%	75%	93%
	120	ENT	99%	101%	100%	87%	96%	108%	103%
	130	Ophthalmology	112%	108%	102%	108%	110%	95%	100%
	140	Oral Surgery	228%	192%	103%	209%	182%	164%	190%
	190	Anaesthetics	86%	100%	84%	102%	78%	95%	87%
	401	Clinical Neurophysiology	0%	0%	0%	0%	0%	0%	0%
Surgery and Critical Care Total			**95%**	**100%**	**94%**	**94%**	**96%**	**90%**	**100%**
Medicine	300	General Medicine	148%	173%	148%	108%	103%	153%	97%
	301	Gastroenterology	166%	129%	105%	165%	105%	103%	128%
	302	Endocrinology	159%	130%	151%	161%	146%	142%	118%
	303	Clinical Haematology	67%	62%	68%	67%	65%	72%	73%
	307	Diabetic Medicine	102%	113%	112%	126%	116%	105%	104%
	320	Cardiology	82%	82%	86%	66%	90%	81%	101%
	329	Transient Ischaemic Attack	89%	64%	82%	79%	77%	71%	94%
	330	Dermatology	77%	65%	56%	57%	75%	63%	75%
	340	Respiratory Medicine	127%	126%	115%	97%	100%	107%	99%
	370	Medical Oncology	87%	91%	112%	99%	103%	93%	106%
	400	Neurology	67%	70%	51%	61%	50%	46%	35%
	410	Rheumatology	130%	105%	96%	104%	117%	107%	99%
	430	Geriatric Medicine	106%	112%	94%	131%	100%	113%	88%
Medicine Total			**101%**	**95%**	**95%**	**94%**	**94%**	**93%**	**97%**
Surgery Endoscopy Total			**98%**	**109%**	**99%**	**104%**	**103%**	**95%**	**107%**
Family Services	103	Breast Surgery	79%	79%	94%	93%	73%	102%	96%
	223	Paediatric Epilepsy	133%	67%	70%	53%	79%	74%	93%
	263	Paediatric Diabetic Medicine	87%	132%	92%	94%	92%	92%	112%
	290	Community Paediatrics	105%	93%	87%	76%	103%	91%	112%
	420	Paediatrics	107%	109%	121%	89%	100%	97%	109%
	502	Gynaecology	95%	94%	85%	85%	89%	85%	88%
Family Services Total			**94%**	**93%**	**93%**	**87%**	**88%**	**91%**	**95%**
Trust Total			**96%**	**98%**	**94%**	**94%**	**94%**	**91%**	**99%**

In year Elective activity performance should also be taken into context with Non-Elective inpatient demand which is considerably higher than 2021/22 with 3,353 more inpatient spells for the equivalent YTD period in 2021/22. The Trust has been able to manage this increased demand effectively through its SDEC services and improving its performance on patients waiting less than 21 days. However, it has seen an increase in patients waiting over 21 days which has driven 10,847 additional bed days and therefore the requirement to open additional escalation and surge beds. (Non Elective Activity excludes Paediatrics & Maternity).

	No of Patients		Bed Days				Avg Los	
LoS	2021/22	2022/23	2021/22	2022/23	Variance		2021/22	2022/23
0	8,190	11,677	-	-	3,487	0	0.00	0.00
1-7	10,563	10,101	33,200	31,962	(462)	(1,238)	3.14	3.16
8-14	2,932	2,873	30,234	29,941	(59)	(293)	10.31	10.42
15-21	1,018	1,118	17,811	19,544	100	1,733	17.50	17.48
22+	778	1,065	26,618	37,263	287	10,645	34.21	34.99
Total	**23,481**	**26,834**	**107,863**	**118,710**	**3,353**	**10,847**	**4.59**	**4.42**

8. Capital Plan:

	NHSI Plan £mil	YTD Plan £mil	YTD Actual £mil	YTD Variance £mil
Major Schemes				
DPoW Reconfiguration Programme	1.74	0.05	0.03	(0.02)
SGH & GDH Reconfiguration Programme	0.95	0.95	0.73	(0.22)
Emergency departments/AAU	18.13	11.92	8.83	(3.08)
SGH CT & Fit out	0.86	0.00	0.00	0.00
Elior Fit out	0.00	0.00	0.00	0.00
Feasibility Fees	0.10	0.05	0.00	(0.05)
Disabled access	0.05	0.00	0.00	0.00
Fire doors	0.35	0.00	0.00	0.00
Mortuary	0.40	0.00	0.00	0.00
SGH Max Fax	0.30	0.00	0.00	0.00
SGH fire Alarm	2.16	0.00	0.01	0.01
DPOW & SGH Theatres TIF	6.30	0.03	0.06	0.03
MRI software upgrade	0.06	0.00	0.00	0.00
Endoscopy simulator	0.07	0.00	0.00	0.00
Pathology LIMS	0.06	0.00	0.00	0.00
Transfer to HUTH	1.40	0.00	0.00	0.00
ICS contribution	0.16	0.00	0.00	0.00
Unallocated	0.00	0.00	0.00	0.00
Facilities Maintenance Programme	3.09	1.48	0.38	(1.10)
IM&T Programme	2.43	1.43	1.51	0.09
Equipment Renewal Programme	3.62	0.71	0.12	(0.59)
Right of Use Assets	0.53	0.26	0.50	0.24
Donated/Grant funded	0.25	0.12	0.15	0.02
Capital Programme Total	**43.00**	**16.99**	**12.33**	**(4.66)**

The Trust capital funding for 2022/23 is now £43.0m. The Trust has received notification of the additional funding of £5.83m relating to TIF funding for theatres at DPOW and SGH and further funding of £0.13m for MRI software upgrade and Endoscopy training simulator. The details of EPR funding of £1.2m is still to be confirmed, this is not included in the above.

The actual spend at 31st October was £12.33m, £12.18m relating to Trust funded schemes and £0.15m for donated and grant funded. The key variances are as follows:

- The handover for Ward 25 has now been agreed as the beginning of November.
- DPOW Gamma Camera scheme is progressing, final equipment lists are being agreed and costed ready for orders to be placed. The scheme is still expected to be completed in March 2023.

- The contractor for the Emergency Department at DPOW are continuing to work through the outstanding works and snagging items. The AAU works at DPOW will be starting late November. The Trust has now received confirmation of the delay to SGH ED, the completion date is now 28th February. The Trust is managing the slippage from this scheme by bringing forward schemes from 2023/24. We are also working with Hull to broker funding from 22/23 into 23/24.

- Facilities maintenance spent £0.38m to date, further orders have been placed totally £0.77m. Works relating to critical infrastructure water improvements and fire doors is progressing. Additional funding of £0.14m has also be agreed to complete the oxygen works at DPOW.

- IM&T spend is in line with the plan, with further orders placed of £0.26m.

- Equipment replacement is behind plan by £0.59m, orders have been placed for £0.95m. The list of equipment for the endoscopy stacks and scopes has now been signed off by clinical staff, the order for £0.99m is expected to be placed before the end of November.

9. Balance Sheet, Cash and Working Capital:

	Last Month	This Month
	£mil	£mil
Total Fixed Assets	263.80	264.73
Stocks & WIP	3.55	3.86
Debtors	9.81	9.71
Prepayments	6.61	6.86
Cash	36.22	32.47
Total Current Assets	56.20	52.89
Creditors : Revenue	40.98	35.76
Creditors : Capital	5.75	5.35
Accruals	22.98	20.89
Deferred Income	2.00	6.61
Finance Lease Obligations	1.25	1.06
Loans < 1 year	0.74	0.76
Provisions	0.69	0.68
Total Current Liabilities	74.38	71.12
Net Current Assets/(Liabilities)	(18.18)	(18.23)
Debtors Due > 1 Year	1.25	1.25
Creditors Due > 1 Year	0.00	0.00
Loans > 1 Year	8.21	8.21
Finance Lease Obligations > 1 Year	14.39	14.87
Provisions - Non Current	5.50	5.50
TOTAL ASSETS/(LIABILITIES)	218.78	219.19
TOTAL CAPITAL & RESERVES	218.78	219.19

- Debtors have remained stable in month.

- Stock has increased in month, relating to Pharmacy, Pathology and Scunthorpe pacemakers.

- The Trust cash balance has reduced again this month. The Trust is continuing to catch up on authorising and payment of invoices after the cyber-attack downtime. The Trust has also paid some large invoices for managed service contracts.

- Deferred income has increased, the Trust has invoiced Health education for the contract income relating to the period October to January 2023.

- Revenue creditors and accruals have all reduced in month, this relates to the catch up in processing and payment of supplier invoices.

- The total BPPC figures for the Non-NHS and NHS invoices continues to be above 90%, total number of invoices paid within 30 days is 91.2% and total value is 92.8%. The year to date value of invoices paid for NHS was 91.64% and Non NHS 92.93%. We are continuing to monitor the BPPC and are communicating to staff the importance of authorising invoices.

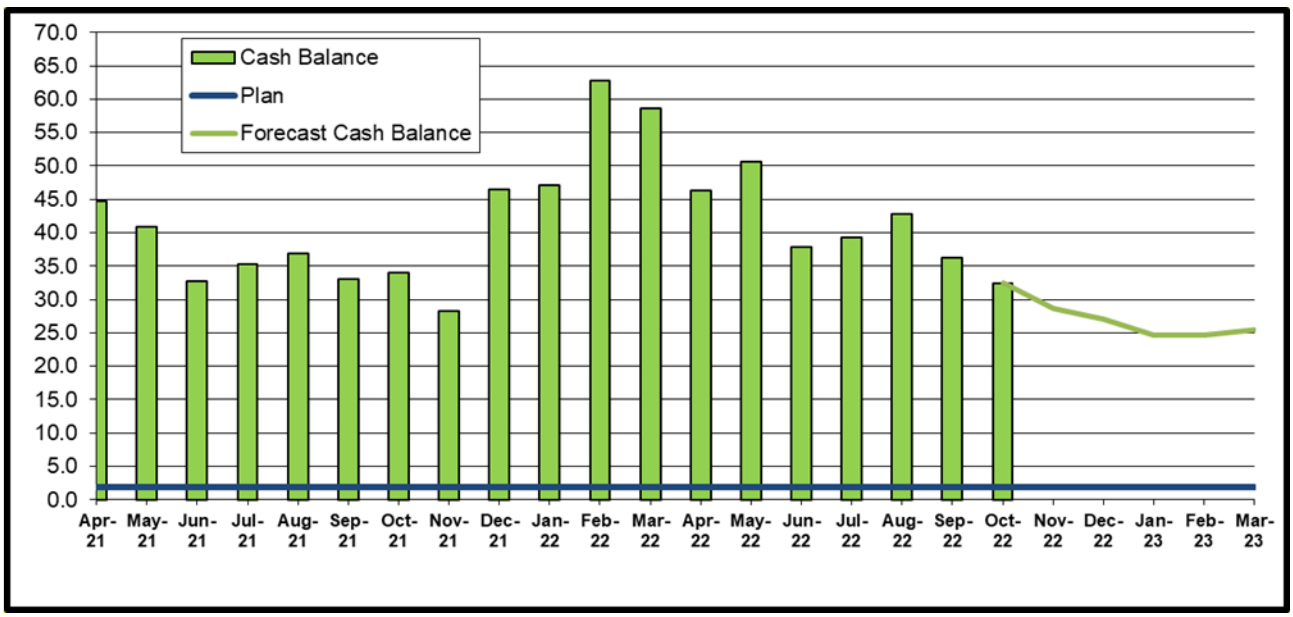
The cash balance at 31st October was £32.47m, an in-month reduction of £3.8m.

	£m	£m
Cash Balance as at 31st October		**32.47**
Commitments:		
Income received in advance	6.61	
Capital creditors	5.35	
Capital plan underspend	4.93	
PDC due for Capital	-8.80	
Capital loan repayments	0.61	
Oct PAYE/NI/Pension	12.14	
Public Dividend Capital payment	0.00	
To support other creditors due	9.74	
		(30.57)
NHSi minimum balance		**1.90**

Cashflow Forecast

The cash flow forecast has been modelled on a potential £9.0m forecast deficit and the impact it would have on the Trust's cash balances if it maintained its BPPC performance.

	Apr-22 £000s	May-22 £000s	Jun-22 £000s	Jul-22 £000s	Aug-22 £000s	Sep-22 £000s	Oct-22 £000s	Nov-22 £000s	Dec-22 £000s	Jan-23 £000s	Feb-23 £000s	Mar-23 £000s
Closing Cash Balance	46,376	50,581	37,865	39,347	42,746	36,219	32,467	28,716	27,033	24,726	24,653	25,458



10. Underlying Financial Position:

The Trust continues to assess the recurrent impacts on its underlying financial position bridging from its 2022/23 break-even plan. The following provides an update at this point for the known in year developments to the Trust's planning assumptions resulting in a revised underlying deficit of £34.5m.

	Last Month	Current Month
	£m	£m
Planned Surplus / Deficit 2022/23	**0.00**	**0.00**
Non Recurrent Adjustments		
Elective Recovery Funding	(9.17)	(9.17)
Elective Recovery Capacity	7.30	7.30
NR System Funding Smoothing	3.16	3.16
Technical Savings	(6.82)	(6.82)
NR Savings Delivery	(3.22)	(3.27)
COVID Funding	(11.39)	(11.39)
FYE 2022/23 Investment Programme	(8.04)	(8.04)
Cost of Capital – Depreciation & CDC	(4.05)	(3.75)
22/23 Pay Award Funding Shortfall	(2.30)	(2.30)
22/23 Recurrent in Year Cost Pressures	tbc	(4.62)
Revised Underlying Deficit 2022/23	**(34.52)**	**(38.90)**

In year cost pressures driving the headline £8.5m in year deficit risk have initially been assessed as £4.6m recurrently. Further work is ongoing as part of 2023/24 planning to stress test the assumptions underpinning the recurrent nature of these cost pressures.

11. Conclusion:

The Trust had a £0.46m surplus in month with a year to date deficit of £3.55m and is forecasting a potential £8.5m deficit risk to the balanced financial plan.

The material issues for the Trust over the coming months are:

- Maximising its planned care activity delivery, with a requirement to return to 19-20 productivity and activity levels within its core capacity and budget, reducing reliance on IS and WLI premium costs.
- Delivering a challenging stretch CIP programme, mitigating risks to delivery and conversion of non-recurrent savings into recurrent delivery schemes and identifying new schemes.
- Reducing its additional Covid-19 expenditure as soon as possible.
- Reducing its material cost pressures, including additional beds, and additional duties in both Nursing and Medical Staffing.

Brian Shipley
Deputy Director of Finance
November 2022

Appendix 1 – Income & Expenditure Month 7

Income & Expenditure	Annual Plan to 31st March 2023 £'000	Current Month Plan £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
Clinical Income	374,338	31,195	31,464	269	218,360	221,222	2,862
Block Top Up	58,394	4,866	4,947	81	34,063	34,628	565
Covid Inside Envelope Block	11,387	949	965	16	6,642	6,753	110
Covid Outside the Envelope	1,700	142	89	(52)	992	475	(517)
Other Income	39,338	3,300	3,872	572	22,829	24,672	1,843
Donated Income	0	0	46	46	0	147	147
Total Operating Income	**485,157**	**40,452**	**41,383**	**931**	**282,887**	**287,896**	**5,009**
Clinical Pay	(256,495)	(21,259)	(23,005)	(1,746)	(149,736)	(159,724)	(9,989)
Other Pay	(65,707)	(5,458)	(4,425)	1,033	(38,350)	(38,410)	(60)
Total Pay	**(322,203)**	**(26,716)**	**(27,430)**	**(713)**	**(188,086)**	**(198,135)**	**(10,049)**
Clinical Non Pay	(70,187)	(5,848)	(6,300)	(452)	(40,667)	(42,366)	(1,698)
Other Non Pay	(71,403)	(5,970)	(5,557)	414	(41,340)	(39,502)	1,838
Total Non Pay	**(141,590)**	**(11,818)**	**(11,857)**	**(39)**	**(82,007)**	**(81,867)**	**140**
Operating Expenditure	**(463,793)**	**(38,534)**	**(39,287)**	**(752)**	**(270,093)**	**(280,002)**	**(9,910)**
EBITDA	**21,364**	**1,918**	**2,096**	**178**	**12,794**	**7,894**	**(4,900)**
Depreciation	(16,169)	(1,315)	(1,282)	33	(8,806)	(8,879)	(73)
Interest Expenses & Other Costs	(233)	(19)	61	80	(136)	337	473
Dividend	(6,251)	(503)	(461)	42	(3,520)	(3,111)	409
Total Post EBITDA Items	**(22,653)**	**(1,837)**	**(1,682)**	**156**	**(12,462)**	**(11,653)**	**809**
Remove Capital Donated I&E Impact	1,289	107	43	(65)	752	329	(423)
Remove variance on gains on disposals	0	0	0	0	0	(120)	(120)
I&E Surplus / (Deficit)	**0**	**188**	**457**	**269**	**1,084**	**(3,550)**	**(4,634)**

Northern Lincolnshire and Goole NHS Foundation Trust

Appendix 2: Monthly CIP Report

Report produced on 17/11/22

M07 Update

CIP Summary Position and Commentary

For the period ending 31st October 2022 Month 7

YEAR TO DATE POSITION	**The Oct 22 (month 7) Year To Date delivery for 2022-23 savings is £13.77m against a plan of £12.46m**
IN MONTH POSITION	**In-month delivery was £3,021k against a plan of £1,829k an over delivery of £1192k**
FORECAST POSITION	**Forecast delivery was £23,932k against a plan of £22,400k an over delivery of £1,532k**

M07 SUMMARY (October 2022)

At the end of October, the Trust had delivered £5.93m of savings against its core year to date plan of £6.40m, an under delivery of £468k. Expenditure on COVID was high in month meaning that the usual mitigation wasn't provided however further non-recurrent in-year support was provided through technical adjustments. As a result of these changes the year to date position for the full programme was £13.76m delivered against the plan of £12.46m.

The year to date position improved significantly due to the non-recurrent technical support. However, the core programme continues to decline slipping from a £274k shortfall at the end of September to £468k behind at the end of October. This is due to planned increases in nursing recruitment and pharmacy biosimilars which haven't been matched by increased CIP delivery.

Nursing savings in the first six months have largely been through sickness reductions in Medicine, cessation of the bank incentive scheme and the full year effects of last year recruitment with only £67k of in-year recruitment savings reported in Surgery.

The profiling of nursing recruitment savings increases substantially in the second half of the year with NQN appointments and the overseas recruitments coming out of their supernumery period. The forecast position, although below original plan, contributes to overall achievement of the CIP programme. Nursing, along with medical recruitment savings, are dependant on timely on-boarding along with retention of existing staffing and the replacement of agency.

A biosimilar switch for Lucentis was planned to commence from October but this has been put back, initially, to December. The switch is still expected to be made delivering £244k of savings however this is extremely risky until it has been agreed with the medical body and plans put firmly in place to deliver.

Corporate and AHP vacancies continue to provide non-recurrent support to the challenged areas of the programme.

Any residual shortfall on the core programme in previous months has been more than covered by an over delivery on COVID expenditure reductions. In October this expenditure increased, and the relief wasn't available although it is expected to be back on track for the remainder of the financial year. Further non-recurrent support has been provided through some technical schemes such as rebates and VAT reclaims. These are anticipated to be about £1.1m.

Despite the in-month challenges the forecast position has improved and is now expected to be £23.93m. This is almost entirely due to the non-recurrent technical schemes. However, increased optimism on nursing recruitment and Corporate and AHP vacancies has slightly improved the core programme forecast.

RISKS TO 2022-23 COST IMPROVEMENT PROGRAMME

With the Trust finding achievement of its activity targets challenging. Improved productivity through its theatre and outpatient initiatives is highly unlikely to provide cash releasing efficiencies but instead enable delivery of additional activity.

The main cost driver for financial efficiency is pay and specifically agency costs. Delivery of the cost improvement programme in full will be dependent on the ability of the organisation to drive down its pay bill and this is therefore the principal risk.

The risks identified to date are:

i.£3.3m of the programme is dependent on new recruitment. Review of the current pipelines is a continuous process, but current numbers suggest that the Medicine Division still face a significant challenge.

ii.The next biggest driver of agency spend is sickness presenting an opportunity of £691k in nursing. Savings assumed have been reduced to £345k. In-roads have been made on this scheme, but it will continue to be closely monitored as it is not delivering in full currently and any major resurgence of COVID could compromise this.

iii.A lucentis biosimilar switched was originally planned from October. This hasn't happened and is now expected to be December, but it is anticipated to be a larger uptake than originally planned thus mitigating the slippage. Due to the uncertainty around the scheme and until there is more clarity no savings have been assumed. This will be reviewed on a month by month basis.

iv.It was recognised that the delivery of pay cost reductions were going to be difficult and as a result were heavily risk adjusted. To support this, attempts have been made to set up a workforce group to oversee the delivery of major workforce schemes such as recruitment and sickness. Initial interest was good however engagement has slipped on this, and the group is now on hold. Without any oversight on the workforce schemes, it is felt that their delivery will be made more challenging.

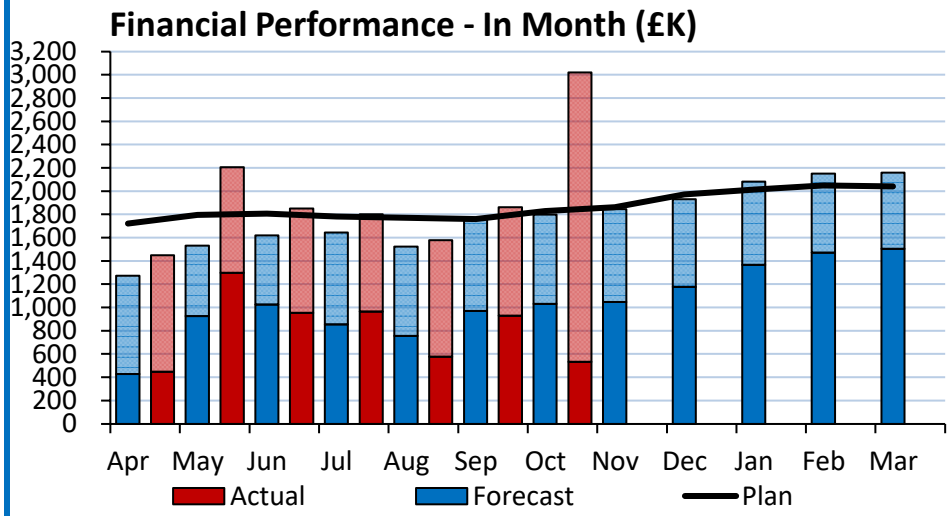
v.Actions taken to support the reduction of agency rate did not realise benefits due to increased demand for agency staff. The workforce resource centre is currently trying to progress a reduction to nursing rate, along with other schemes to reduce cancellations; address hours owed and planned leave and the development of a local medical bank.

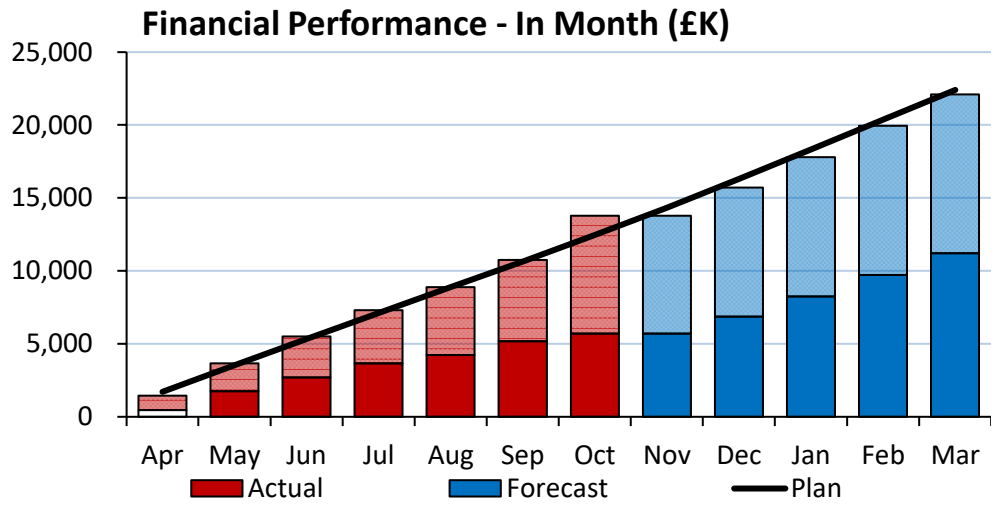
vi.With the pandemic, OPEL 4 and the planning cycle, and more recently the delivery of activity, focus on CIP has been variable across the areas. To support delivery full engagement is required however, any resurgence of COVID could seriously compromise this.

vii.Corporate and AHP vacancies have all over delivered in previous years and this year so far. However, this has been non-recurrently and will impact the Trust going forward if at least some of this delivery is not made recurrent.

viii.The current core CIP ask is 2.50% which will provide the organisation with significant challenge. The overall financial position of the ICS could impact on the size of this requirement.

2022-23 CIP RUN RATE

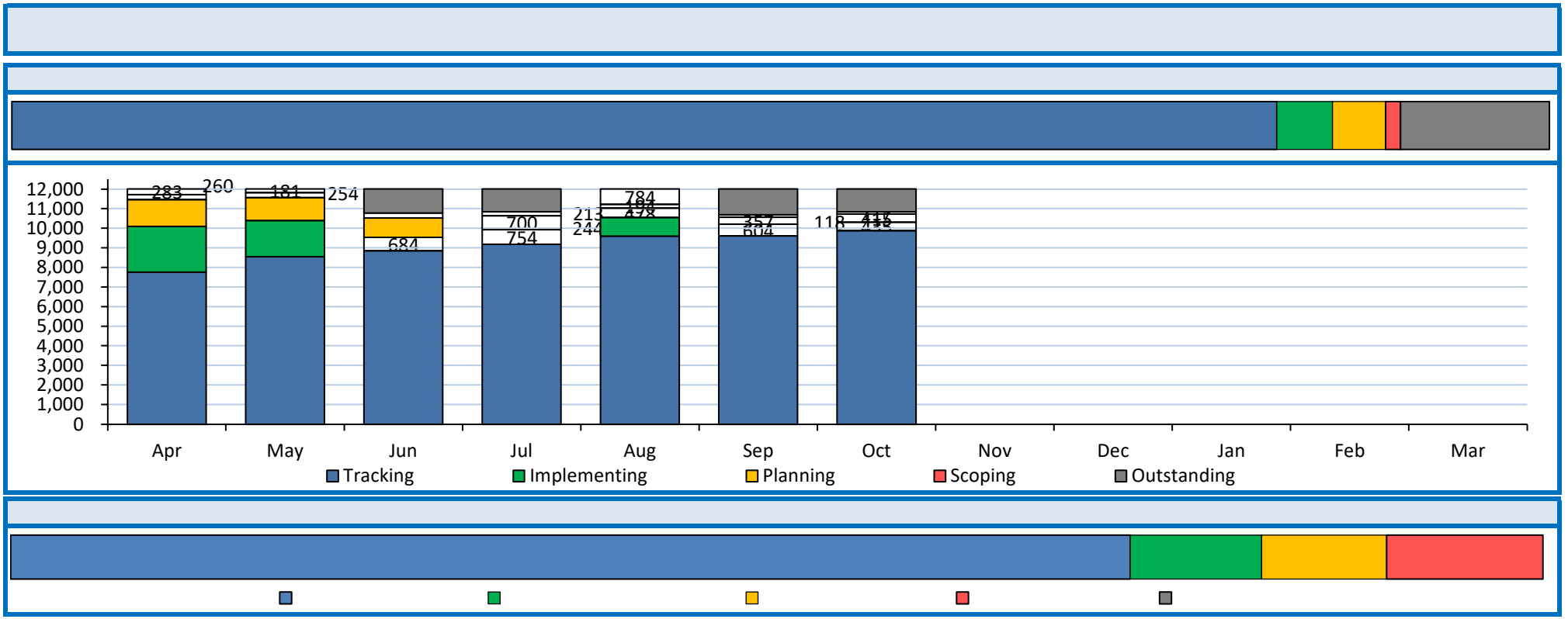




Key: Solid = Recurrent/ Translucent = Non-recurrent

Workstream													
Clinical Workforce - Medical Staff													
Clinical Workforce - Nursing and Midwifery													
Clinical Workforce - AHP Staff													
Corporate and Non-Clinical Workforce													
QI & Efficiency													
Capital Programme													
Estates & Facilities													
Non-Pay and Procurement													
Digital Transformation													
Grip & Control													
Income													
Unidentified													

Delivering to or exceeding plan	Within 5% of plan	Under delivering by more than 5%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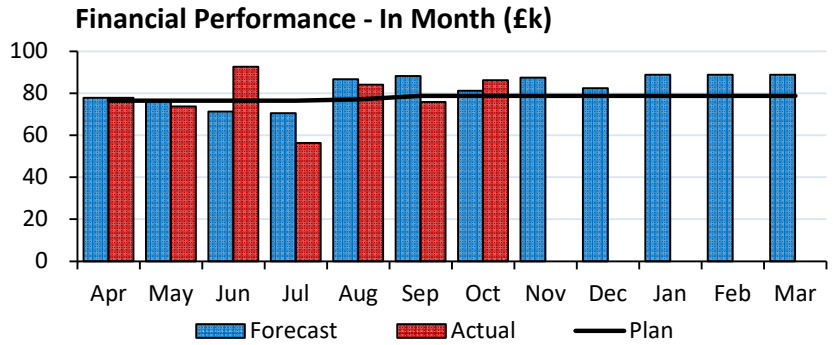
754
784
604
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Tracking
Implementing
Planning
Scoping
Outstanding

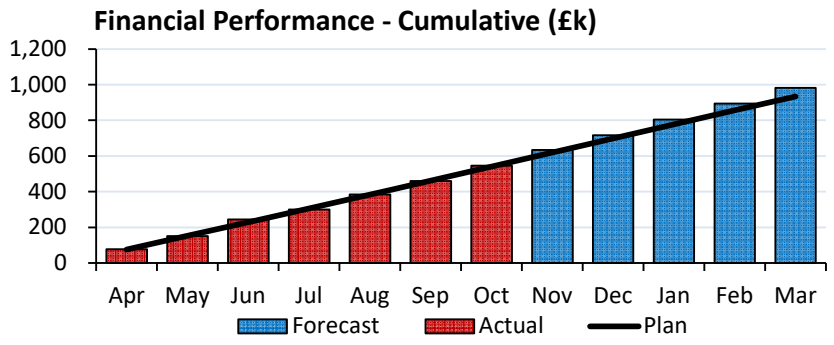
Risk	Workstream	Owner	Summary	Year End Value (£K)	Chance	Impact	Score	Response
Opportunity	QI & Efficiency	Jen Orton	Surgery theatres transformation - the theatres transformation board has been re-launched and a project plan is being drafted.	TBC	4	4	16	1. Keep abreast of and support modelling and monitoring of benefits for theatres productivity schemes
Opportunity	Non-pay	Paulash Haider	Switch from lucentis to biosimilar ranizumab to treat wet AMD.	£400K-£1M	4	5	20	1. Pharmacy to engage clinicians regarding biosimilar switch. 2. Monitor delivery when the biosimilar option becomes available.
Opportunity	Digital transformation	Chris Evans	Medical record digitisation is part of the digital strategy and should also deliver significant efficiencies and CIP. As should other digital transformation schemes.	TBC	4	4	16	1. Get early insight into benefits modelling for digital programme. 2. Monitor benefits realisation of digital programme
Opportunity	Workforce	COO/ People Director	Model hospital shows us as highest for total and medical pay cost per wau for 2020-21.	TBC	4	4	16	~~1. Launch workforce efficiency group.~~ ~~2. Produce a paper reviewing workforce efficiency~~
Threat	Programme-Level	CND/ COO	Establishment increases for nursing staff may be greater than net recruitment increases. This will impact vacancy rate and therefore pose a threat to nursing agency savings. Nurse recruitment profiles are also at risk as NQNs forecasts have reduced and international nurse starts have already slipped.	2,851	5	5	25	1. Keep abreast of establishment changes and review vacancy modelling at earliest opportunity. 2. Heavily risk adjust all nursing agency estimates until revised modelling is available. 3. Develop mitigating schemes.
Threat	Programme-Level	COO/ People Director	Demand for agency staff remains high despite efforts and we are an outlier on MH. Will present schemes really deliver required benefits?	6,727	4	5	20	1. Strengthen governance for workforce efficiency programme 2. Review and further develop programme as needed
Threat	Programme-Level	COO/ CIP Team	Engagement - if colleagues delivering efficiencies are not engaged it could hinder progress.		3	4	12	1. Maintain relationships with ops via FIMs and escalate where required
Threat	Programme-Level	CFO	ICS position - the CIP target increased last year in November to support the ICS.		3	4	12	1. Staying in touch with the bigger picture
Threat	Programme-Level	COO	Pandemic - a number of initiatives were suspended during the pandemic.		3	3	9	1. Staying in touch with the bigger picture

Issue	Impact (£K)	Summary
Recurrent gap	4,428	Areas heavily reliant on non-recurrent savings are corporate, estates and community & therapy services.
Slippage	-4,117 (YTD)	Most of this is from workforce schemes.

Workstream Summary

Project												
QI & Efficiency												
**Gynae Establishment*												
Theatres productivity gains												
Goole Site Services Review												
Theatres efficiency consultation												
Other schemes												
Capital Programme												
**MRI Vans*												
Digital Transformation												
*Electronic Patient Communication**												
Other Schemes												





COMMENT

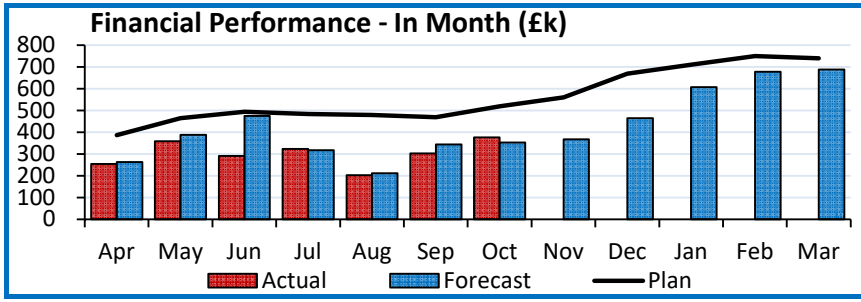
Overall delivery is ahead of plan due to theatre productivity gains which is more than mitigating for the non commencement of the Goole Services review which is reliant on recruitment in order for it to start delivering.

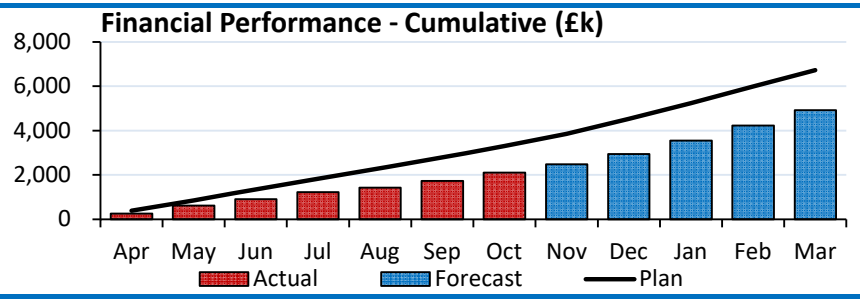
QI & Efficiency		Improvement Summary	RAG
Project Sponsor	Shaun Stacey	There are a variety of clinical productivity and efficiency initiatives that should deliver financial benefits to the Trust including in Pathology, Endoscopy, Outpatients, AAU and Theatres.	**On Track**
Project Lead			
Date	Jul 20		

													YTD	22-23
Month														
Plan													261	448
Delivery														

Theatres productivity gains are delivering more than plan which has put this workstream 'on track'.	1. COVID-19 and the general context.	

Project													
Medical Staff													
Recruitment & Retention Medical													
Rota Management													
Agency Market Management Medical													
Job Planning													
Other schemes													
Nursing and Midwifery													
Recruitment & Retention Nursing													
Sickness & Absence Nursing													
Agency Market Management Nursing													
Other schemes													
AHP Staff													



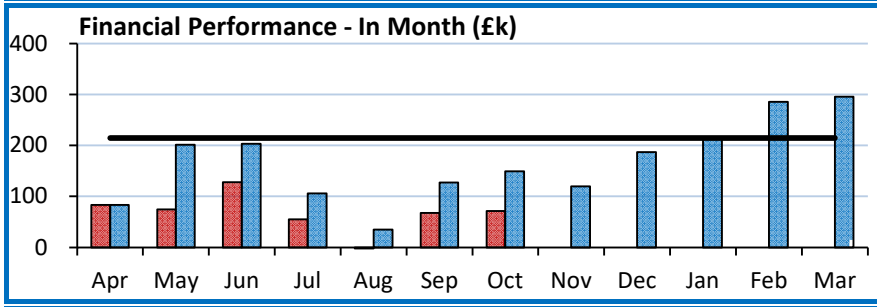


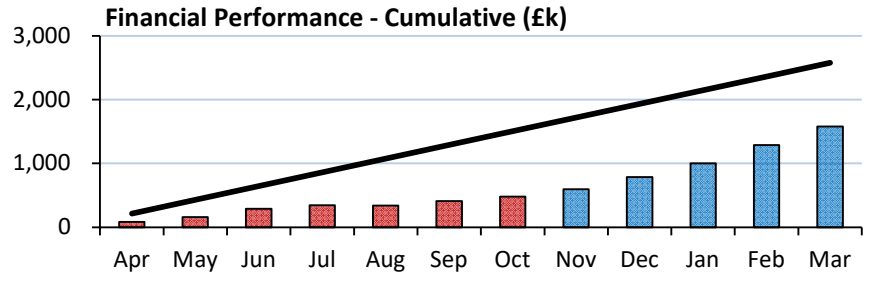
The medical recruitment scheme is significantly off-track due to more leavers than planned and less starters, the latter being compounded by suspension of MTI recruitment following a request from the Royal College of Physicians. The vast majority of this under delivery is in the medicine division. Although net recruitment did improve in September there was still 10WTEs more vacancies than March. This has resulted in no new savings being declared as well as a reduction to the full year effect

Nursing recruitment in the medicine division is also behind trajectory although an increase in substantive numbers is starting to materialise but not to planned levels. The surgery Division is ahead of plan currently however lower than expected NQN numbers means that their forecast position is now £50k adrift

Benchmarking information suggests that pay is the primary area of opportunity for cost efficiencies but to tackle this the Trust needs to reduce its temporary staffing expenditure. The delivery of the year-end target now seems unlikely without major intervention i.e., strengthening transformation governance/ planning (so WTE changes are supported by a recruitment plan) and also establishment of a workforce group to drive pay efficiency initiatives with SRO leadership.

*MEDICAL STAFF		Improvement Summary	RAG
Project Sponsor	Shaun Stacey	Medical staffing encompasses a range of projects and operational workforce activities. The WRC is leading operational workforce transformation of policies, systems and processes. This is alongside campaigns by recruitment to reduce vacancies and by divisions to improve utilisation.	Off Track
Project Lead			
Date			



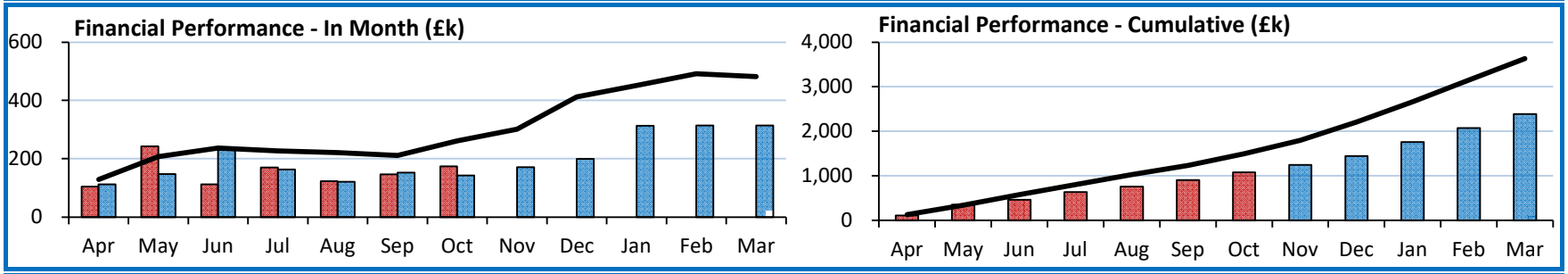


Financial Performance - In Month (£k) — Higher is Better

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	FOT
Plan	215	215	215	215	215	215	215	215	215	215	215	215	1,503	2,577
Delivery	83	75	128	55	- 2	68	71	120	187	216	285	295	477	1,580

Comments	Risk	Issue
This workstream is a major concern - The issue with the MTI programme needs resolving as there are now 14 potential employees. Although the pipeline is healthy it is essential to get these staff employed in order to start reducing our reliance on agency staff.	1. COVID19 and contextual factors 2. Large expectations on recruitment	
	Mitigation	

*Nursing and Midwifery		Improvement Summary	RAG
Project Sponsor	Shaun Stacey	Nurse and midwifery staffing encompasses a range of projects and operational workforce activities. The WRC is leading operational workforce transformation of policies, systems and processes. This is alongside campaigns by recruitment to reduce vacancies and by divisions to improve utilisation.	**Off Track**
Project Lead			
Date			



Financial Performance - In Month (£k) — **Higher is Better**

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	FOT
Plan	129	207	236	226	221	211	262	302	412	452	492	482	1,494	3,632
Delivery	104	242	113	170	123	146	174	171	200	313	314	315	1,073	2,385

Comments

Delivery is behind plan and year-end is now forecast to be significantly less than plan due to nursing recruitment (£1,039k adverse variance just for Medicine on nursing recruitment). The causes of this include an adverse change in NQN pipeline and slippage on the international nurse starts. This is combined with an increase in budgeted establishment driving an increase in vacancy position.

Risk

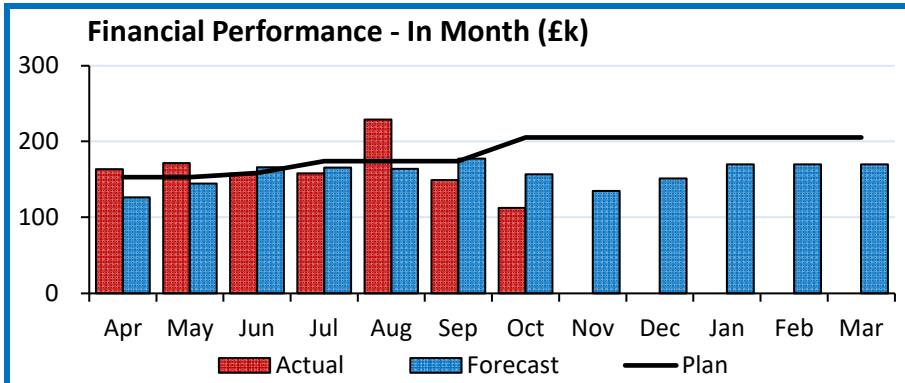
1. COVID19 and contextual factors
2. Large expectations on recruitment

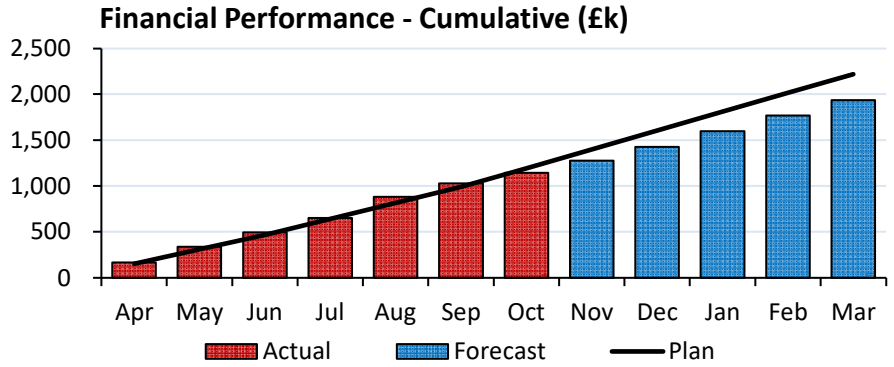
Mitigation

Issue

The nursing establishment review has resulted in a major rise in vacancy position and the recruitment plan did not include the additional posts.

Project												
***Procurement**												
Scanning Productivity												
*Legal Fees**												
Equipment hire												
Procurement Led Schemes												
Contact lenses & spectacles (HESP)												
NHSSC Category Towers Savings												
Other schemes												
Pharmacy Biosimilars												
Grip & Control												

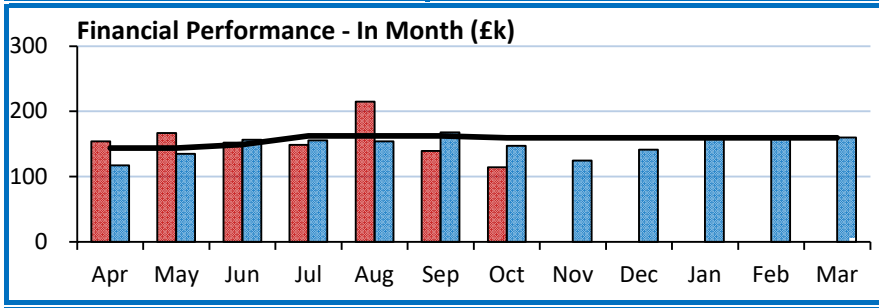


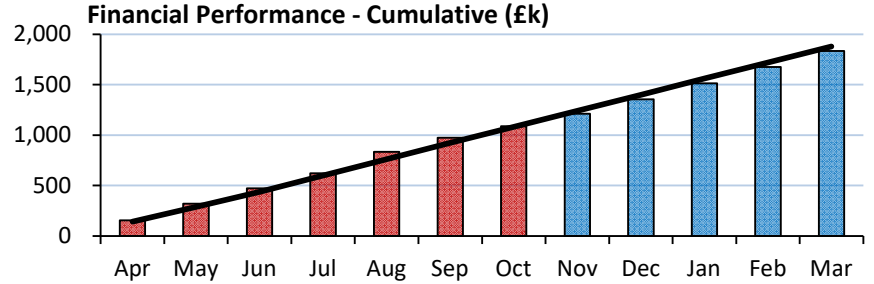


COMMENT

The workstream had expected to over-deliver but there has been significant slippage on the lucentis biosimilar schemes that has arisen following a period of clinical engagement. It may yet recover depending on the outcome of the engagement work and the level of uptake. The Grip and Control schemes relate to the technical savings that have been declared this month.

*PROCUREMENT		Improvement Summary	RAG
Project Sponsor	Lee Bond	Commercial and operational leads will identify, progress and monitor initiatives that improve value for money for goods and services by negotiating better prices, leading tenders, consolidating products and suppliers, and generally delivering all associated opportunities to improve financial position.	**On Track**
Project Lead	Ivan Pannell		
Date	Jul 20		





	Month	YTD	FOT
Plan		1,082	1,879
Delivery			

The programme is mostly either NHSSC, central procurement team or COO led. Additional savings have been identified in corporate (inc. finance system, legal fees and reprographics) and travel.

Delivery is above plan at present.

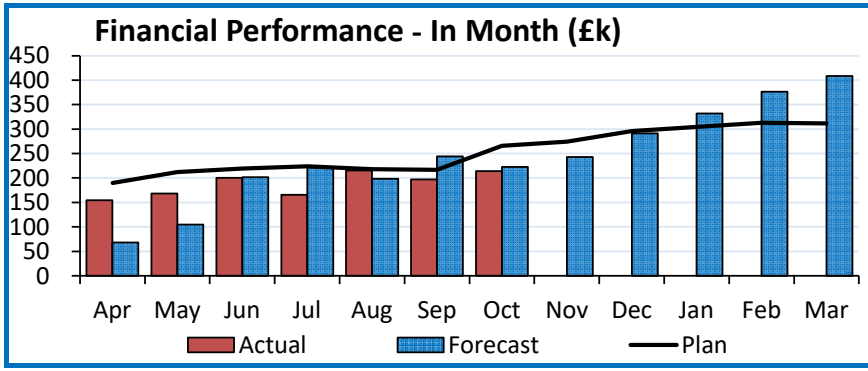
1. COVID19 and contextual factors
2. 67 x £50k+ contracts are expired due to a backlog in tender work.

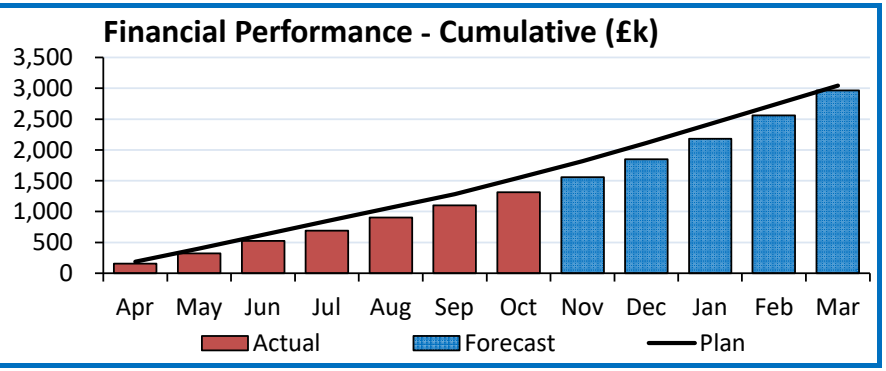
Division Summary

Surgery & Critical Care

2022-23 DELIVERY SUMMARY

The YTD variance is due to workforce initiatives not delivering, mostly related to medical workforce schemes including recruitment and temporary staffing schemes led by WRC. Plans are being redefined for theatres productivity and efficiency which might positively impact the financial benefits profile and increase in-year CIP delivery.
In addition to recruitment the forecast variance also incorporates reduced nursing savings due to less NQN recruitment than expected.
There is the potential for quite significant biosimilar switch savings (lucentis) however this needs to be agreed and plans commenced in order to realise these.



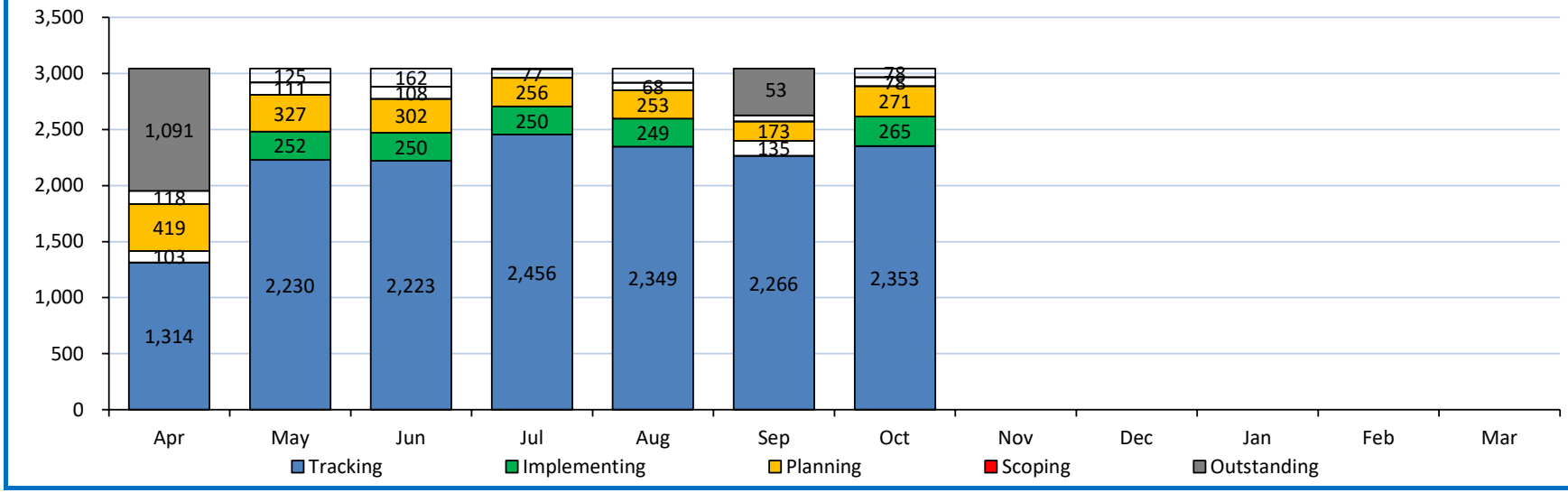


Workstream	Projects (No.)	M07 Plan (£k)	M07 Actual (£k) Rec	M07 Actual (£k) Non Rec	M07 Variance (£k)	YTD Plan (£k)	YTD Delivery (£k) Rec	YTD Actual (£k) Non Rec	YTD Variance (£k)	Annual Plan (£k)	FOT (£k) Rec	FOT Actual (£k) Non Rec	FOT Variance (£k)
Capital Programme	2	33	33	0	0	230	230	0	0	395	395	0	0
Clinical Workforce - Medical Staff	29	58	46	0	-12	408	174	0	-234	700	566	0	-135
Clinical Workforce - Nursing and Midwifery	8	70	61	0	-9	423	394	0	-29	943	862	0	-81
Clinical Workforce - AHP Staff	3	4	4	0	0	27	16	0	-12	47	35	0	-12
Corporate and Non-Clinical Workforce	0	0	0	0	0	0	0	0	0	0	0	0	0
Digital Transformation	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Pay and Procurement	12	92	47	0	-45	397	348	45	-4	856	858	45	47
QI & Efficiency	2	8	23	0	15	58	109	0	51	99	206	0	107
Unidentified	2	0	0	0	-0	3	0	0	-3	5	0	0	-5
Total	58	265	215	0	-51	1,546	1,271	45	-230	3,045	2,921	45	-78

Surgery & Critical Care

2022-23 DELIVERY SUMMARY

Schemes - Risk-adjusted Value (£K)

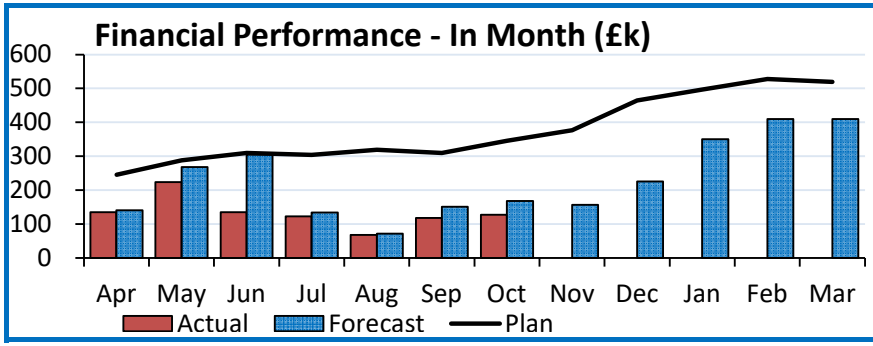


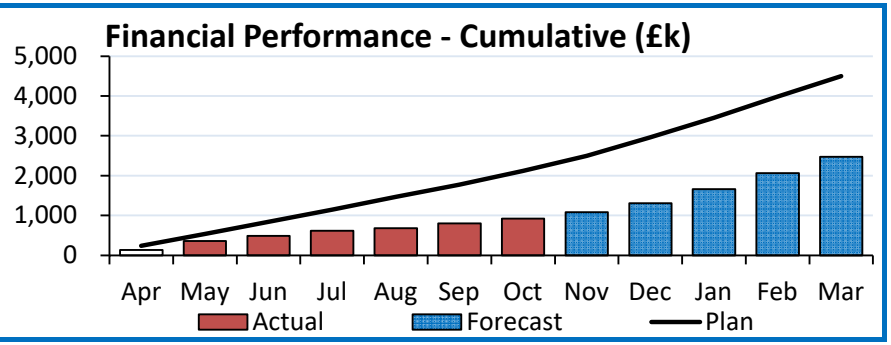
Schemes - Volume (No.)

Medicine

2022-23 DELIVERY SUMMARY

The Division had a significant CIP target on the back of its high agency spend. Expectations regarding recruitment have not been met and consequently delivery of CIP has slipped by £218k in-month taking them to £1,193k under-delivered at the end of the period. With prudent assessments on their recruitment pipeline as well as a hold on the appointment of MTIs, agency savings have been down graded to the year end leading to an anticipated £2.03m shortfall on the £4.5m annual plan.
The Division accounts for nearly all of the £2.1m slippage on the forecast for all of operations.



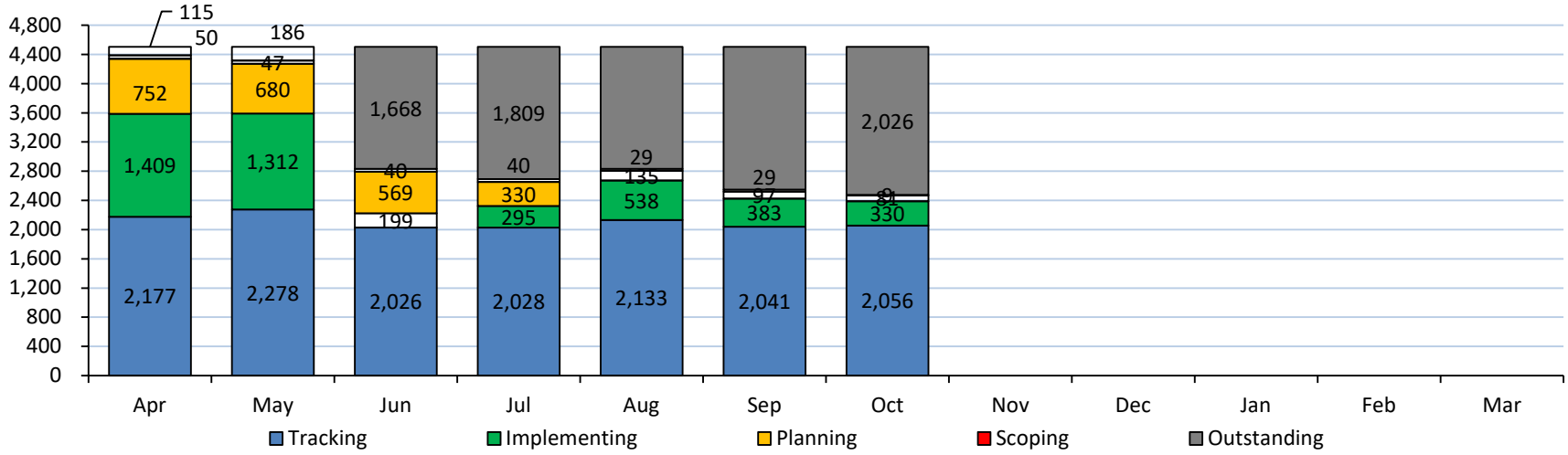


Workstream	Projects (No.)	M07 Plan (£k)	M07 Actual (£k) Rec	M07 Actual (£k) Non Rec	M07 Variance (£k)	YTD Plan (£k)	YTD Delivery (£k) Rec	YTD Actual (£k) Non Rec	YTD Variance (£k)	Annual Plan (£k)	FOT (£k) Rec	FOT Actual (£k) Non Rec	FOT Variance (£k)
Clinical Workforce - Medical Staff	9	147	24	0	-123	1,032	281	0	-752	1,770	962	0	-808
Clinical Workforce - Nursing and Midwifery	7	176	100	0	-76	924	551	0	-373	2,465	1,320	0	-1,145
Clinical Workforce - AHP Staff	1	1	0	0	-1	6	0	0	-6	10	3	0	-7
Corporate and Non-Clinical Workforce	0	0	0	0	0	0	0	0	0	0	0	0	0
Digital Transformation	0	0	0	0	0	0	0	0	0	0	0	0	0
Grip & Control	1	1	0	0	-1	6	0	5	-0	10	0	0	-10
Non-Pay and Procurement	8	11	1	-1	12	94	69	0	-25	151	130	13	-8
QI & Efficiency	3	8	3	0	-5	57	20	0	-37	98	49	0	-49
Total	29	345	128	-1	218	2,120	921	5	-1,193	4,503	2,464	13	-2,026

Medicine

2022-23 DELIVERY SUMMARY

Schemes - Risk-adjusted Value (£K)

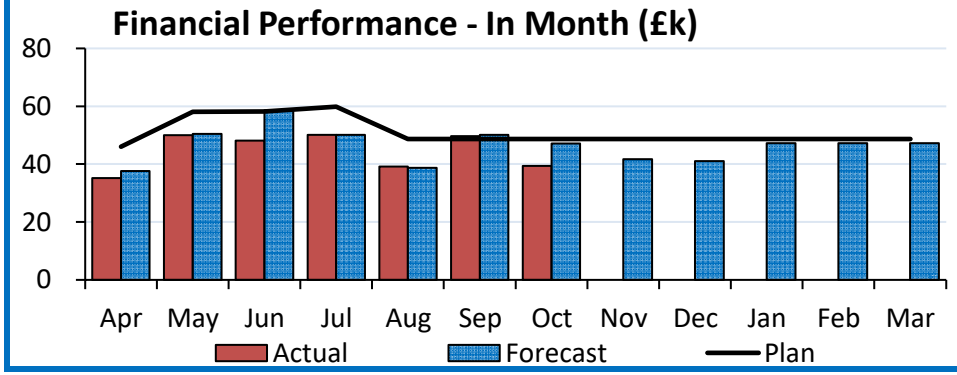


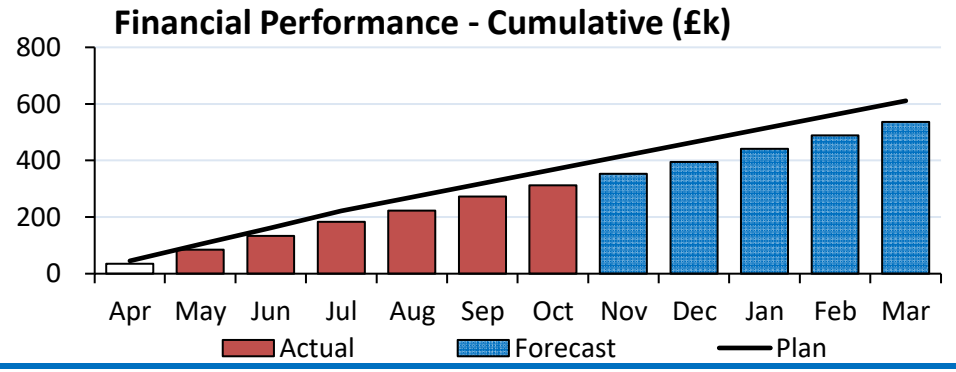
Schemes - Volume (No.)

Family Services

2022-23 DELIVERY SUMMARY

The main issue for the team, common with other Divisions is recruitment of medical staffing. However this does not form a major part of the plans. The Division is currently off track by £47k YTD with medical recruitment accounting for £32k and midwifery recruitment £5k. In addition to the recruitment issue no delivery of the enseal project is £9k, £16k by year end, and non-delivery of maternity pack digitisation £3k.



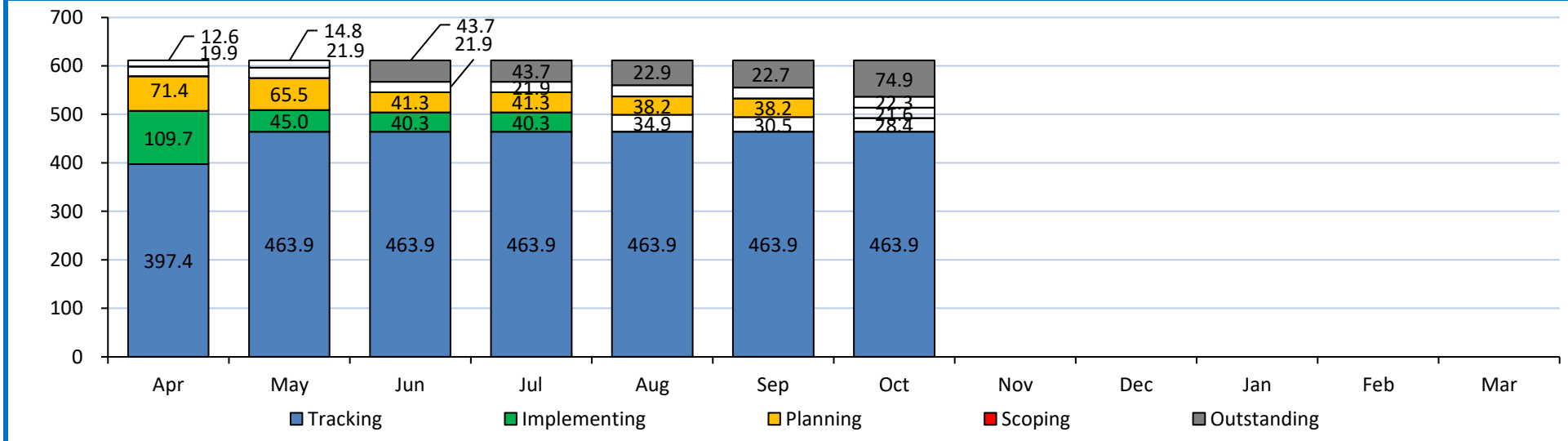


Workstream	Projects (No.)	M07 Plan (£k)	M07 Actual (£k) Rec	M07 Actual (£k) Non	M07 Variance (£k)	YTD Plan (£k)	YTD Delivery (£k) Rec	YTD Actual (£k) Non	YTD Variance (£k)	Annual Plan (£k)	FOT (£k) Rec	FOT Actual (£k) Non	FOT Variance (£k)
Clinical Workforce - Medical Staff	6	7	1	0	-6	47	10	0	-37	81	33	0	-48
Clinical Workforce - Nursing and Midwifery	6	9	8	0	-2	102	91	0	-11	149	138	0	-11
Clinical Workforce - AHP Staff	0	0	0	0	0	0	0	0	0	0	0	0	0
Corporate and Non-Clinical Workforce	1	2	2	0	0	13	13	0	0	23	23	0	0
Digital Transformation	1	0	0	0	-0	3	0	0	-3	5	1	0	-4
Non-Pay and Procurement	9	9	8	0	-1	57	54	0	-3	102	92	0	-9
QI & Efficiency	4	21	21	0	-1	146	144	0	-2	252	248	0	-3
Unidentified	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	27	49	39	0	-9	368	312	0	-56	611	536	0	-75

Family Services

2022-23 DELIVERY SUMMARY

Schemes - Risk-adjusted Value (£K)

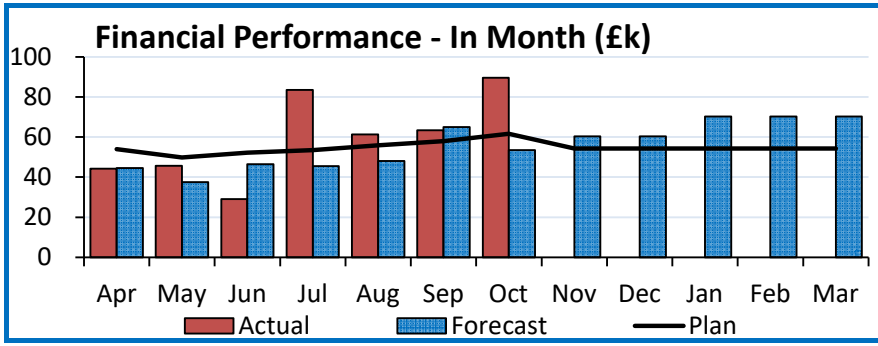


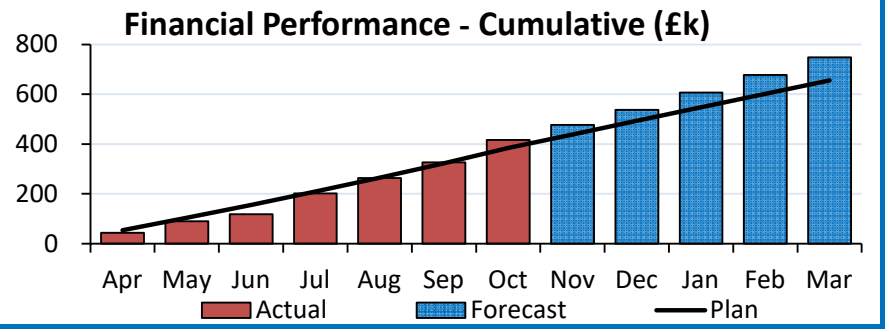
Schemes - Volume (No.)

Community & Therapy Services

2022-23 DELIVERY SUMMARY

The Division is currently forecasting a £92k over delivery its £656k programme, £4k YTD. However only £460k of the forecast delivery is recurrent.



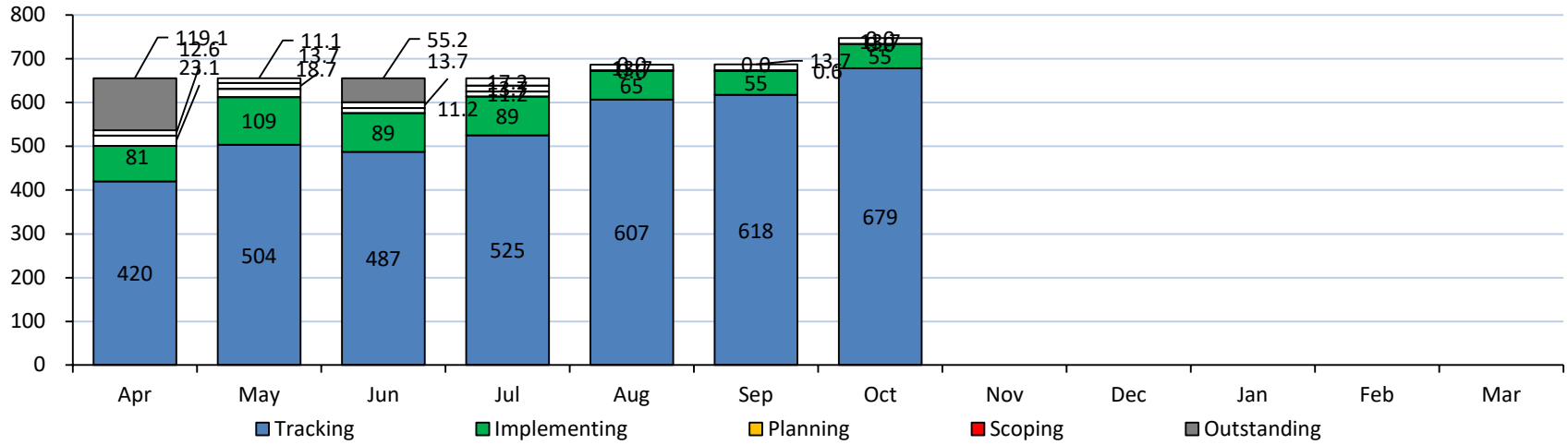


Workstream	Projects (No.)	M07 Plan (£k)	M07 Actual (£k) Rec	M07 Actual (£k) Non Rec	M07 Variance (£k)	YTD Plan (£k)	YTD Delivery (£k) Rec	YTD Actual (£k) Non Rec	YTD Variance (£k)	Annual Plan (£k)	FOT (£k) Rec	FOT Actual (£k) Non Rec	FOT Variance (£k)
Capital Programme	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Workforce - Medical Staff	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Workforce - Nursing and Midwifery	5	3	3	0	-0	28	25	162	160	44	39	0	-5
Clinical Workforce - AHP Staff	3	23	28	58	63	158	158	0	0	271	271	287	287
Corporate and Non-Clinical Workforce	2	8	0	-7	14	41	3	0	-38	44	6	0	-38
Digital Transformation	1	2	0	0	-2	3	0	0	-3	12	8	0	-3
Income	1	2	2	0	0	8	8	0	0	17	17	0	0
Non-Pay and Procurement	9	24	6	0	-18	141	60	0	-81	259	118	0	-141
QI & Efficiency	0	0	0	0	0	0	0	0	0	0	0	0	0
Unidentified	1	1	0	0	-1	5	0	0	-5	9	0	0	-9
Total	22	62	39	51	28	384	254	162	32	656	460	287	92

Community & Therapy Services

2022-23 DELIVERY SUMMARY

Schemes - Risk-adjusted Value (£K)

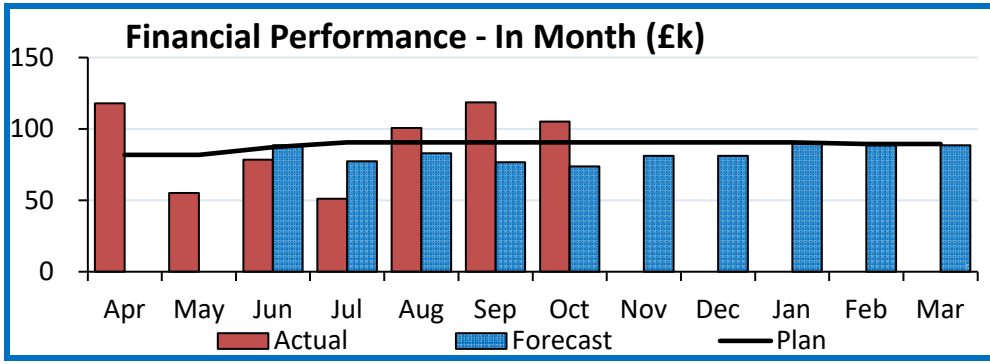


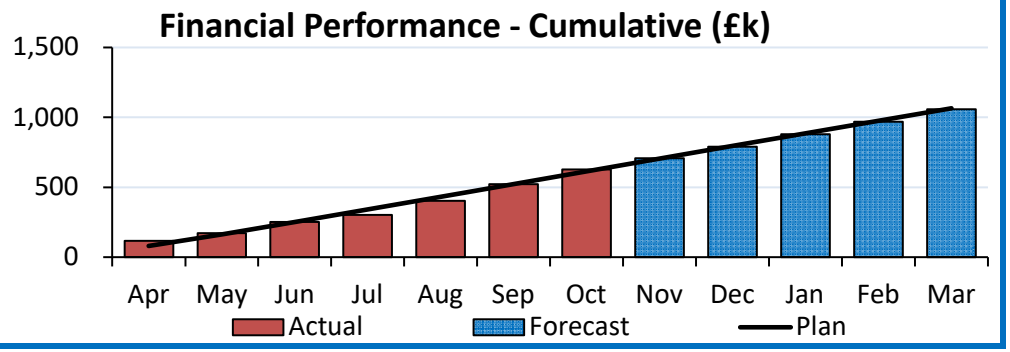
Schemes - Volume (No.)

COO's DIRECTORATE

2022-23 DELIVERY SUMMARY

AHP and Corporate non-recurrent vacancies are covering shortfalls on its income schemes (particularly the ULHT contract, £93k YTD) and slippage on the immunology tender (£27k YTD) and HbA1c scheme (£9k YTD). The forecast position is only £8k short of the £1,065k plan. However only £256k is currently recurrent.



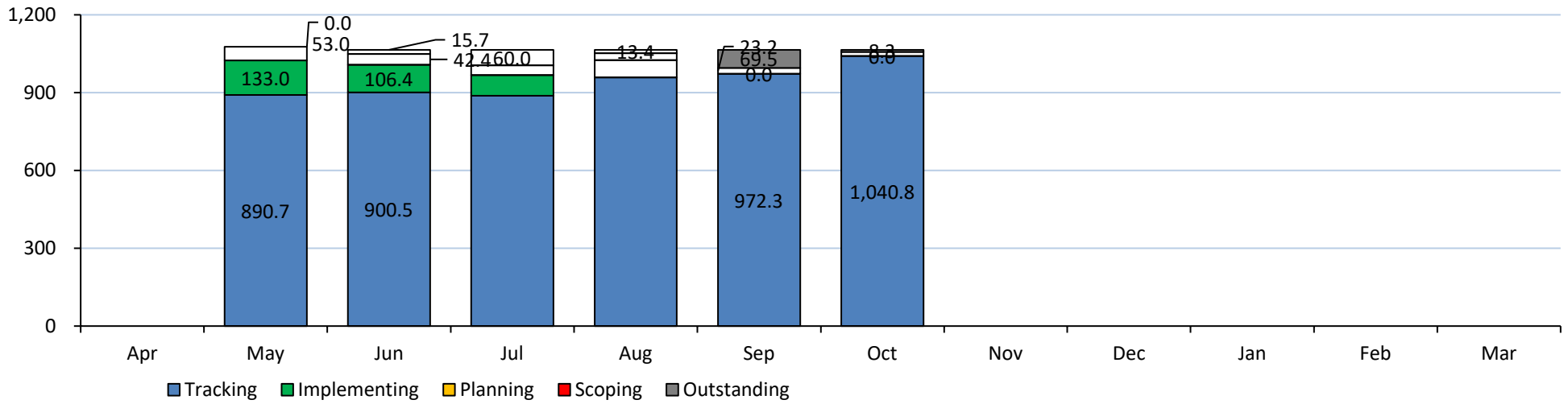


Workstream	Projects (No.)	M07 Plan (£k)	M07 Actual (£k) Rec	M07 Actual (£k) Non Rec	M07 Variance (£k)	YTD Plan (£k)	YTD Delivery (£k) Rec	YTD Actual (£k) Non Rec	YTD Variance (£k)	Annual Plan (£k)	FOT (£k) Rec	FOT Actual (£k) Non Rec	FOT Variance (£k)
Capital Programme	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Workforce - Medical Staff	1	2	0	2	0	15	0	15	0	26	0	26	0
Clinical Workforce - Nursing and Midwifery	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Workforce - AHP Staff	2	16	0	43	27	111	0	225	113	191	0	354	163
Corporate and Non-Clinical Workforce	4	13	8	20	15	91	45	74	28	154	87	95	28
Digital Transformation	0	0	0	0	0	0	0	0	0	0	0	0	0
Income	4	45	4	22	-19	315	31	191	-93	540	65	326	-150
Non-Pay and Procurement	7	15	6	0	-8	81	47	0	-34	154	104	0	-50
QI & Efficiency	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	18	91	18	87	15	614	123	504	13	1,065	256	801	-8

COO's DIRECTORATE

2022-23 DELIVERY SUMMARY

Schemes - Unadjusted Value (£K)



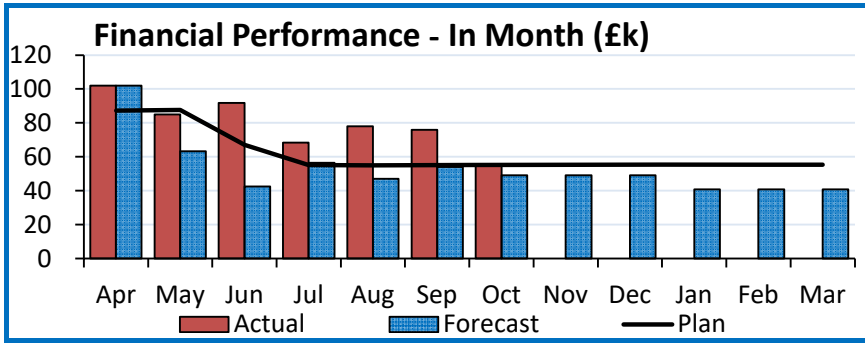
Schemes - Volume (No.)

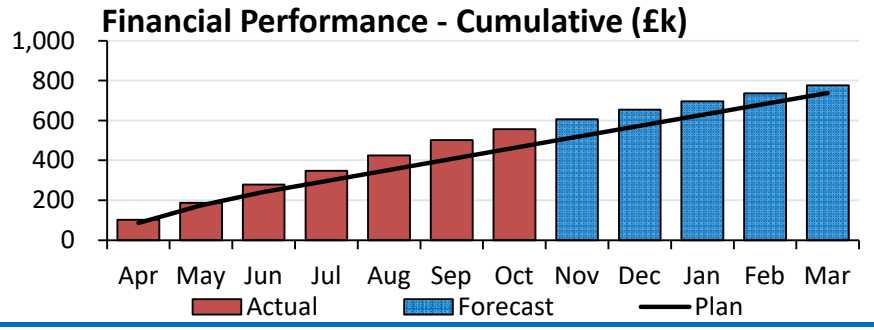
Corporate Summary

Estates & Facilities

2022-23 DELIVERY SUMMARY

Income over delivery has mitigated an under delivery on vacancies and the Directorate is over-delivering by £94k as at M07. Progress has been made in identifying recurrent savings but a lot of the delivery is still non-recurrent with only £310k of recurrent savings forecast against the £739k programme.



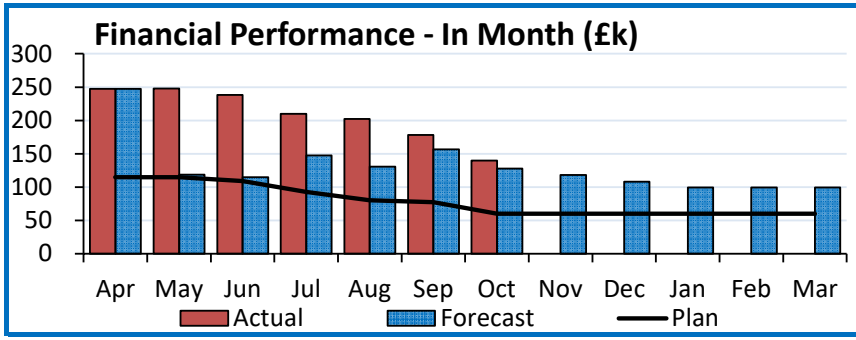


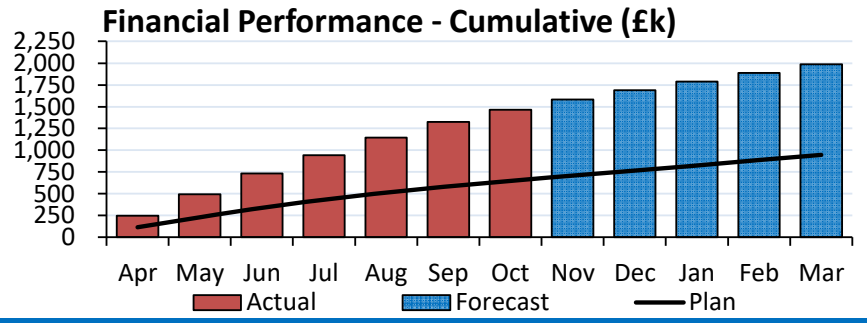
Workstream	Projects (No.)	M07 Plan (£k)	M07 Actual (£k) Rec	M07 Actual (£k) Non Rec	M07 Variance (£k)	YTD Plan (£k)	YTD Delivery (£k) Rec	YTD Actual (£k) Non Rec	YTD Variance (£k)	Annual Plan (£k)	FOT (£k) Rec	FOT Actual (£k) Non Rec	FOT Variance (£k)
Clinical Strategy	0	0	0	0	0	0	0	0	0	0	0	0	0
Corporate and Non-Clinical Workforce	0	0	0	0	0	0	0	361	361	0	0	0	0
Estates & Facilities	24	50	18	32	-0	427	160	0	-267	679	250	467	38
Non-Pay and Procurement	0	0	0	0	0	0	0	0	0	0	0	0	0
Digital Transformation	1	5	5	0	0	35	35	0	0	60	60	0	0
Unidentified	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	25	55	23	32	-0	463	195	361	94	739	310	467	38

Corporate Directorates

2022-23 DELIVERY SUMMARY

Corporate CIP plans in the main, similar to last year, are based on holding vacancies. Alongside vacancies are a small number of 'big ticket' non-pay schemes continued from last year such as the non-recurrent saving on Legal Fees. There is a focus this year on converting non-recurrent schemes to recurrent. The corporate areas continue to over-deliver albeit non-recurrently and are £816k ahead of plan as at M07.





Workstream	Projects (No.)	M07 Plan (£k)	M07 Actual (£k) - Rec	M07 Actual (£k) - Non-Rec	M07 Variance (£k)	YTD Plan (£k)	YTD Delivery (£k) - Rec	YTD Actual (£k) - Non-Rec	YTD Variance (£k)	Annual Plan (£k)	FOT (£k) - Rec	FOT Actual (£k) - Non-Rec	FOT Variance (£k)
QI & Efficiency	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital Programme	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Workforce - Medical Staff	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Workforce - Nursing and Midwifery	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Workforce - AHP Staff	0	0	0	0	0	0	0	1,084	1084	0	0	0	0
Corporate and Non-Clinical Workforce	49	37	23	113	98	454	158	0	-296	640	272	1,397	1029
Digital Transformation	1	1	1	0	0	8	8	97	97	14	14	0	0
Non-Pay and Procurement	10	21	3	0	-18	185	115	0	-70	291	208	97	13
Risk Mitigation	0	0	0	0	0	0	0	0	0	0	0	0	0
Unidentified	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	60	60	27	113	80	648	282	1,181	816	946	494	1,494	1,042

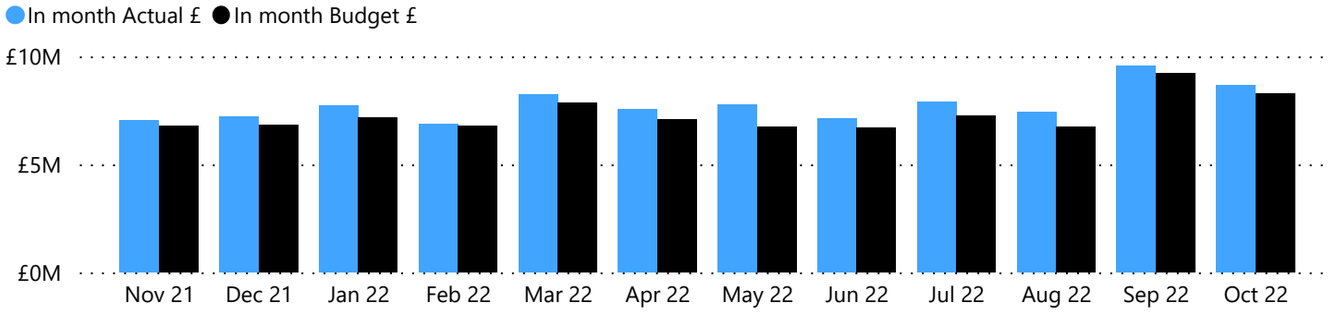
Spend

Updated M07 2022-23

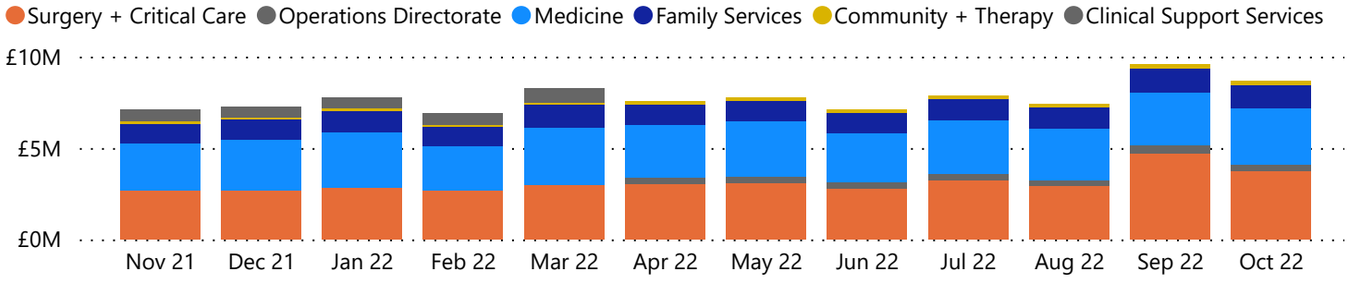
HOME

Northern Lincolnshire and Goole NHS Foundation Trust

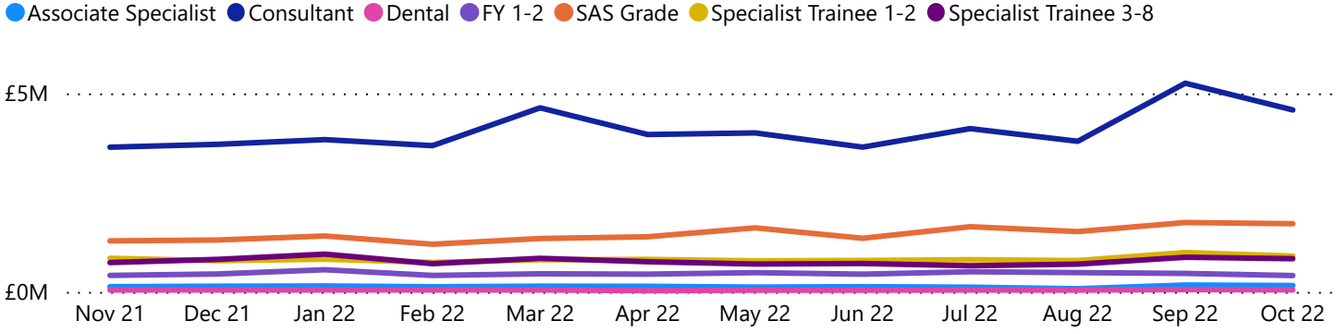
Is the Trust 'living within its means' for medical workforce?



How much is being spent on medical staff by division?



Are we spending more on specific grades of doctor?



NOTE: A filter is by default applied to exclude COVID-19 expenditure and corporate areas. Note that not all additional sessions are clearly identified in the Trial Balance but most 'over-baseline' are in additional activity cost centres.

What is total medical staff spend?

Pay Type	Actual (£)	Actual (%)
Additional Session	£3,274,846	4%
Agency	£11,668,439	13%
Locum	£10,831,499	12%
Substantive	£67,275,835	72%
Total	**£93,050,618**	**100%**

Year

Multiple selections

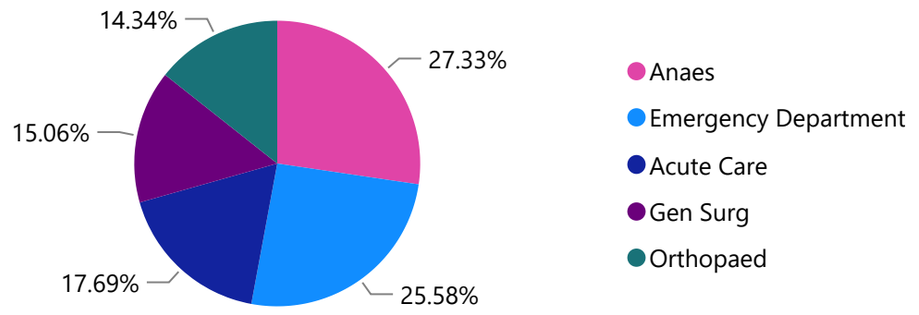
Period i.e., from, to...

01/11/2021 — 01/10/2022

Division

All

What are the top 5 departments on medical spend?



Division	2022-23 YTD Budget	2022-23 YTD Actual	2022-23 YTD Variance	2021-22 YTD Actual
Surgery + Critical Care	£17,619,846	£19,773,957	-£2,154,111	£15,823,998
Medicine	£16,286,035	£17,282,194	-£996,159	£15,426,676
Family Services	£6,777,923	£7,039,852	-£261,929	£6,283,022
Operations Directorate	£2,010,587	£2,123,570	-£112,983	
Total	**£43,734,703**	**£47,279,344**	**-£3,544,641**	**£41,911,539**

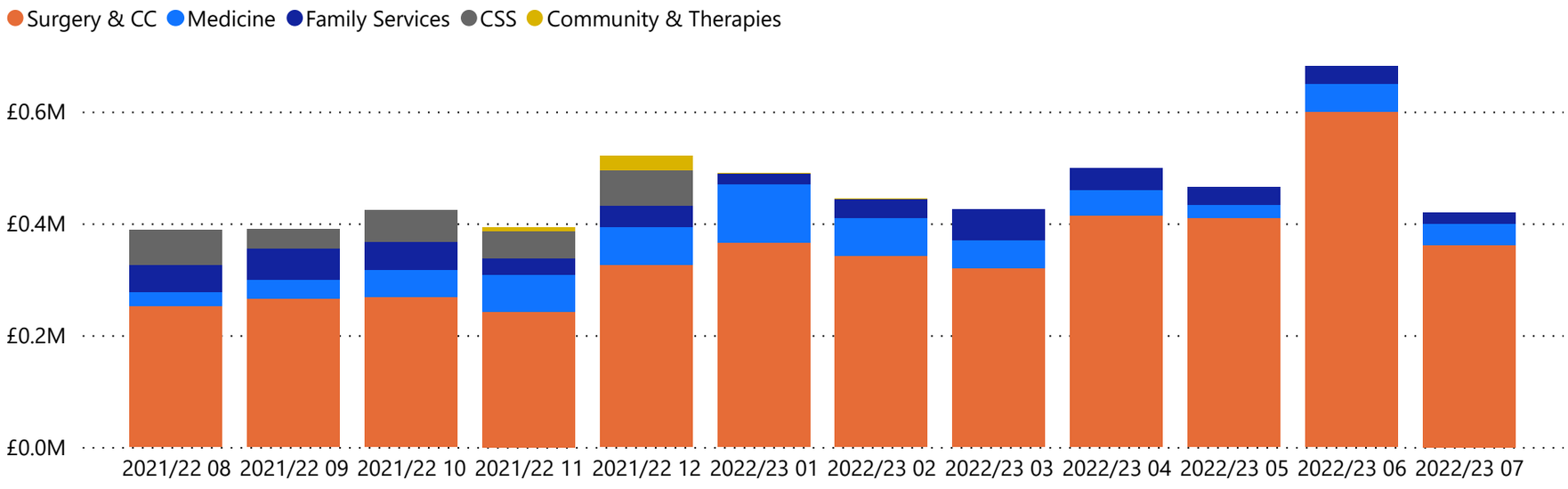
Additional Sessions

Updated M07 2022-23

HOME

Northern Lincolnshire and Goole NHS Foundation Trust

What is the cost of medical staff additional work?



Year

Multiple selections

Month[s]

Multiple selections

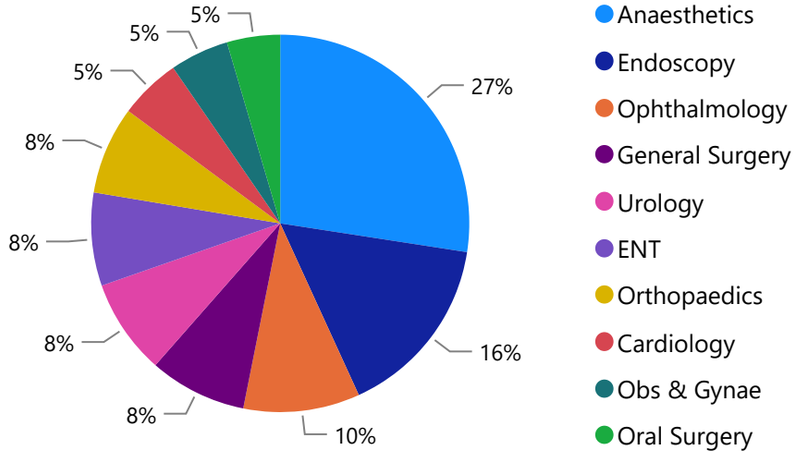
Work Day

All

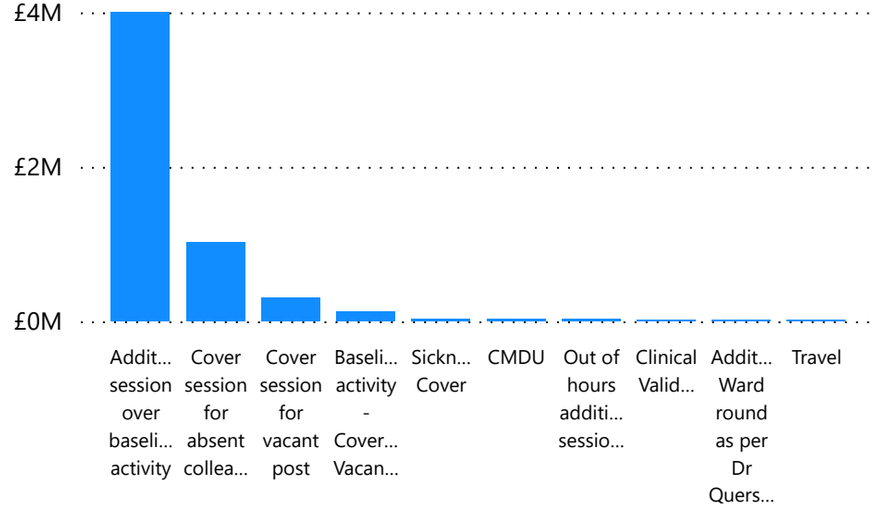
What is the bottom line spend on additional sessions?

£5.54M

Which 10 specialties spend most on medical staff additional work?



What reasons are given for medical staff additional work?



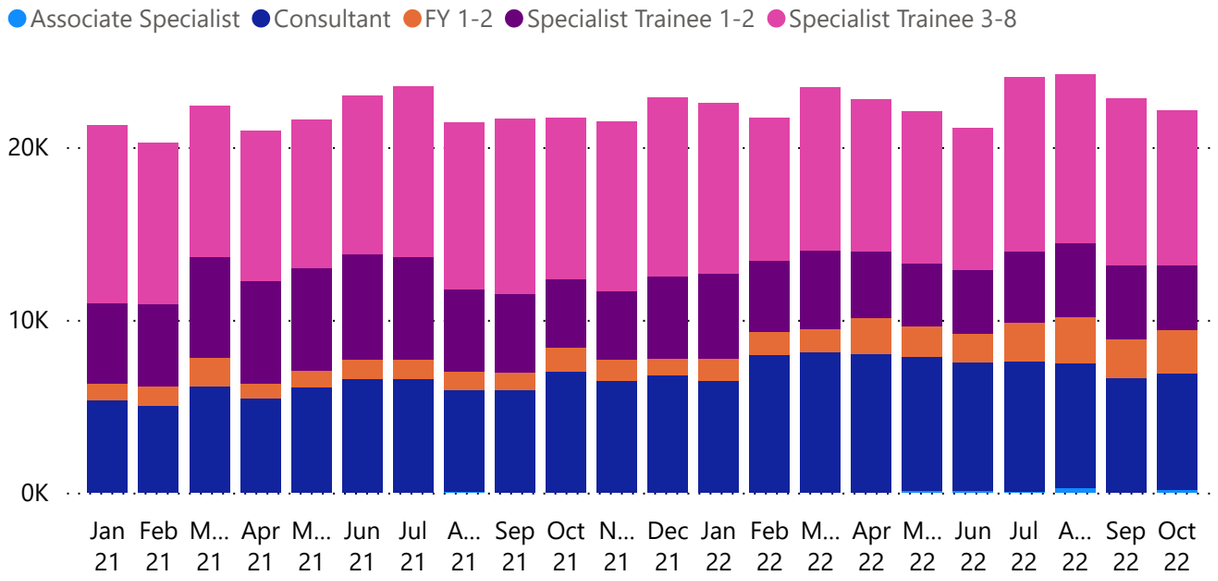
Rate & Volume

Updated M07 2022-23

HOME

Northern Lincolnshire and Goole NHS Foundation Trust

How many hours of temporary medical staff are we using each month?



What cost and hours are incurred by source?

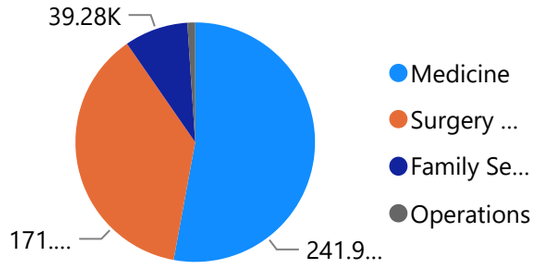
Filled By	Total Cost	Hours
Agency	£22,327,945	257,771.60
Care1Bank	£3,549,315	48,310.26
Internal Bank	£13,782,054	182,883.29

Period i.e., from, to...

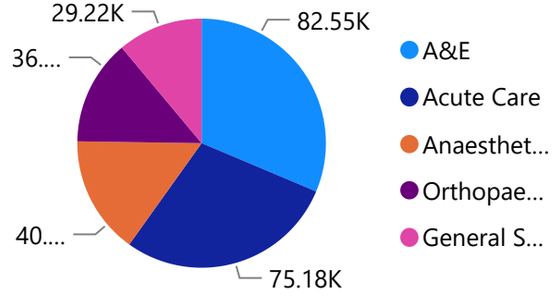
31/12/2020 01/10/2022

Select or drag fields to populate this visual

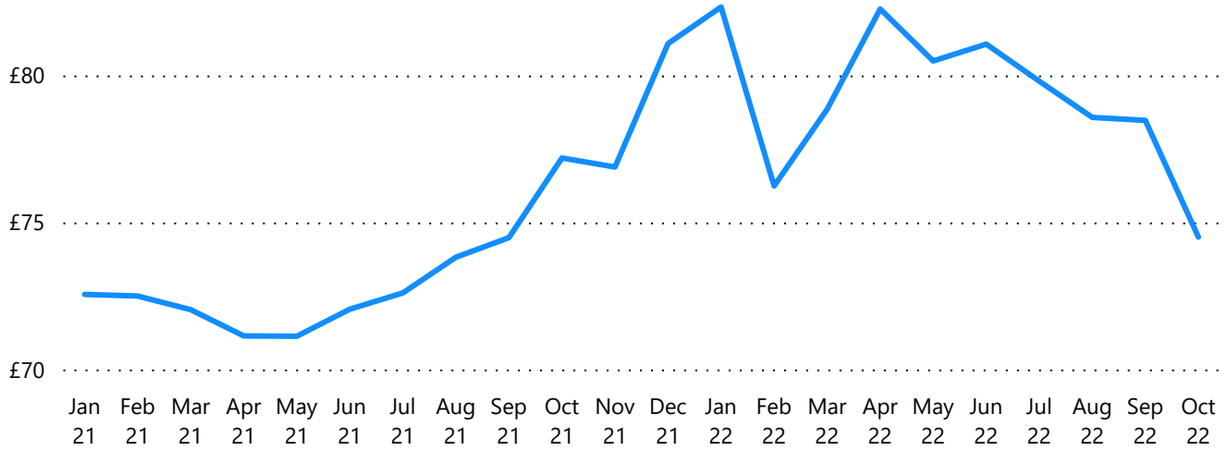
What hours occur across divisions?



Which 5 departments use most hours?

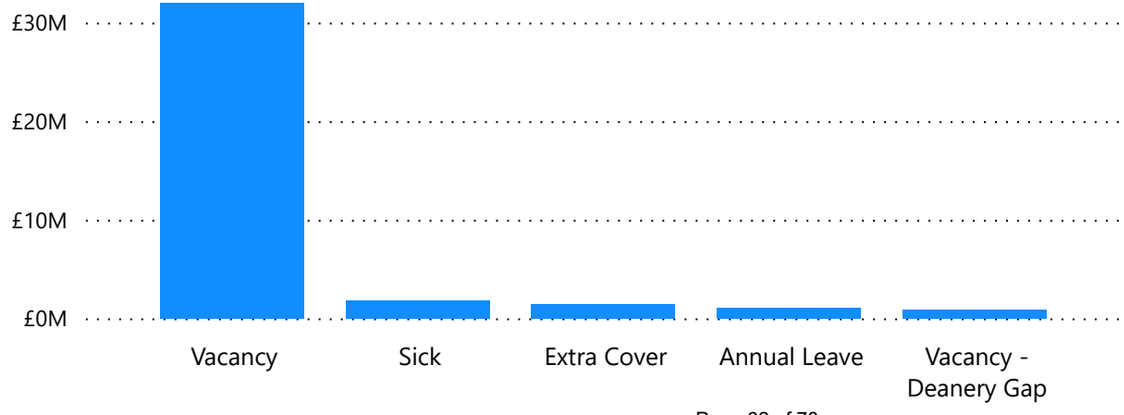


What is the pay cost per hour for temporary medical staff?



NOTE: A filter is by default applied to exclude COVID-19 expenditure.

What top 5 reasons given for temporary staff shift requests?



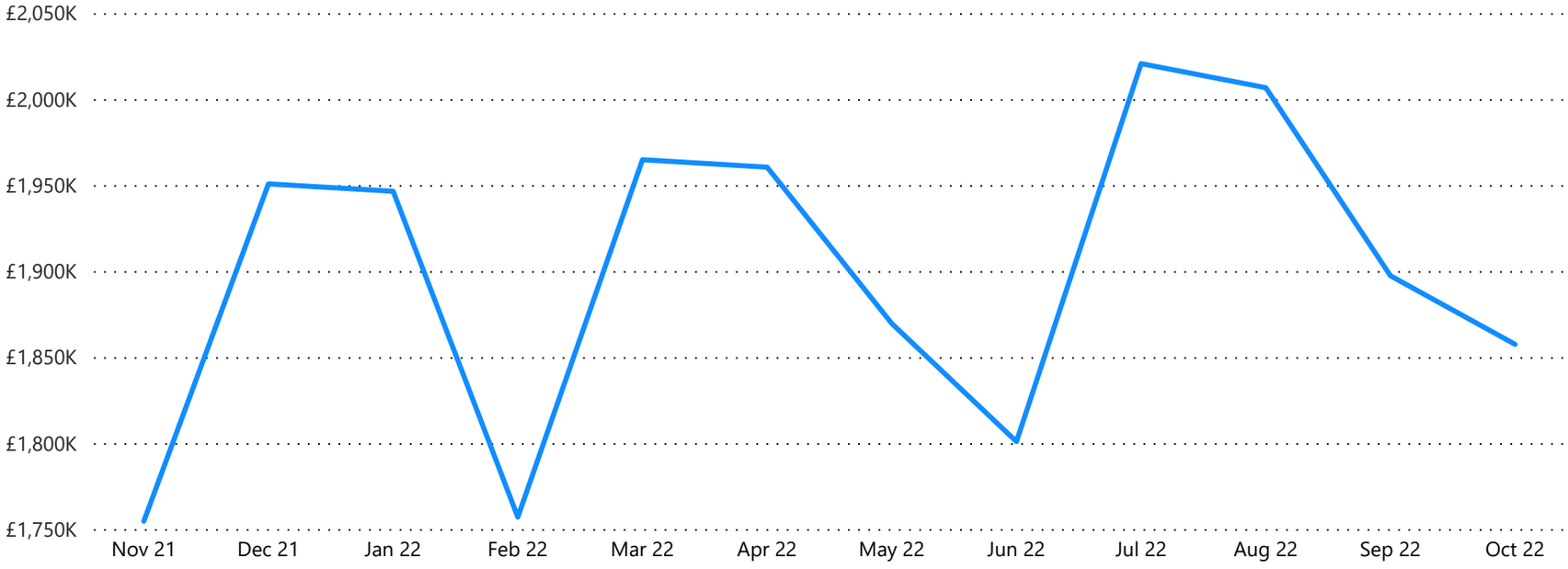
Temporary Staffing Cost

Updated M07 2022-23

HOME

Northern Lincolnshire and Goole NHS Foundation Trust

How much are we spending on temporary medical staff each month?



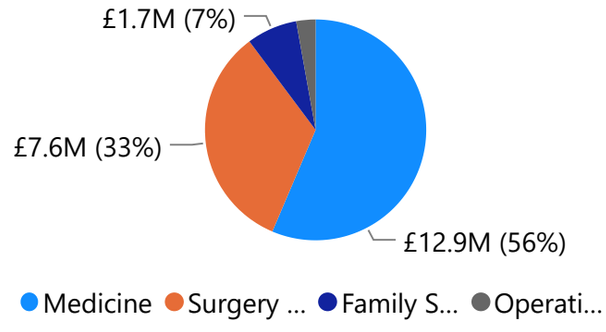
Period i.e., from, to...

01/11/2021 01/10/2022

Filled By	Total Cost	Hourly Pay
Agency	£12,283,250	£82.17
Internal Bank		

Select or drag fields to populate this visual

Where are temporary staff costs by division?

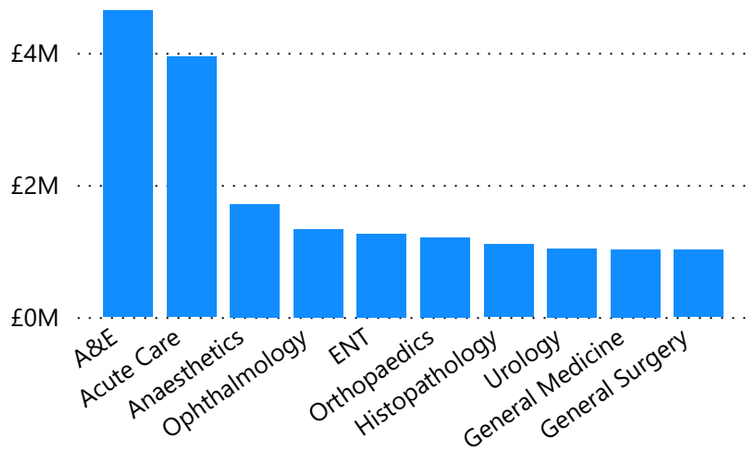


Which temporary staff are costing most?

Pseudonym	Specialty	Cost	Hours	Pay/ Hr
Doctor 1187	Acute Care	£398,042	3,096.00	£119.87
Doctor 1193				
Doctor 950	Haematology			
Doctor 1293				
Doctor 1742	A&E			
Doctor 56				
Doctor 616	Urology			
Doctor 1562				
Doctor 1192	ENT			

NOTE: A filter is by default applied to exclude COVID-19 expenditure.

Which 10 specialties spend most on temporary staffing?



What is the hourly cost of locums by grade?

Aligned Grade	Hourly Pay
Consultant	£102.43
Associate Specialist	£87.79
Specialist Trainee 3-8	£77.88
Nurse	£55.77

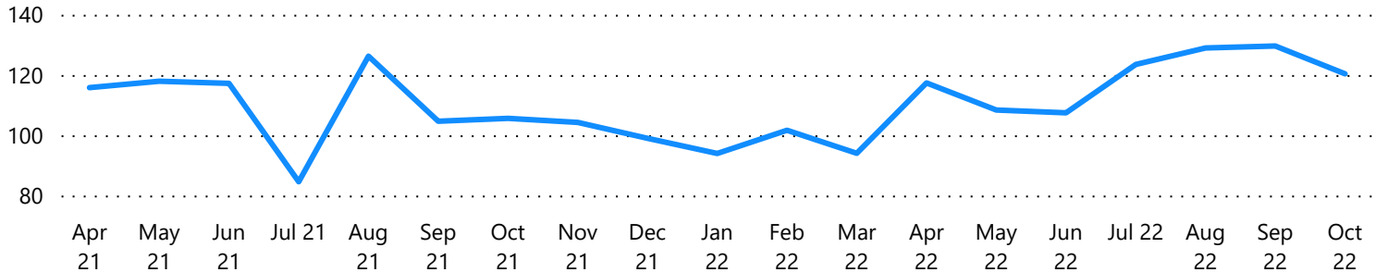
Medical Vacancies

Updated M07 2022-23

HOME

Northern Lincolnshire and Goole NHS Foundation Trust

Is the Trust managing medical vacancy position (WTE)?



How many vacancies are there (WTE)?

120.4

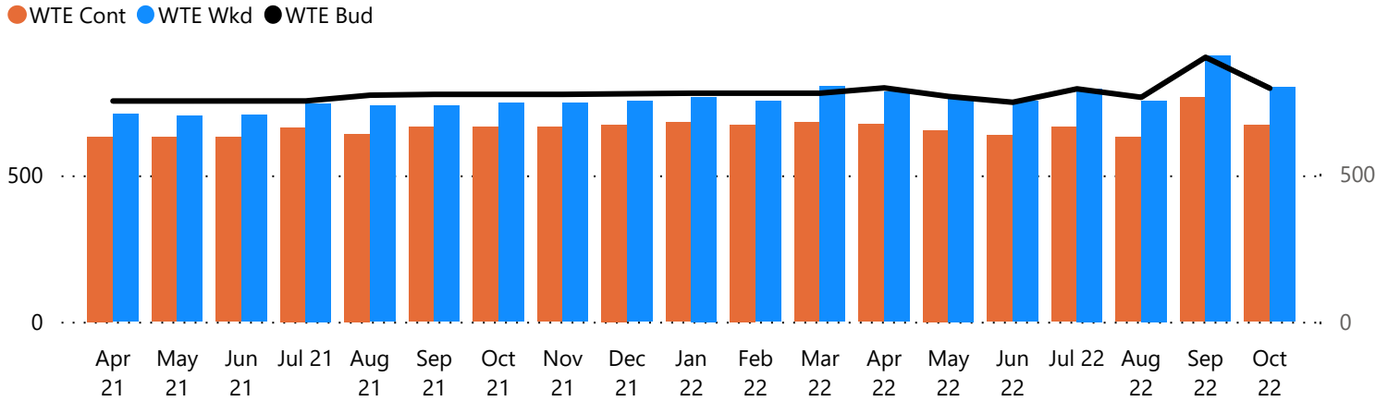
Year

Multiple selections

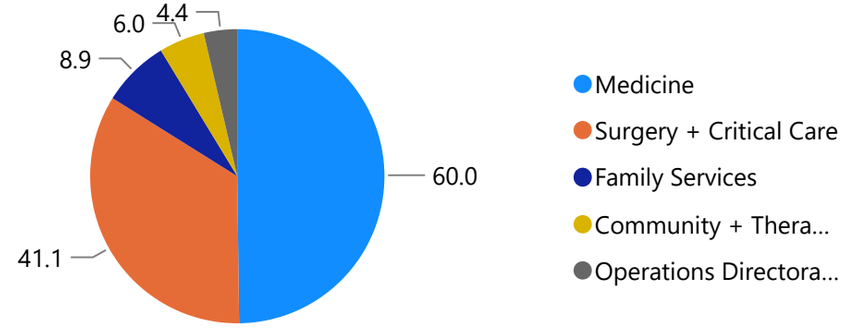
Period i.e., from, to...

01/04/2021 01/10/2022

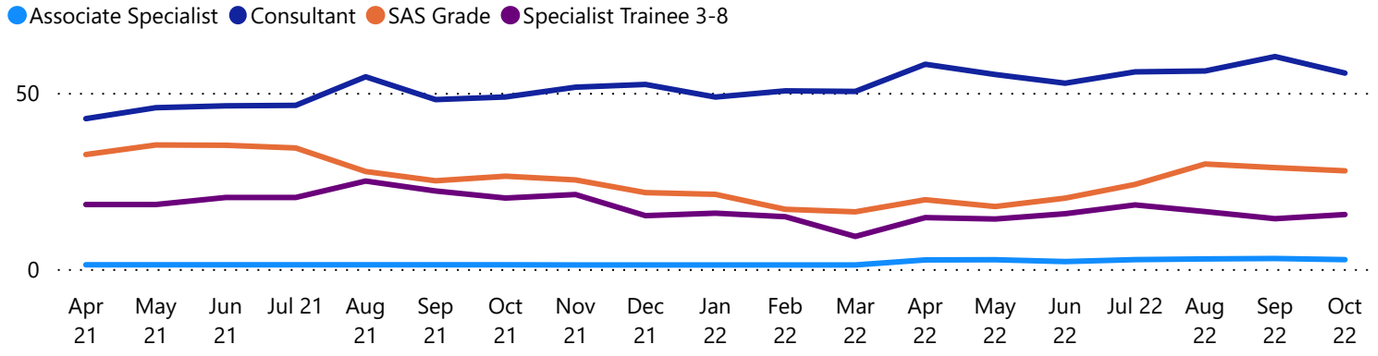
Is the Trust working within its budget for medical staff (WTE)?



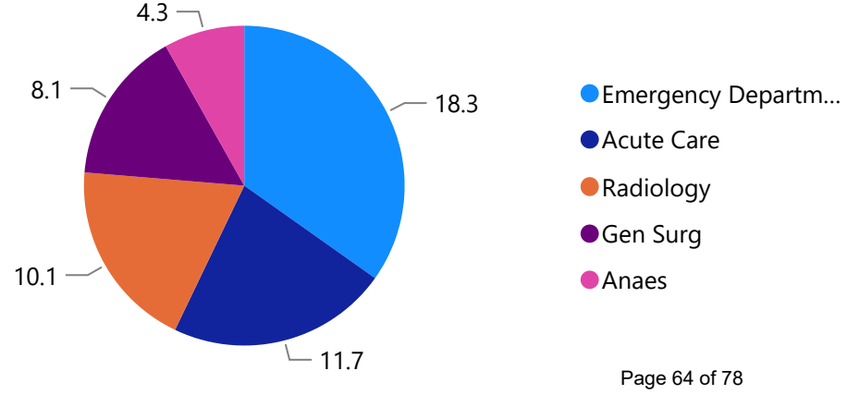
Which divisions have the most vacancies (WTE)?



Which grade of doctors have most vacancies (WTE)?



Which 5 specialties have the most vacancies (WTE)?



NOTE: A filter is by default applied to exclude COVID-19 expenditure and corporate areas.

Recruitment (example data)

Updated M00 2022-23 (awaiting Trac recruitment data)

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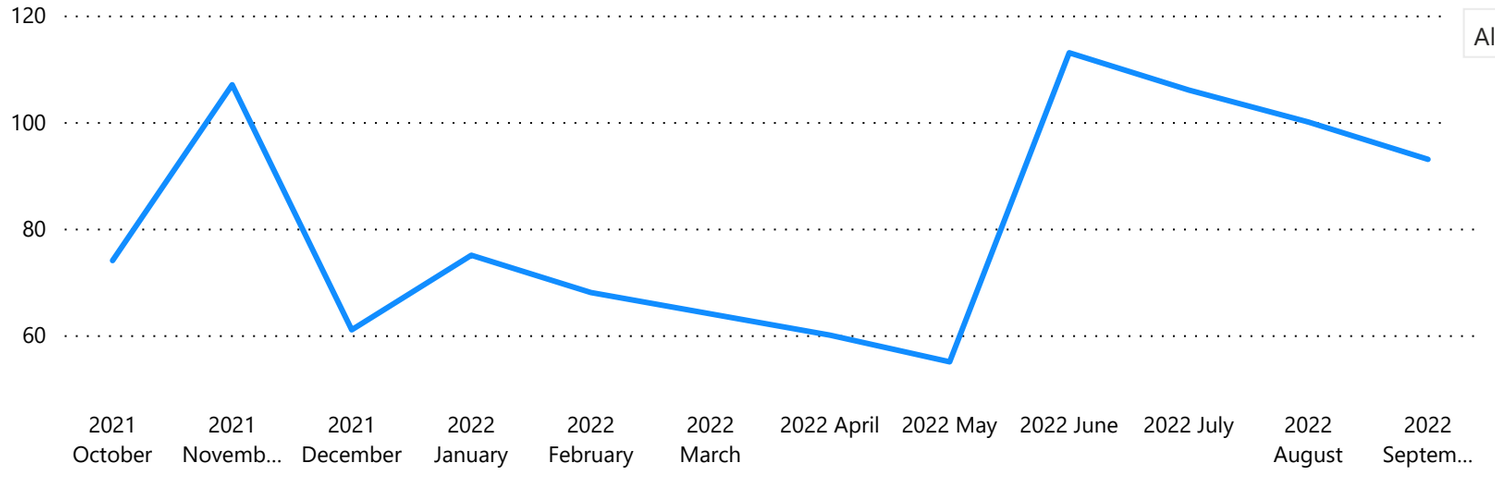
Northern Lincolnshire and Goole NHS Foundation Trust

How long does it take to recruit (days)?



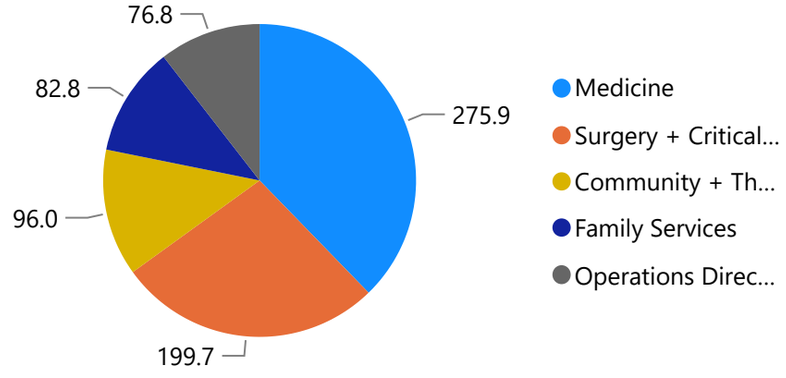
Status i.e., vacancy live...

All

Period i.e., from, to...

01/10/2021 01/09/2022

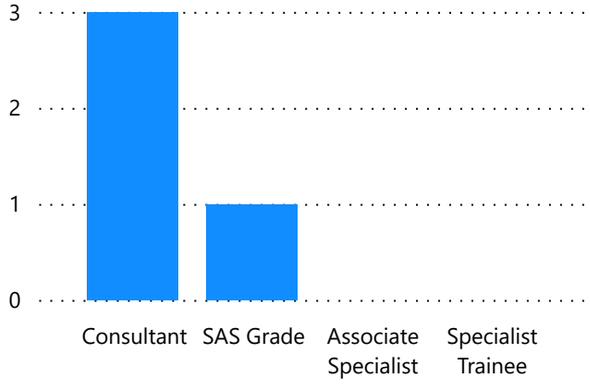
Which divisions have the most vacancies on Trac (WTE)?



How many vacancies are there (WTE)?

120.4

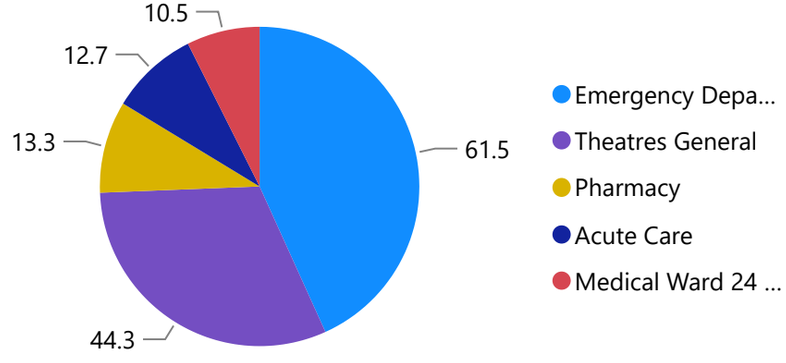
How many vacancies are currently being advertised?



What doctors are in our pipeline?

Doctors Name	Est. Start	Grade	Status
Example Doctor 1	15/02/23	Consultant	Offer pending
Example Doctor 10	10/02/23	SAS Grade	Offer pending
Example Doctor 11			
Example Doctor 12	19/01/23	SAS Grade	Awaiting reference
Example Doctor 13			
Example Doctor 14	30/01/23	SAS Grade	Awaiting reference
Example Doctor 15			
Example Doctor 16	03/12/22	Specialist Trainee	Start confirmed
Example Doctor 17			
Example Doctor 18	20/01/23	SAS Grade	Awaiting reference
Example Doctor 19			

Which 5 departments have the most vacancies on Trac (WTE)?



Starters and Leavers

Updated M07 2022-23

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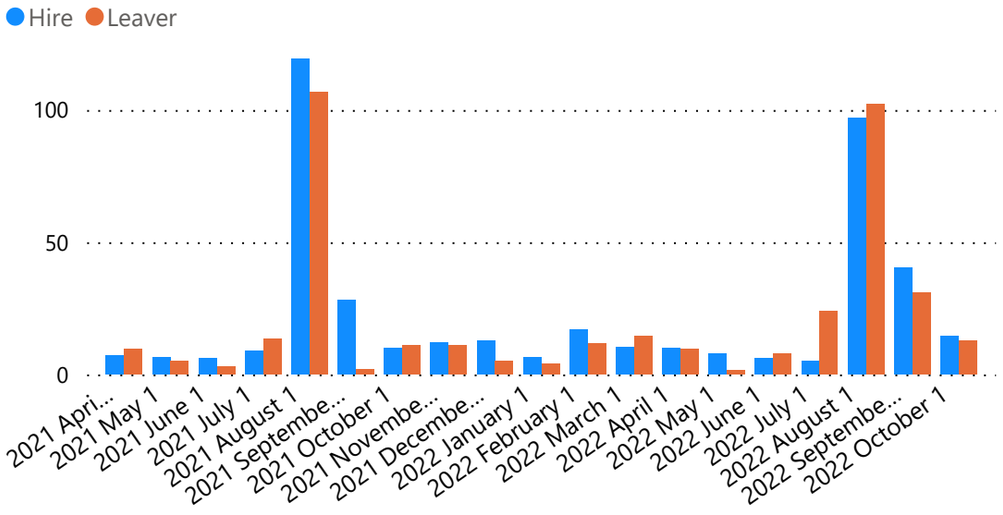
Northern Lincolnshire and Goole NHS Foundation Trust

Are medical staff coming or going (WTE)?



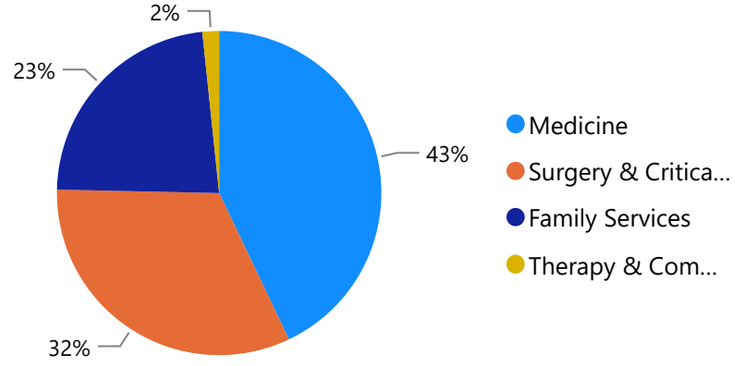
Which reasons are most commonly given for leaving?

Reason for Leaving	FTE
End of Fixed Term Contract	268.93
Voluntary Resignation - Other/Not Known	29.43
Voluntary Resignation - Relocation	23.17
Voluntary Resignation - To undertake further education or training	20.00
End of Fixed Term Contract - Other	11.91
End of Fixed Term Contract - Completion of Training Scheme	7.00
Retirement Age	6.82
Flexi Retirement	3.31
End of Fixed Term Contract - External Rotation	2.80
Voluntary Resignation - Better Reward Package	2.00
Total	**385.76**

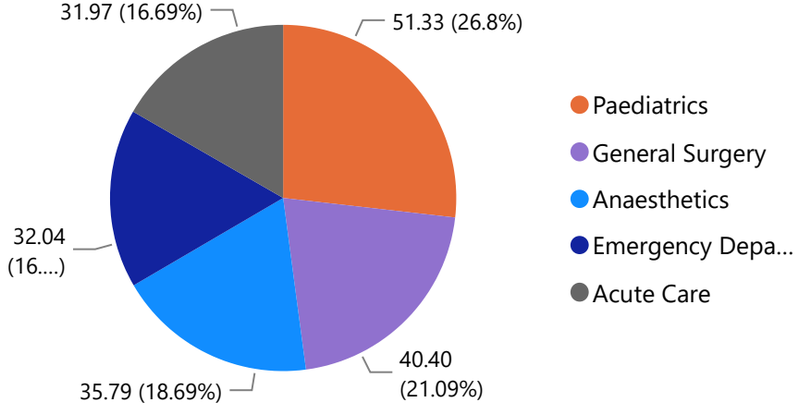
Hire/ Leaver

Leaver

Which divisions have most starters/ leavers (WTE)?



Which 5 specialties have most starters/ leavers (WTE)?



Start/ Termination Date

01/04/2021 01/10/2022

Permanent/ Fixed-term

Assignment Category

Multiple selections

How many doctors came/ went by grade (WTE)?

Job Role	FTE
Specialty Registrar	156.94
Foundation Year 2	74.78
Foundation Year 1	56.00
Specialty Doctor	33.55
Trust Grade Doctor - Specialty Registrar	29.00
Consultant	27.68
Trust Grade Doctor - Foundation Level	6.00
Associate Specialist (Closed to new entrants)	1.00
Dental Officer	0.80
Total	**385.76**

Sickness

Updated to 23/09/2022 (absence reporting is always 6 weeks behind)

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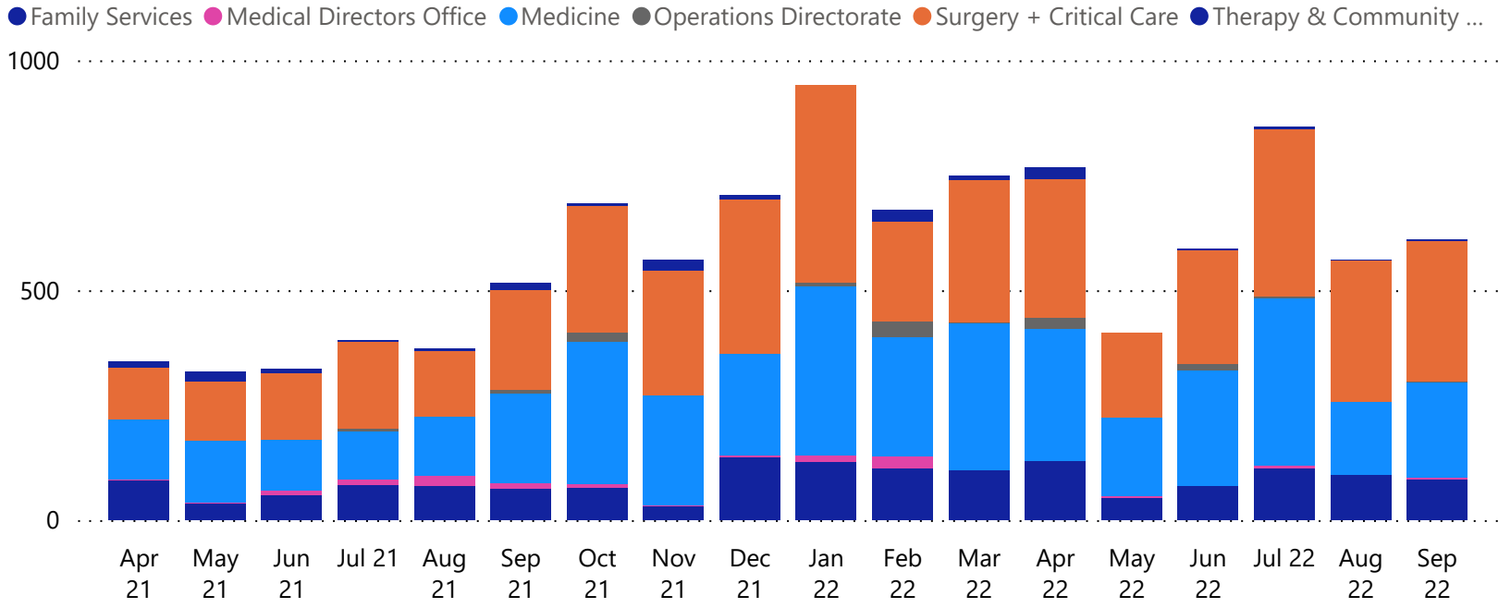
Northern Lincolnshire and Goole NHS Foundation Trust

Note: Data quality may be a problem due to medical staff sickness reporting.

How many days absence have been recorded?



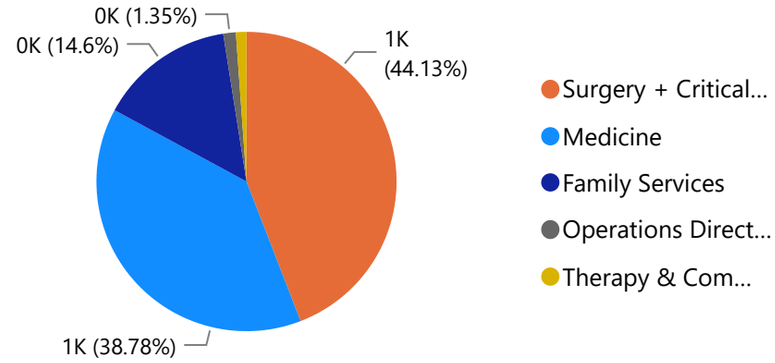
Period i.e., from, to...

01/04/2021 — 23/09/2022

Site

All

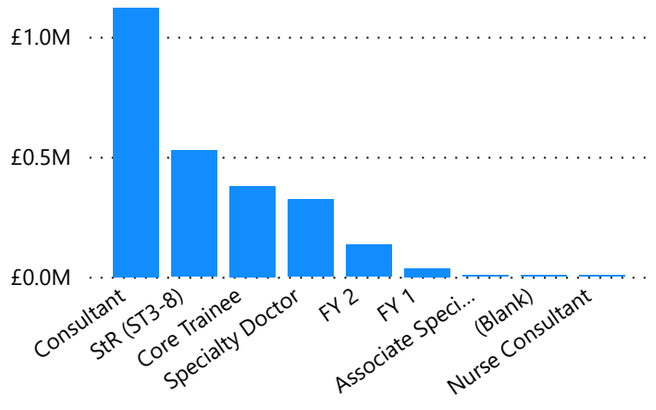
Which divisions had most days lost YTD?



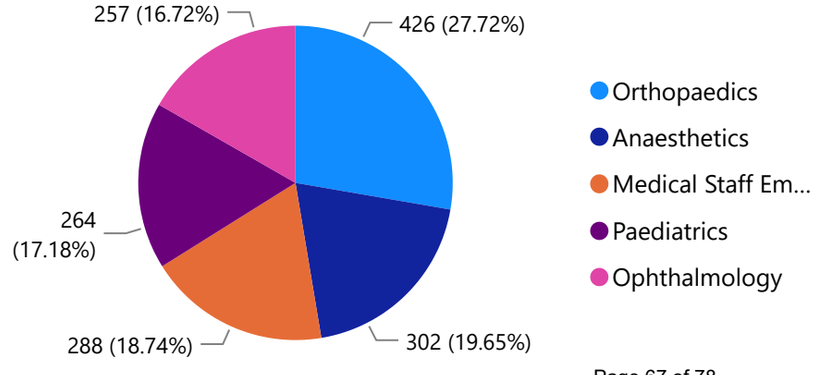
What reasons are given for medical sickness?

Absence Reason	Absence Days YTD 2022-23	Absence Days YTD 2021-22
S10 Anxiety/stress/depression/other psychiatric illnesses	271	318
S11 Back Problems	69	91
S12 Other musculoskeletal problems	197	132
S13 Cold, Cough, Flu - Influenza	1533	238
S14 Asthma	0	0
Total	**3187**	**1762**

What has been spent on temporary staffing YTD due to medical sickness?



Which 5 specialties had most days lost YTD?



Job Planning

Updated M07 2022-23

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Northern Lincolnshire and Goole NHS Foundation Trust

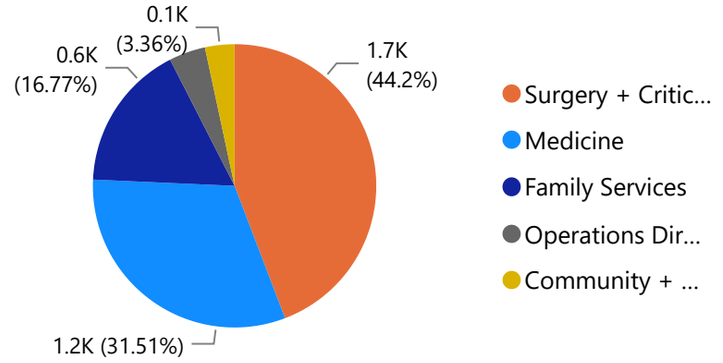
Which doctors have the most PAs?

Pseudonym	Directorate	Department	SPA	Total PAs	Status
Doctor 150	Medicine	Emergency Medicine SGH (Medic)	9.8	12.5	In 'Discussion' stage
Doctor 2	Surgery + Critical Care	Endoscopy Services	5.5	7.5	Awaiting 1st sign-off - awaiting doctor agreement
Doctor 106	Medicine			13.6	Signed-off
Doctor 36	Family Services	Breast Surgery DPOW (Medic)	4.9	11.8	In 'Discussion' stage
Doctor 152	Medicine			13.7	In 'Discussion' stage
Doctor 289	Surgery + Critical Care		4.4	15.0	Signed-off
Doctor 186	Medicine			13.0	In 'Discussion' stage

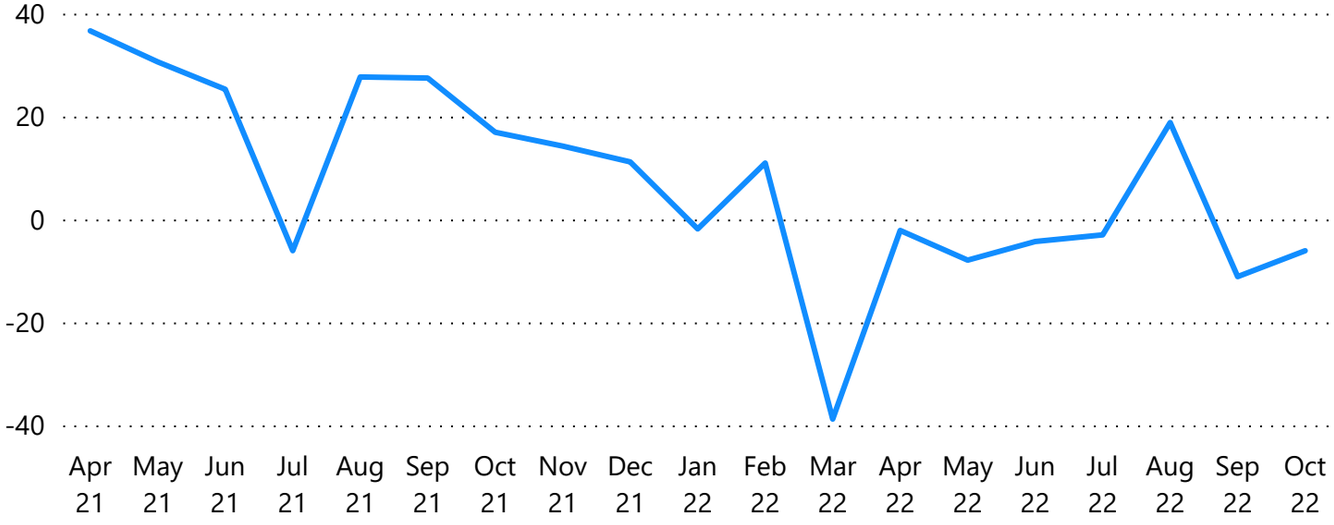
Filter on total PAs

0.8 — 15.9

Count of Job Plans by Division



WTE Variance (Bud - Wkd)



NOTE: Does not reconcile with ESR or finance system.

What is the job plan status by division?

Status	Job Plans (No)	Job Plans (%)
In 'Discussion' stage	**172**	**50%**
Surgery + Critical Care	78	23%
Medicine	61	18%
Family Services	21	6%
Community + Therapy	7	2%
Operations Directorate	5	1%
Signed-off	**74**	**22%**
Medicine	30	9%
Total	**342**	**100%**

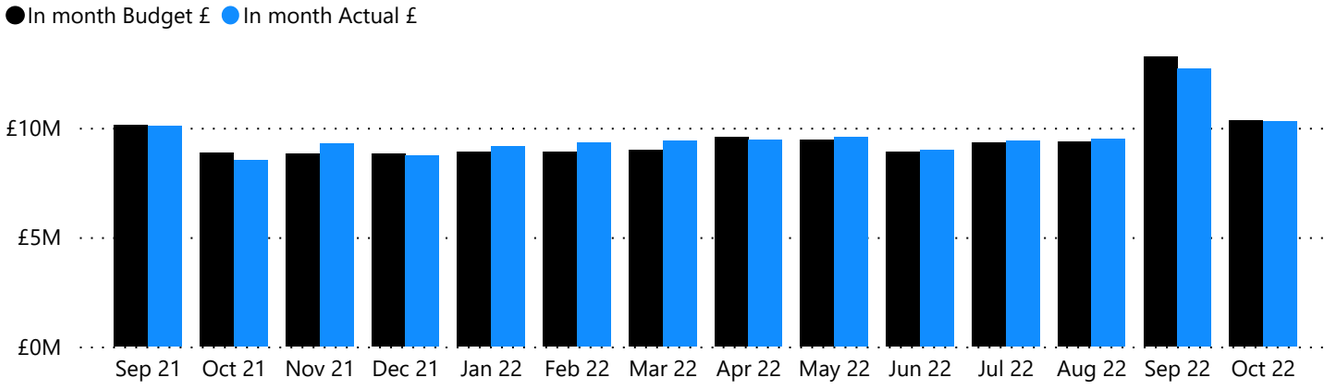
Spend

Updated M07 2022-23

HOME

Northern Lincolnshire and Goole NHS Foundation Trust

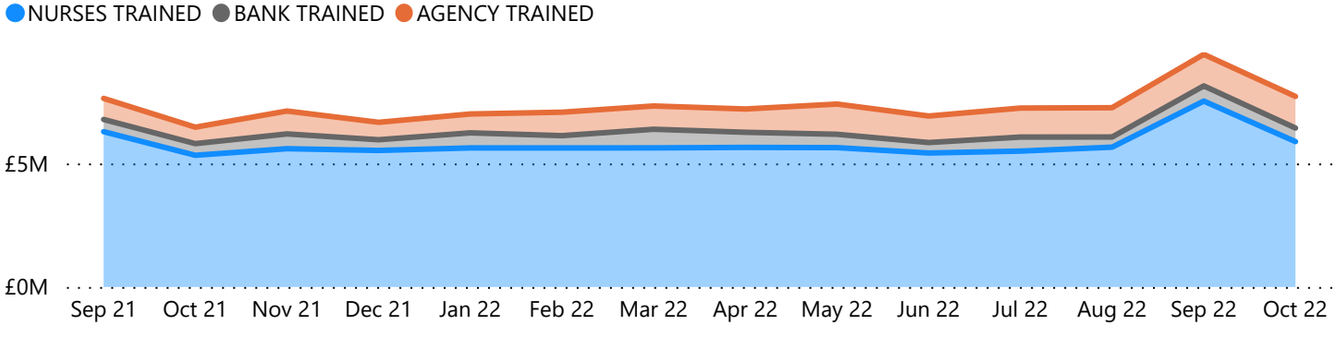
Is the Trust 'living within its means' for nursing workforce?



Is nursing spend YTD under control?

Staff Source	2022-23 YTD Budget (£)	2022-23 YTD Actual (£)	2022-23 YTD Actual (%)	2021-22 YTD Actual (£)	Change YTD Actual (%)
NURSES TRAINED	£43,590,746	£35,398,965	77.89%	£32,752,457	8%
AGENCY TRAINED	£1,259,029	£6,878,491	15.13%	£5,216,274	32%
BANK TRAINED	£269,887	£3,170,774	6.98%	£2,855,051	11%
Total	**£45,119,662**	**£45,448,230**	**100.00%**	**£40,823,782**	**11%**

Is temporary staffing spend going up or down?



NOTE: A filter is by default applied to exclude COVID-19 expenditure and corporate areas.

Which departments have the greatest budget variance?

Specialty	2022-23 YTD Variance
Emergency Department	-£792,379
Medical Ward (Aau Yb)	-£382,886
Medical Ward B2 (Aau Ya)	-£271,652

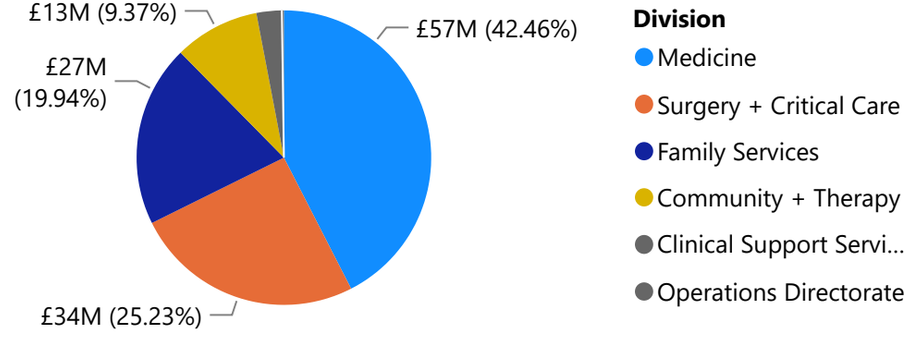
Period i.e., from, to?

01/09/2021 — 01/10/2022

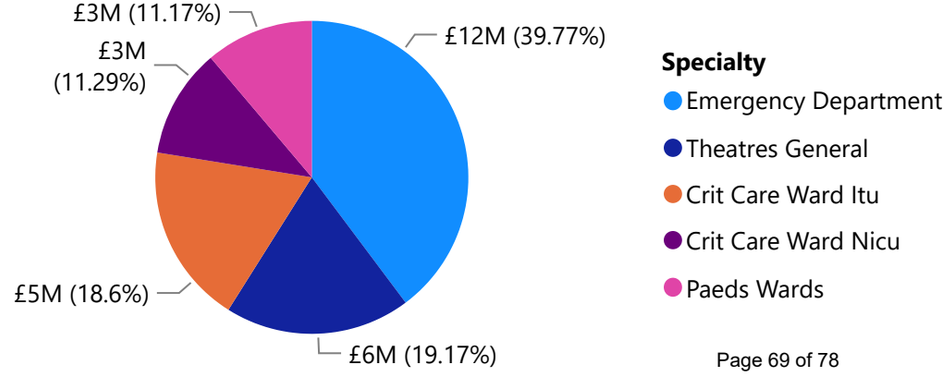
Site i.e., DPOW?

All

Where is nursing spend by division?



What are the top 5 specialties on nursing spend?



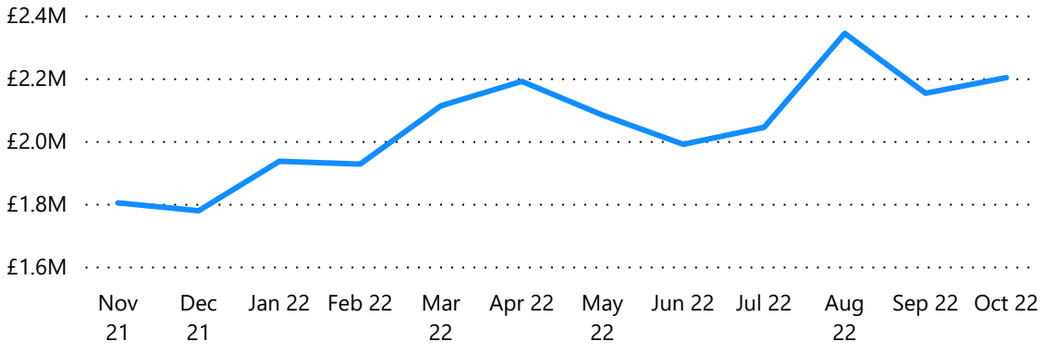
Temporary Staffing Rate

Updated M07 2022-23

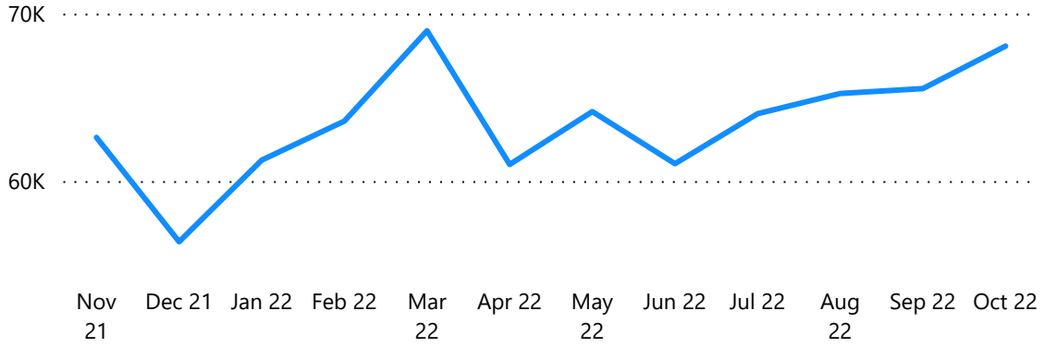
HOME

Northern Lincolnshire and Goole NHS Foundation Trust

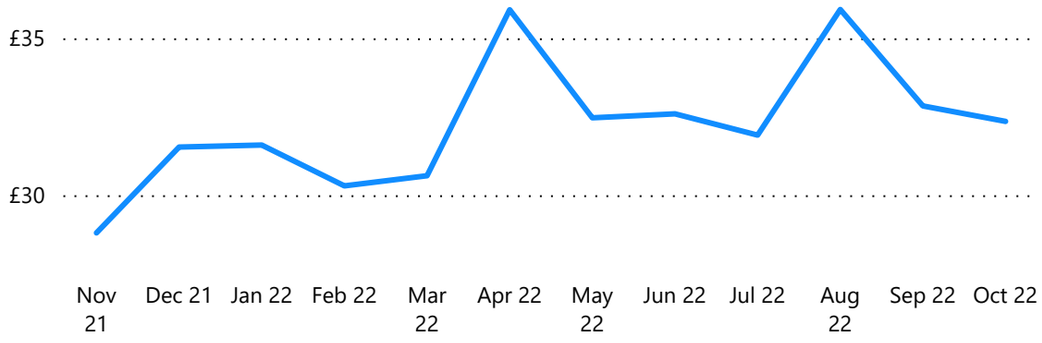
What does it cost?



How many hours?



What cost per hour i.e., rate?



NOTE: A filter is by default applied to exclude COVID-19 expenditure and corporate areas.

What costs are incurred by staff type and source?

Type	Staff Type	Cost	Hours	Cost/ Hr
Agency	Trained	£12,698,078	291,554	£43.55
Bank	Trained	£6,674,167	216,641	£30.81
	Untrained	£5,186,051	253,642	£20.45

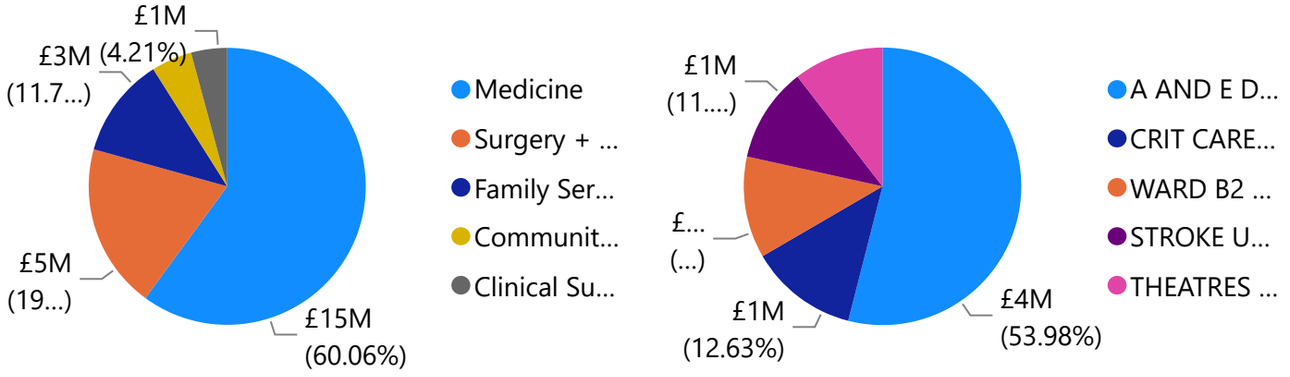
Period i.e., from, too...

01/11/2021 — 01/10/2022

Site i.e., DPOW...

All

What spend occurs across divisions?



Which 5 departments cost most?

Which suppliers are costing most?

Supplier	Cost	Hours	Cost/ Hr
Bank	£11,838,371	470,256	£25.17
Thornbury	£2,192,004	25,451	£86.13
Altrix	£1,970,360	50,241	£39.22
TFS Healthcare	£1,407,588	36,783	£38.27
Coyle (Nutrix)	£1,018,578	21,437	£47.51
Arcadia	£999,936	26,113	£38.29
Next Step	£877,419	20,877	£42.03
NL Group	£784,975	19,302	£40.67

Which temporary staff are costing most?

Pseudonym	Cost	Hours	Cost/ Hr
Temp Nurse 3054	£123,939	2,579	£48.05
Temp Nurse 2445	£117,774	2,535	£46.47
Temp Nurse 983	£105,684	2,275	£46.46
Temp Nurse 1925	£102,008	2,172	£46.96
Temp Nurse 2617	£96,070	2,073	£46.34
Temp Nurse 3266	£94,180	2,494	£37.77
Temp Nurse 1517	£94,091	2,076	£45.33
Temp Nurse 2548	£93,929	2,450	£38.34

Temporary Staffing Reason

Updated M07 2022-23

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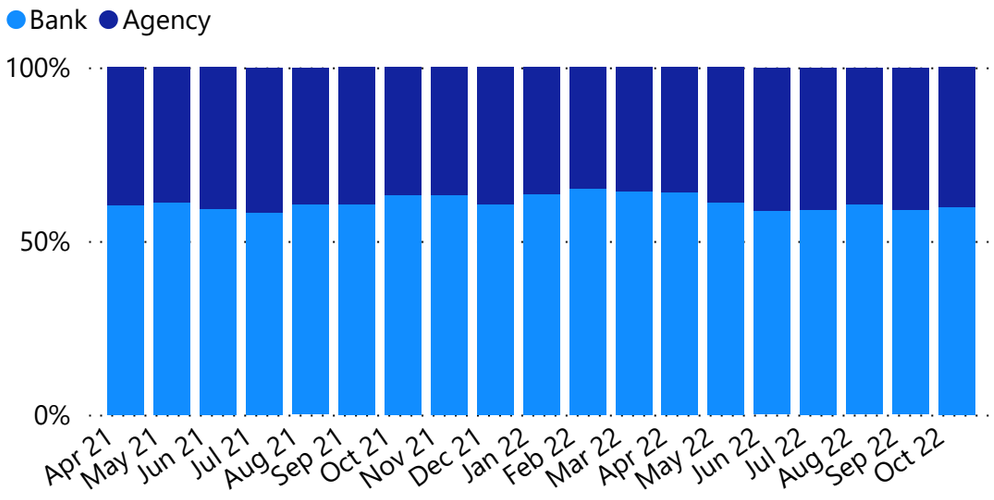
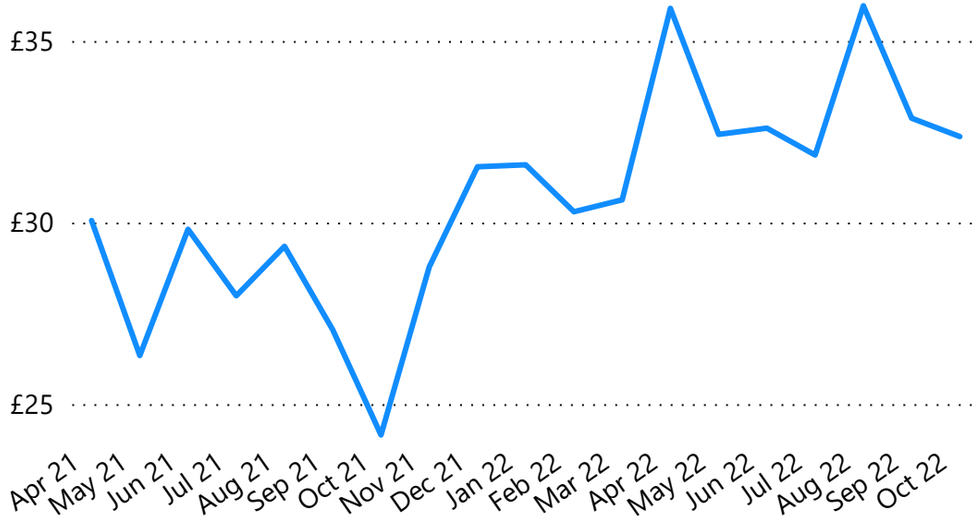
Northern Lincolnshire and Goole NHS Foundation Trust

How are we sourcing temporary staff?



What is hourly cost of temporary nursing staff?



NOTE: A filter is by default applied to exclude COVID-19 expenditure and corporate areas.

What cost and volume is incurred by staff type and source?

Type	Staff Type	Cost	Hours	Cost/ Hr
Agency	Trained	£18,612,967	455,297	£40.88
Bank	Trained	£9,905,590	331,280	£29.90
	Untrained	£7,442,492	386,074	£19.28

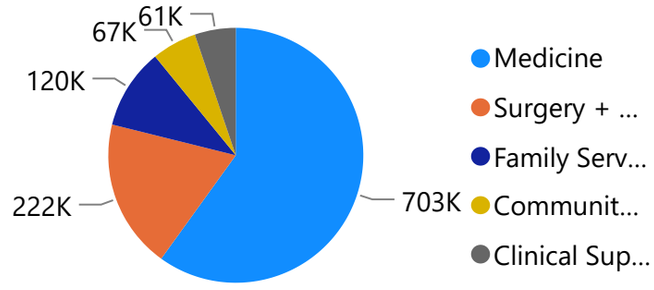
Period i.e., from, to...

01/04/2021 — 01/10/2022

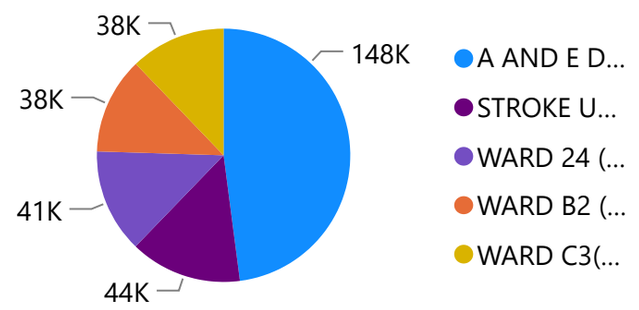
Site i.e., DPOW?

Multiple selections

What hours occur across divisions?



Which 5 departments use most hours?



What reasons are given when requesting temporary staffing shifts?

Reason	Cost	Hours	Cost/ Hr
Vacancy	£22,537,882	686,454	£32.83
Other	£9,392,538	299,755	£31.33
Sickness	£5,722,844	173,890	£32.91
COVID	£317,931	11,781	£26.99

What detailed reason is given when requesting shifts?

Detailed Reason	Cost	Hours	Cost/ Hr
Vacancy	£20,334,757	626,508	£32.46
Short term sickness	£3,586,219	104,217	£34.41
Estab Vacancies	£2,197,327	59,730	£36.79
LT sickness - > 4 weeks	£1,703,429	55,450	£30.72
High Acuity	£1,607,951	56,487	£28.47
Redeployed staff	£1,565,287	41,095	£38.09
Escalation Beds	£1,549,527	44,596	£34.75
Annual leave	£951,557	33,222	£28.64
Additional Clinical Session	£691,695	24,661	£28.05

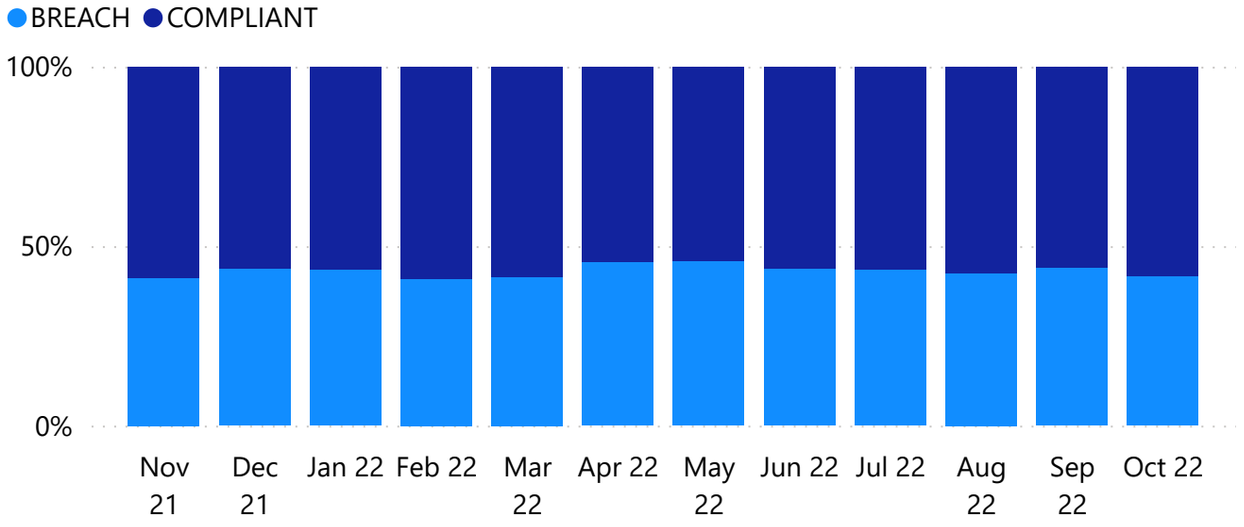
Rate Compliance (WIP)

Updated M07 2022-23

HOME

Northern Lincolnshire and Goole NHS Foundation Trust

What proportion of hours are over the national rate ceiling?



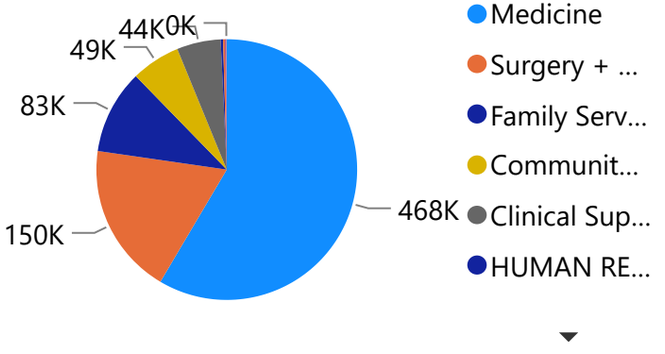
Period i.e., from, to...

01/11/2021 01/10/2022

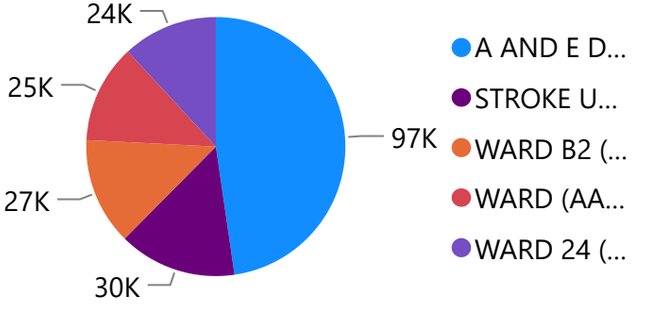
Site i.e., DPOW?

All

What hours occur across divisions?



Which 5 departments use most hours?



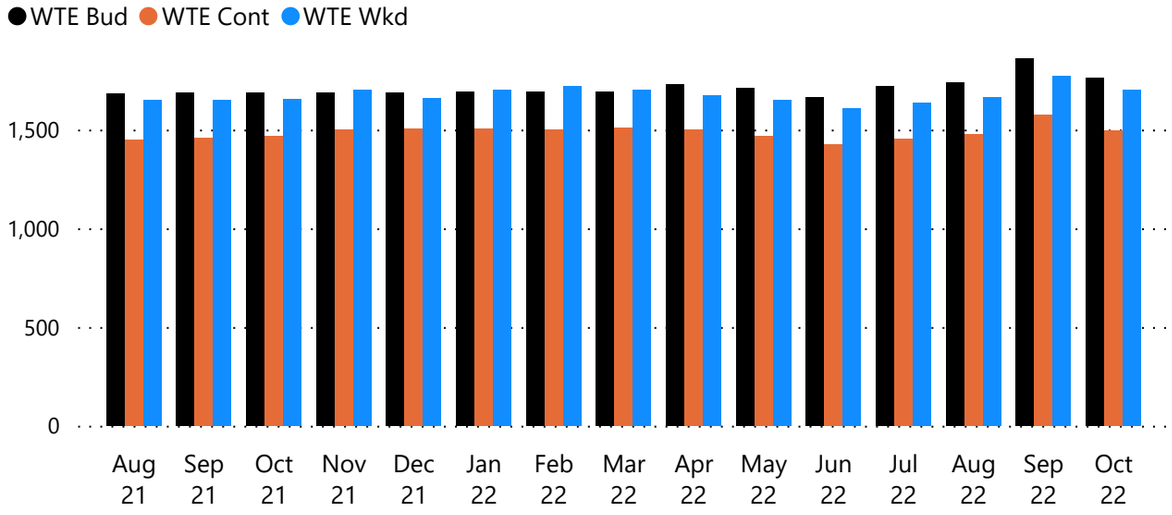
Vacancies

Updated M07 2022-23

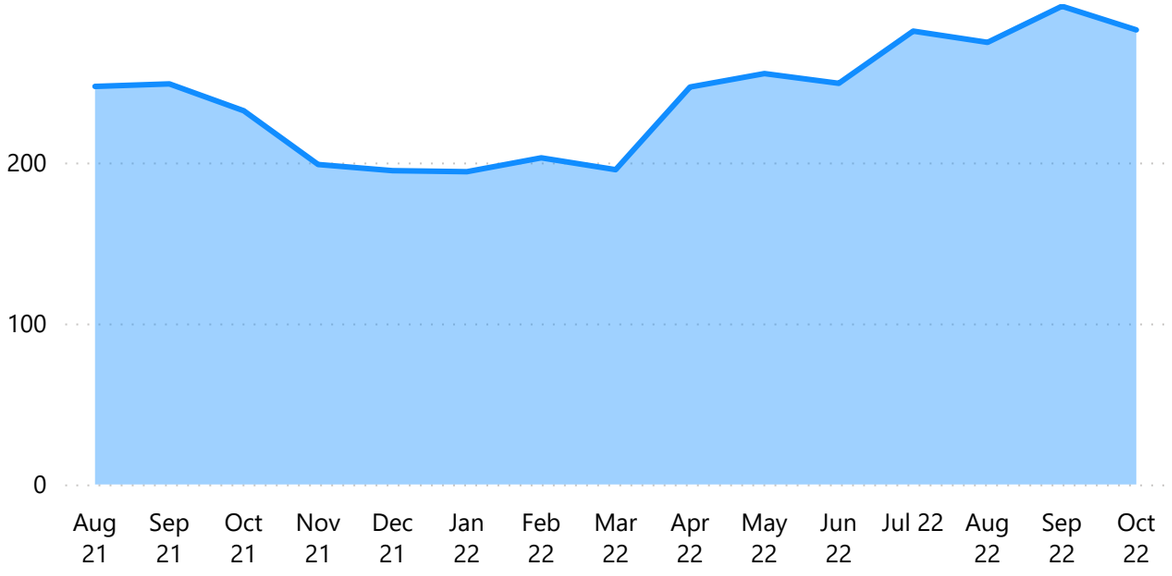
HOME

Northern Lincolnshire and Goole NHS Foundation Trust

Is the Trust 'living within its means' for nursing workforce (WTE)?



Are we reducing nursing vacancies (WTE)?

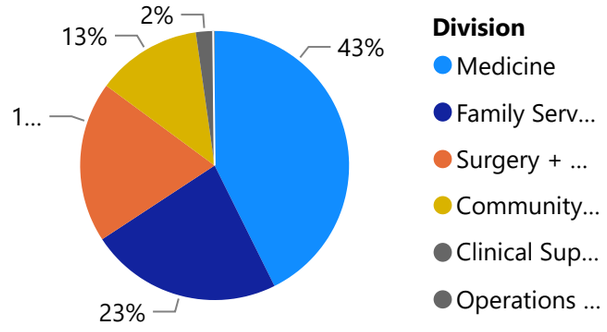


NOTE: A filter is by default applied to exclude COVID-19 expenditure and corporate areas.

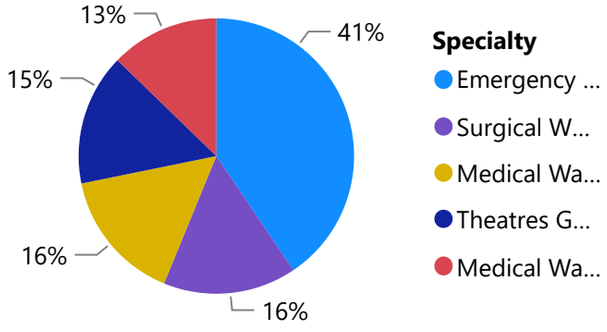
How many vacancies are there (WTE)?

282.4

Where are nursing vacancies by division?



Which 5 departments have most nursing vacancies?



Period i.e., from, to?

01/08/2021 — 01/10/2022

Focus on RN/ HCA?

Registered Nurs,Midw,Health Vi

Site i.e., DPOW?

All

Which departments have most WTE variance?

Specialty	Var Sep 22	Vac Sep 22
Trainee Advanced Clinical Practitioners	13.00	12.0
Care Network East	9.85	11.3
Care Network West	7.88	5.0
Care Network South	6.85	7.5
Midwifery Athena Team	6.58	6.2
Paeds Wards	6.42	5.4
Mid Community Team	5.58	6.2
Crit Care Ward Nicu	5.48	8.6
Network Hub	4.81	4.3

Recruitment

Updated M00 2022-23

HOME

Northern Lincolnshire and Goole NHS Foundation Trust

Page is a work in progress. Awaiting recruitment Trac data...

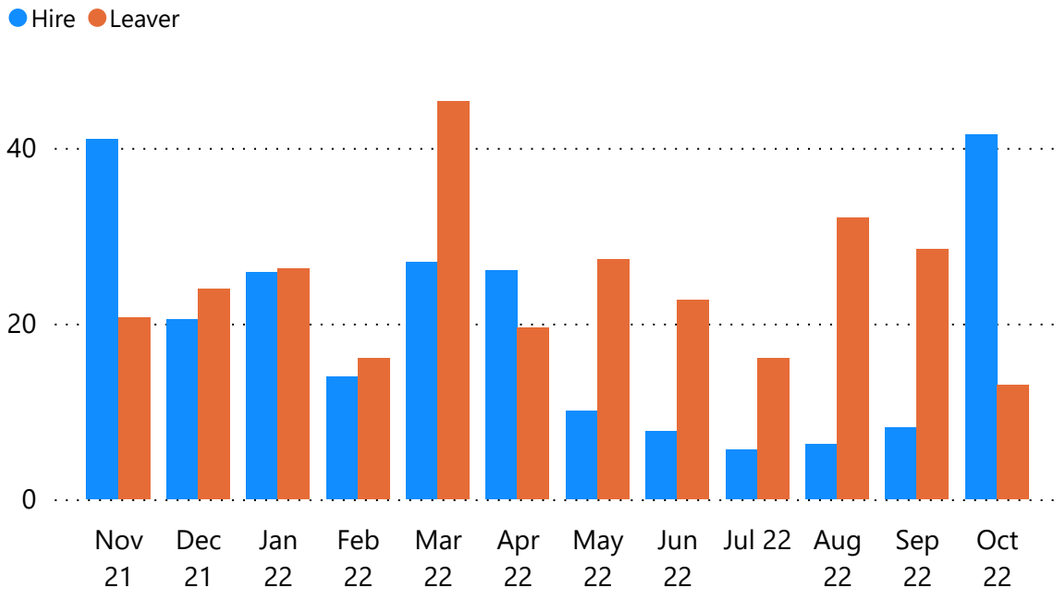
Starters and Leavers

Updated M07 2022-23

HOME

Northern Lincolnshire and Goole NHS Foundation Trust

Are nursing staff coming or going (WTE)?



Why are people going?

Reason for Leaving	FTE
Voluntary Resignation - Other/Not Known	56.53
Flexi Retirement	38.22
Retirement Age	34.30
Voluntary Resignation - Relocation	33.32
Voluntary Resignation - Work Life Balance	26.28
Voluntary Resignation - Promotion	23.13
Voluntary Resignation - Better Reward Package	12.92
End of Fixed Term Contract	11.48
Voluntary Resignation - Health	9.92
Total	**291.32**

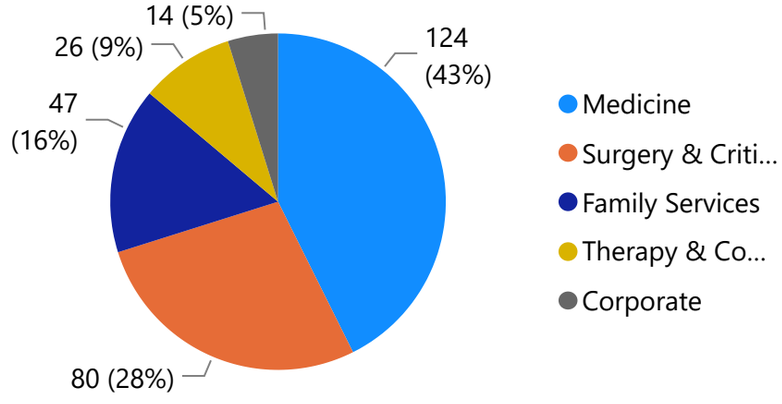
RN/ HCA

Multiple selections

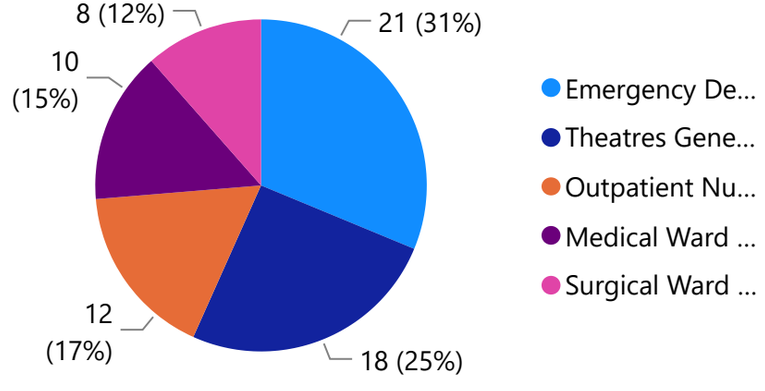
Hire/ Leaver

Leaver

Which divisions have most starters/ leavers (WTE)?



Which 5 departments have most starters/ leavers (WTE)?



Start/ Termination Date

01/11/2021 — 01/10/2022

Permanent/ Fixed-term

All

NET Position...

-57.74

What volume are coming/ going by role?

Job Role	FTE
Healthcare Assistant	107.40
Staff Nurse	94.46
Midwife	16.51
Specialist Nurse Practitioner	13.20
Nurse Manager	12.90
Sister/Charge Nurse	11.28
Community Nurse	10.17
Community Practitioner	6.37
Health Care Support Worker	6.04
Advanced Practitioner	3.00
Total	**291.32**

Nursing Sickness

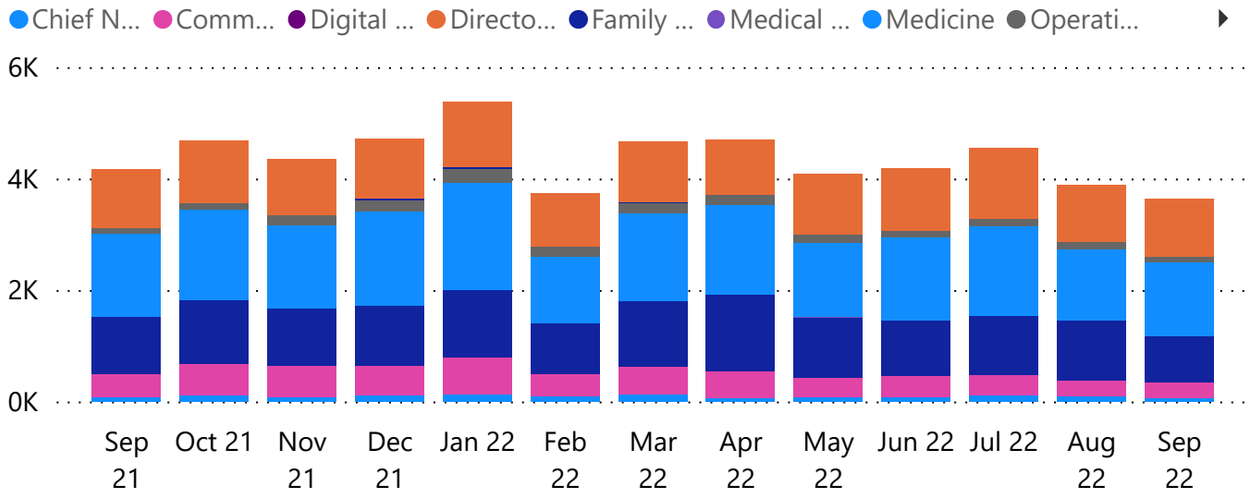
Updated to 23/09/2022 (reported 6 weeks behind)

HOME

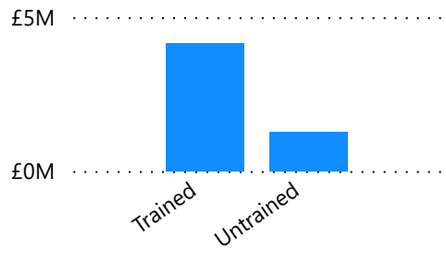
Northern Lincolnshire and Goole NHS Foundation Trust

Note: Data quality may be a problem due to medical staff sickness reporting.

How many absence days have been recorded?



Sickness temp staff cost YTD?

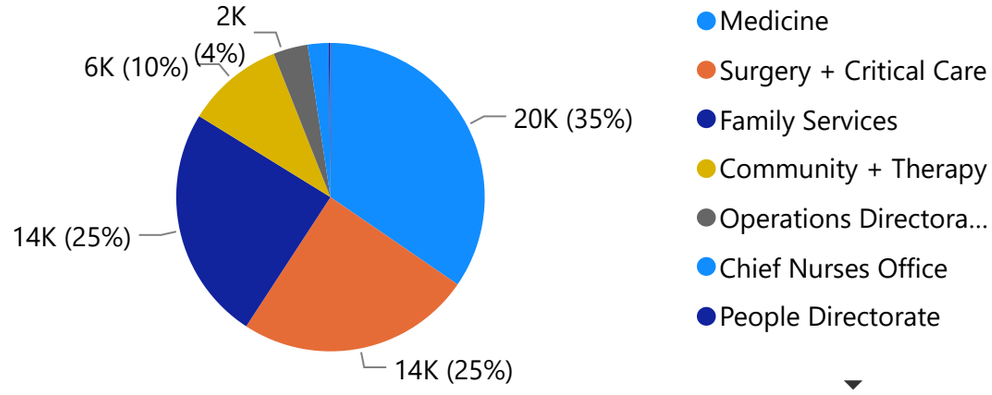


Period i.e., from, to...

01/09/2021 — 23/09/2022

Site: All

Which divisions are recording most absence days?



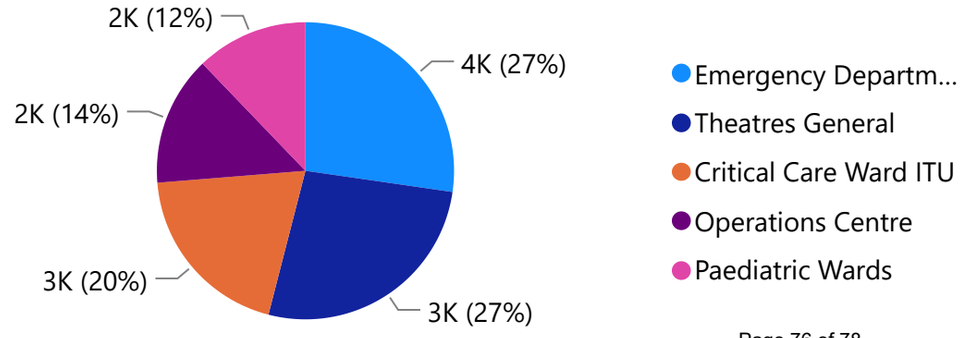
What reasons are given for sickness?

Absence Days Reason	YTD 22-23	YTD 21-22
S13 Cold, Cough, Flu - Influenza	5001	1755
S10 Anxiety/stress/depression/other psychiatric illnesses	4431	4618
S12 Other musculoskeletal problems	2146	1908
S98 Other known causes - not elsewhere classified	1494	1746
S25 Gastrointestinal problems	1419	1228
S11 Back Problems	897	1021
S30 Pregnancy related disorders	783	362
S28 Injury, fracture	743	1473

What reasons are given for sickness?

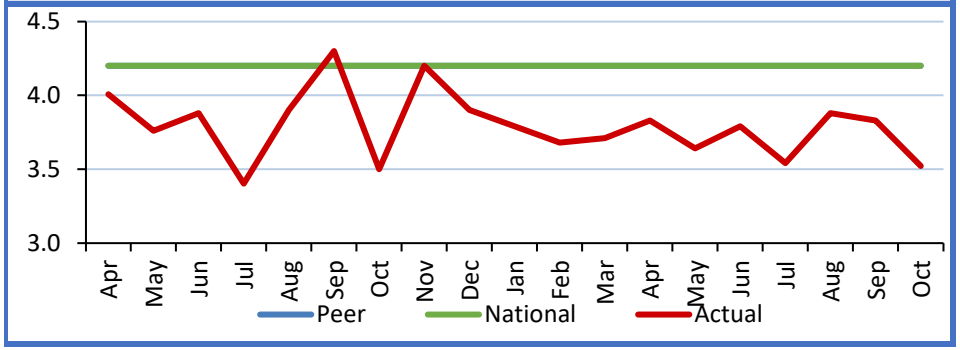
Absence Days Detailed Reason	YTD 22-23	YTD 21-22
	17257	14265
S10017 Stress	423	506
S11001 Back ache/pain	362	29
S12017 Tendon problem	298	0
S10001 Anxiety	259	227
S13003 Flu Influenza	147	146
S12998 Other musculoskeletal problems	140	14
S18001 Anaemia	87	0
S21006 Laryngitis	86	14

Which 5 departments are recording most absence days?

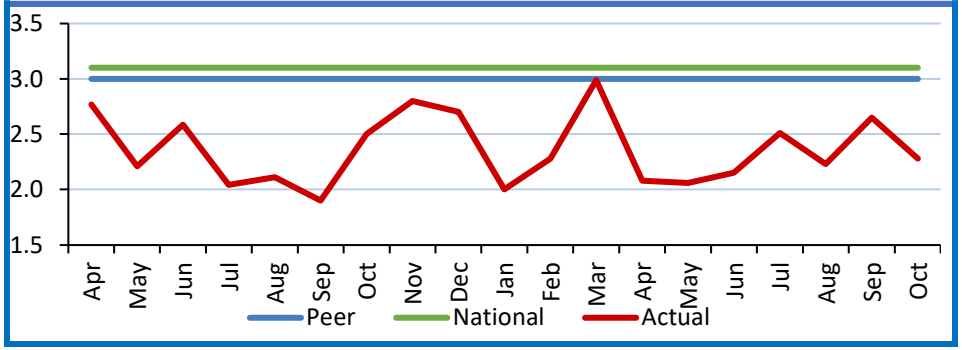


Appendix 2 - Clinical Productivity

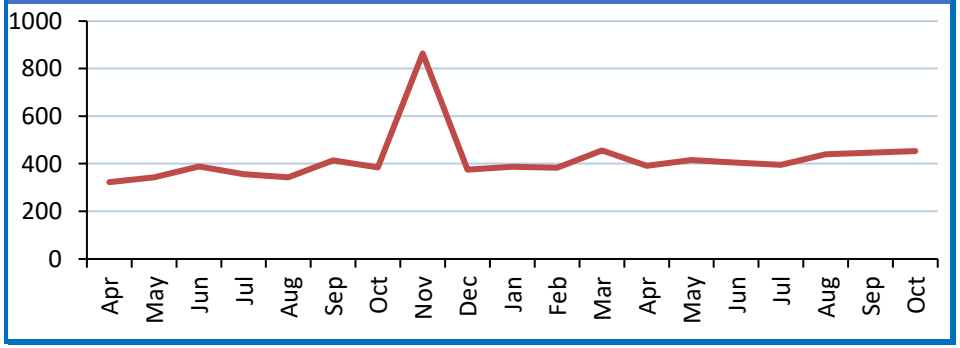
How long is our Non-Elective Length of Stay (Days)?



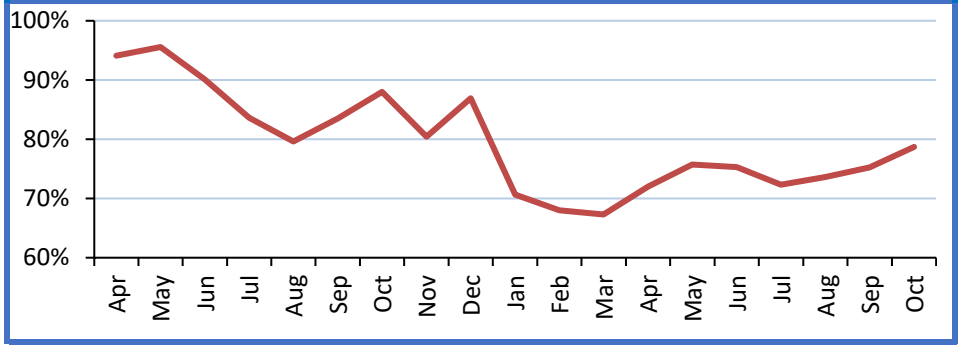
How long is our Elective Length of Stay (Days)?



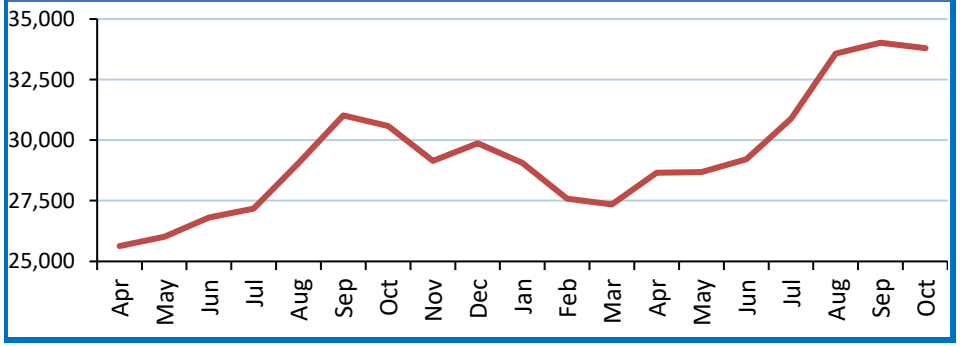
How many theatre sessions do we utilise?



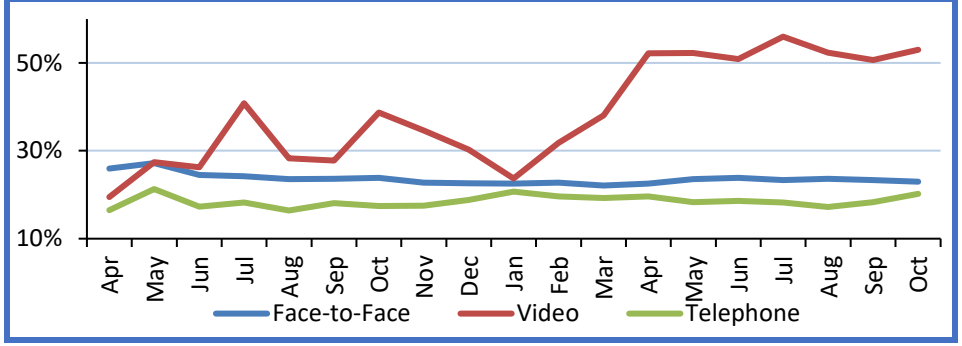
How many outpatient slots are utilised inc. overbooks?



How many patients are on a follow-up backlog?

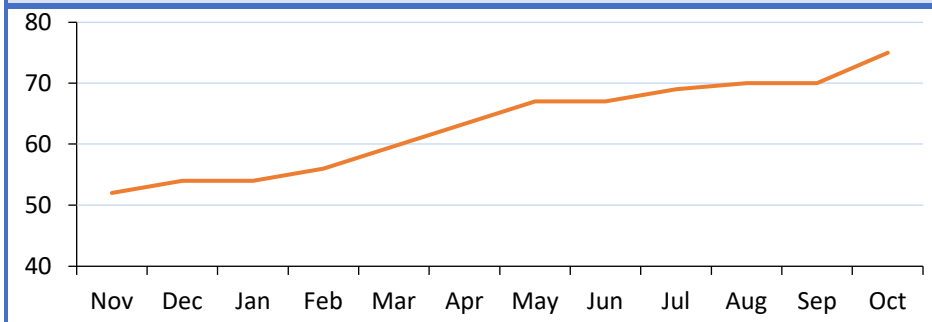


How many patients are discharged by type?



Appendix 3 - Procurement

How many known £50K> contracts that have expired?



What is our total amont on Non PO?

Data unavailable

What is the Percentage of Non-PO Invoices?

Data unavailable

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	Tuesday 6 December 2022
Director Lead	Jug Johal – Director of Estates and Facilities
Contact Officer/Author	Keith Fowler – Associate Director of Facilities and Sustainability
Title of the Report	**NLaG Green Plan and Travel Plan**
Purpose of the Report and Executive Summary (to include recommendations)	The NLaG Green and Travel Plan sets out how NLaG will work to achieve the NHS Net Zero Carbon emissions target. The Green Plan provides information on the challenge Net Zero presents the NHS and details how NLaG contributes to that carbon footprint. The Green Plan and Travel Plan provides information on sources of carbon as a result of our operations, and projects how we can work as an organisation to reduce carbon from utilities, procurement, medicines, gasses, and travel, as examples of carbon emitting functions. The Green Plan and Travel Plan sets out a strategy towards 2025 to reduce carbon and embed sustainable changes for the future improvements to our business for the benefit of our healthcare communities. Recommendation – The Trust Board is asked to approve the Strategic Trust Green Plan and Travel Plan 2022 – 2025.
Background Information and/or Supporting Document(s) (if applicable)	NLaG Green Plan 2022 – 2025, NLaG Travel Plan 2022 - 25
Prior Approval Process	✓ TMB ☐ PRIMs ✓ Divisional SMT ✓ Finance and Performance Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	Allocation of salary sacrifice benefits for EV charging Infrastructure. Band 4 Sustainability Officer 2023 Business Plan

Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	✓ Approval ✓ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Green Plan

2022-2025

Foreword

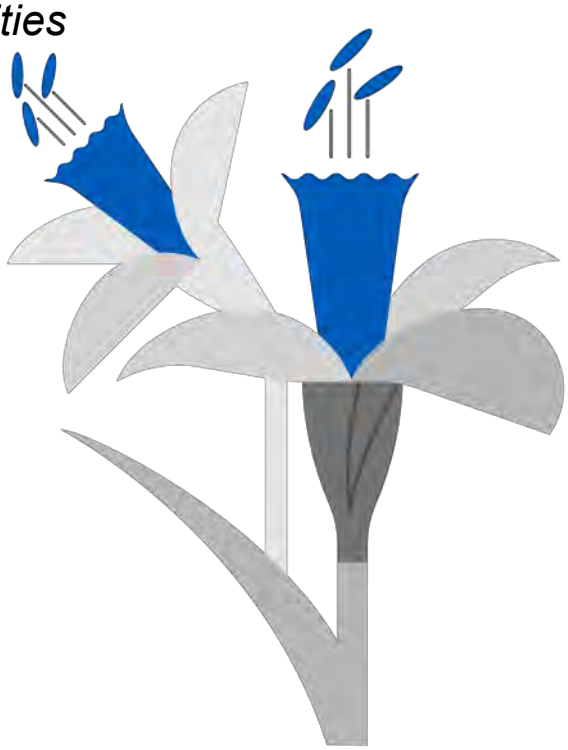
The Trust has a forward-thinking approach to sustainability. It places social and environmental responsibilities at the core of decision-making and healthcare services in order to make a real difference to the patients and communities we serve.

This new Green Plan seeks to challenge every member of the Trust, our partners, suppliers and wider stakeholders to play their part in the net zero carbon and Greener NHS agenda, to reduce their carbon footprint and adopt more sustainable behaviours.

NLaG has been committed to sustainable development, having reported our performance annually since 2007/08. We have recently delivered significant programmes to reduce our carbon emissions, particularly relating to the footprint from our estate and transport, and will continue to identify and overcome the challenges of decarbonisation within all impacting areas of our carbon impact.

It gives me great pleasure to launch our 3-year Green Plan for 2022-2025 and I welcome colleagues from across the Trust to adopt and share our vision for embedding sustainability throughout all that we do.

Jug Johal *– Director of Estates and Facilities*



Contents

Introduction

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) provides acute hospital services and community services across North Lincolnshire, North East Lincolnshire, the East Riding of Yorkshire and West and East Lindsey. We have approximately 750 beds across our three hospitals and employ around 6,800 members of staff, serving a population of over 450,000 people. As a Trust, we work with our Humber, Coast and Vale Integrated Care Partnership (Integrated Care System (ICS)) partners, enabling us to collectively provide better and more joined-up care for patients and improve the health and quality of life of local people.

The NHS is one of the largest employers in Britain and is responsible for approximately 4% of the nation's carbon emissions. As an NHS Trust, we recognise our responsibility to reduce our emissions and deliver high quality and sustainable care to the communities we service whilst simultaneously reducing our environmental impact and reducing our emissions. By delivering sustainable and low environmental impact care, we can identify opportunity to maximise resources towards patient care.

We are committed to embedding sustainability and net zero principles into our services and this Green Plan provides a structured approach to delivering upon commitments. This Green Plan also drives a renewed focus to sustainability and ensures alignment with the ambitions and targets of national guidance, most notably the ‘ Delivering a ‘ Net Ze ro’ National Health Service’ report’s two clear and feasible net zero targets for the NHS, which include:

ZERO for the emissions we control directly (the NHS Carbon Footprint), net zero by **2040**, with an ambition to reach an 80% reduction by 2028 to 2032.

ZERO+ for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by **2045**, with an ambition to reach an 80% reduction by 2036 to 2039.

This Green Plan aims to build on our previous Green Plan (2021-2022) and successes to date, including the establishment of a Sustainability Working Group, zero waste to landfill, active travel initiatives and movement towards ultra-low and zero emission vehicles for all of our fleet and business use vehicles. The Green Plan will be updated, monitored, and benchmarked against the wider NHS system and is recognised by the Trust Board as a major contributory plan to enable environmental and social improvements. Our Sustainability Working Group report to the Sustainability Committee, then through to the Trust Board and intends to address the targets set out within this plan. The purpose and structure of the Green Plan is outlined below.

Our vision

Trust vision and priorities

Progress to date

In 2018/19 we published our strategic framework. The framework sets out the Trust vision, values and principles it will work to, as well as the objectives and priorities to achieve by 2024. In 2019/20 the Trust developed a Strategic Plan setting out what we are aiming to achieve under these headings in more detail.

‘ Committed to caring for you’
Trust Vision

Kindness · Courage · Respect

We believe kindness is shown by caring as we would care for our loved ones	We believe courage is the strength to do things differently and stand up for what’s right	We believe respect is having due regard for the feelings, contribution and achievements of others

These values are translated into a range of behaviours, and we have focused on how these values translate into practice when it comes to achieving our net zero and sustainability commitments:

Kindness
I will be kind to nature by reducing my carbon footprint and supporting biodiversity

Courage
I will be positively involved in our Trust net zero and sustainability ambitions

Respect
I will treat my surrounding environment with respect

Trust priorities

As a Trust, we recognise the opportunities we have to tackle climate change whilst delivering high quality care and improving public health. We have identified the following issues that are most important to the community and people our Trust serve:

Tackling and reducing health inequalities

For example, by reducing air pollution and improving local environments

Ensuring a strong, healthy and just society

For example, by promoting personal wellbeing, social cohesion and inclusion

Promoting and ensuring good governance

For example, by promoting effective, participative systems of governance in all levels of society

The actions set out in our action plan will support us to achieve legislative requirements and the issues outlined above. However, we recognise that we have an opportunity to lead change and we will strive to implement innovative processes and measures that will enhance our services and the communities we serve. The Trust recognises that working collaboratively with our ICS partners will be key to delivering upon the wider Greener NHS agenda.

Delivering sustainable healthcare

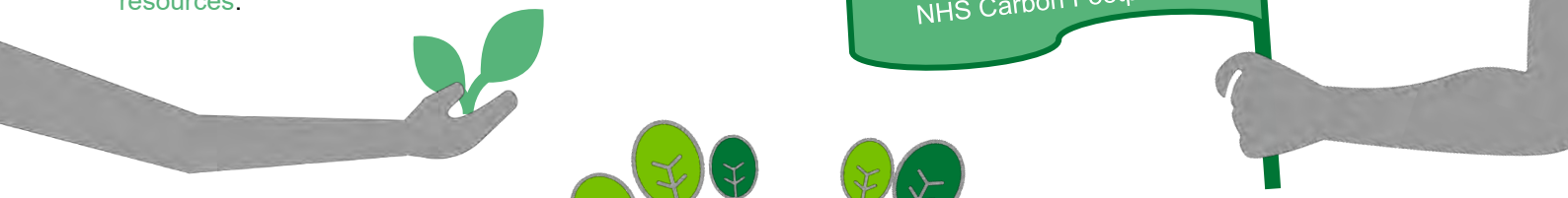
Drivers and responsibilities

There are several factors driving sustainability within the NHS, generally, these can be categorised into the following four categories: legislative requirements; mandatory requirements; International guidance; and UK guidance. There are also additional societal, environmental and financial benefits that further reinforce sustainability in healthcare, for example improved patient health outcomes[1].

January 2019 – The NHS Long Term Plan sets out the key ambitions for the Health Service over the next 10 years. It highlights opportunities to improve efficiency, commits the service to reduce business mileage and fleet air pollutant emissions and references the ability to reduce the use of natural resources.

October 2020 – The campaign published the ' Delivering a ' Net Z ero' National Health Service' report which commits the NHS to two more ambitious targets:

- Net zero by **2040** for the NHS Carbon Footprint
- Net zero by **2045** for the NHS Carbon Footprint Plus

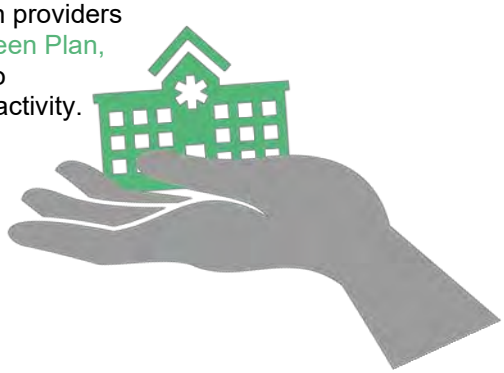


June 2019 – The Climate Change Act (2008) was amended in June 2019 and now commits the UK to cut its carbon emissions to net zero by 2050.

October 2021 – the NHS Assembly reaffirmed its commitment to NHS net zero by 2040 and called on all NHS organisations and individuals to make long-term commitments to bring net zero ambition and action into their everyday work.

January 2020 – the NHS launched the ' For a Greener NHS' programme to support the ambitions set out in the NHS Long Term Plan and the U K's net z ero carbon by 2050 target. The programme addresses the causes of both climate change and air pollution.

2021/22 – the NHS Standard Contract and NHS Planning Guidance set out sustainability priorities for NHS Trusts. For example, requirements on providers to have a board-approved Green Plan, reducing single use plastics to increasing remote outpatient activity.



[1] 2021/22 NHS Standard Contract
NHS Operational Planning and Contracting Guidance 2021/22

The targets we need to meet

NHS Carbon Footprint and Carbon Footprint Plus

The Greener NHS campaign's ‘ Delivering a ‘ Net Ze ro’ National Health Service’ report[2] set out two clear and feasible targets for the NHS net zero commitment, which include:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

To make progress towards the two NHS Carbon Footprint and Carbon Footprint Plus reduction targets, we need to understand our current emissions. Emissions can be categorised into different scopes as defined by the Greenhouse Gas Protocol:

Scope 1 emissions: direct emissions from owned or controlled resources e.g. on-site electricity generation, heating, Trust-owned vehicles

Scope 2 emissions: indirect emissions from the generation of purchased energy e.g. electricity

Scope 3 emissions: all other indirect emissions that occur in producing and transporting goods and services e.g. waste management, purchasing of goods and services

The NHS still has emissions that fall outside these scopes, which is why the NHS Carbon Footprint Plus also considers emissions from patient and visitor travel to and from NHS services and medicines used within the home.

Using the scopes defined within the NHS Delivering a Net Zero Health Service Report, we have calculated our organisational footprint for 2020/21 – more information is provided across the next pages.

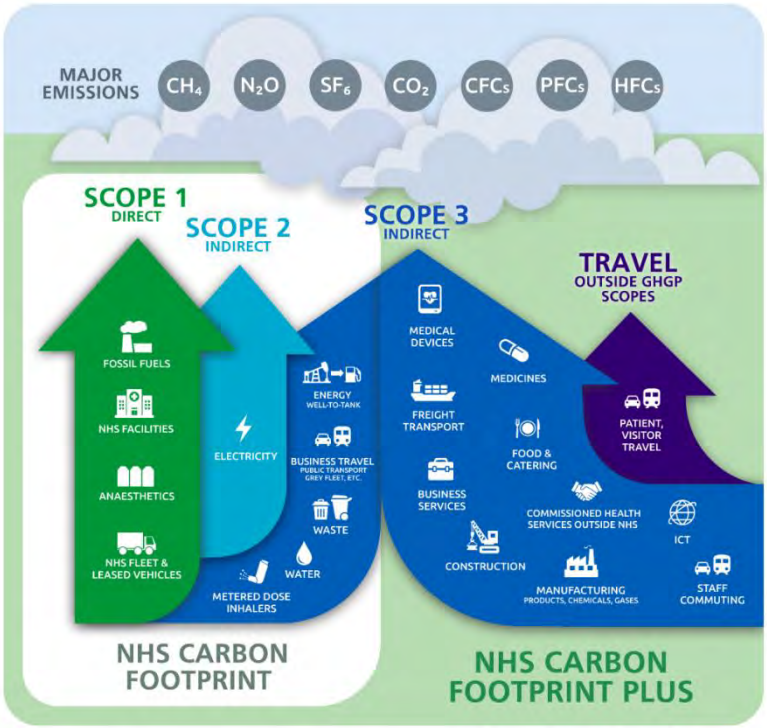


Figure 1: Greenhouse Gas Protocol scopes in the context of the NHS from the ‘Delivering a ‘Net Zero’ National Health Service’ report.

[2] Delivering a ‘N et Z ero’ National Health Service

Progress to date

Our achievements

Our active waste management strategy sets out key projects to reduce single use plastics, increase recycling and reduce food waste, alongside significant reductions in waste to landfill.

1. Estate decarbonisation

We have replaced the coal-fired boilers at Goole with a low-carbon gas CHP system and a variety of other energy efficiency measures – such as improved insulation, windows, Building Management System and LED lighting.

2. Waste

3. Procurement

We review all tender documentation including Pre-Qualification Questionnaires (PQQs) and Invitations to Tenders (ITTs) to ensure that sustainable issues are considered within future procurement decisions.

4. Travel and transport

Our fleet continues to become more carbon efficient, with a new electric van, a cross-site shuttle bus and a fleet of electric cars for staff use through the pool car system introduced.

5. Virtual working

The Trust was awarded £5m to invest in the technology and digital infrastructure we need. This includes improving our digital infrastructure to support mobile working, ward boards and clinical monitoring systems as well as upgrades to digital systems to better support patient care. We are currently developing a Hybrid Working Policy.

6. Food and nutrition

Our fresh food produce is all locally sourced, all suppliers we work with are reviewed in full based on their sustainable procurement policies to ensure that we share the same approach.

Our carbon emissions

NHS Carbon Footprint and Carbon Footprint Plus

The Trust has selected 2020/21 as our baseline emission year as this is the year with the most accurate and up to date data available. Our NHS Carbon Footprint equates to 18,143 tCO_2e and an NHS Carbon Footprint Plus of 9,345 tCO_2e.

The reduction in desflurane and sevoflurane has largely been due to COVID-19, which has led to a reduction in activity in planned/elective procedures in the Trust rather than a change in clinical practice.

The pandemic has presented some opportunities to continue sustainable processes and behaviours that have been taken up as a result.

Using the scopes defined within the *NHS Delivering a Net Zero Health Service* report, we have calculated our organisational footprint for 2020/21, which is provided in further detail throughout this plan.

Our baselining exercise has enabled us to identify our carbon hotspots, that will help prioritise focus areas for carbon reduction, particularly when considering the challenge of heat decarbonisation and transport.

This data will enable the Trust to monitor progress towards net zero carbon targets and the impact that different emission reduction projects will have.

Scope	Emissions category	Emissions (tCO_2e)	% of total
NHS Carbon Footprint	Fossil fuel emissions	10,151	36.9%
	Anaesthetics emissions	716	2.6%
	Fleet & leased vehicle emissions	4	0.0%
	Electricity + heat and steam emissions	4,716	17.2%
	WTT (inc. transmission & distribution) emissions	2,067	7.5%
	Business travel emissions	354	1.3%
	Waste emissions	41	0.2%
	Water emissions	95	0.3%
	Metered dose inhalers emissions	*	*
NHS Carbon Footprint Plus	Agricultural Products	13	0.0%
	Manufactured Fuels / Chemicals / Gases	333	1.2%
	Other Manufactured / Processed Products	71	0.3%
	Construction and Construction Materials	844	3.1%
	Food and Catering	108	0.4%
	Wood and Paper Products	53	0.2%
	Pharmaceuticals	199	0.7%
	Metals and metal products	206	0.7%
	Office and Other Equipment	166	0.6%
	Medical Instruments / Equipment	307	1.1%
	NHS Travel	27	0.1%
	Business Services	600	2.2%
	Other Procurements	315	1.1%
	Staff commuting emissions	1,855	6.7%
	Patient and visitor travel	4,247	15.5%

*Table 1: Numerical breakdown of the Trust's emissions baseline. *Please note some key data limitations as part of our emissions baseline; as part of our action plan, we will review data gaps and ensure inclusion within subsequent reporting years.*

The pathway to net zero carbon

The graph below provides an overview of our carbon emissions reported since 2007/08. We have and will continue to improve our reporting for sustainability performance and will utilise the Greener NHS dashboard and tools to benchmark against other similar NHS Trusts. As shown in Figure 2, we have successfully reported on our utilities and waste data throughout, and have more recently incorporated activities such as transport, medical gases and scope 3 emissions.

Having a well-defined emissions baseline enables us to highlight reduction opportunities and measure progress in order to achieve net zero NHS Carbon Footprint by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 and net zero NHS Carbon Footprint Plus by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

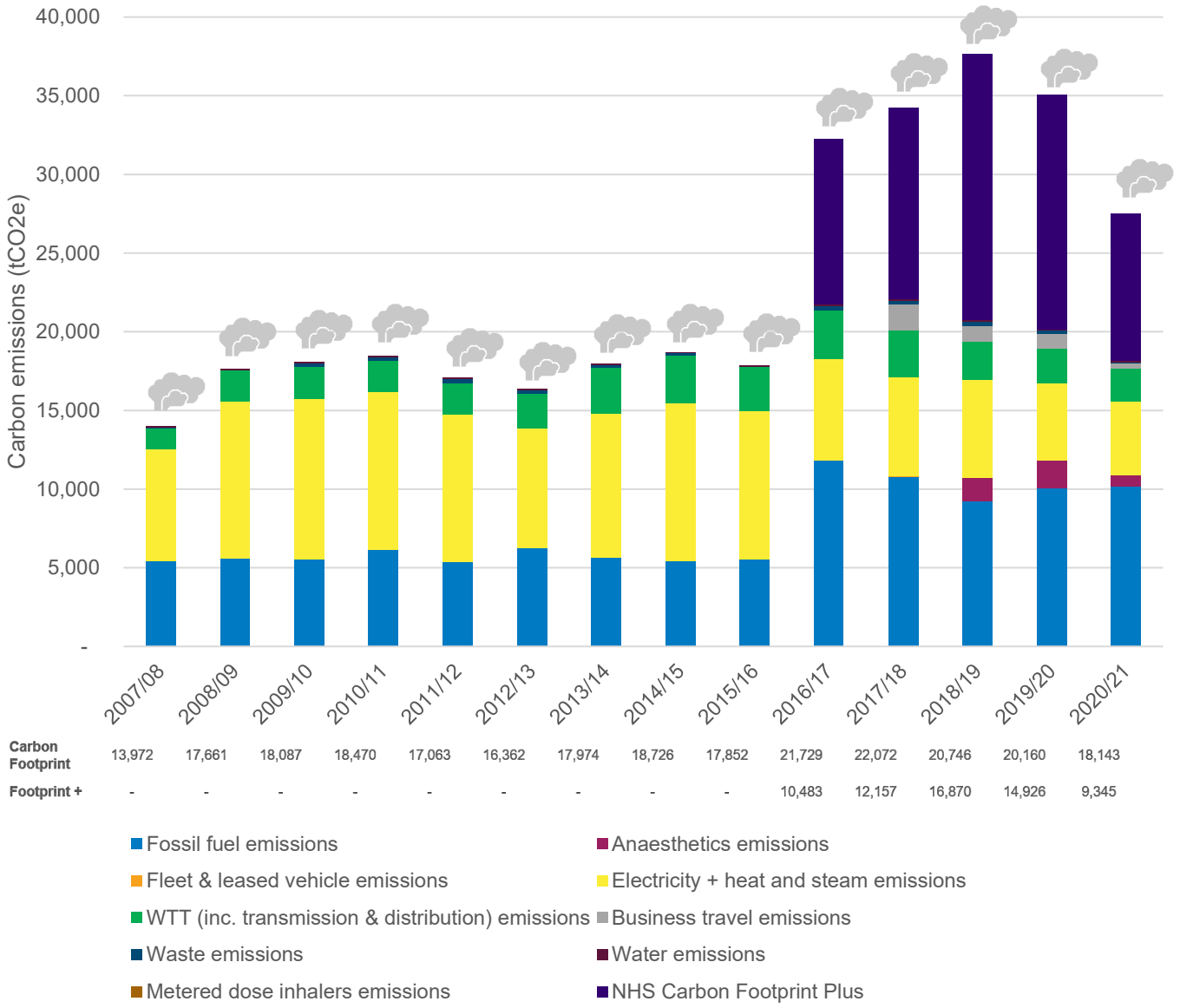


Figure 2: Overview of NLaG's carbon emissions reported since 2007/2008
**Please note, Carbon Footprint Plus data not calculated until 2016/17.*

NHS Carbon Footprint

As outlined in Figure 3 our NHS Carbon Footprint equates to 18,143 tCO_2e with the largest emissions resulting from our use of fossil fuels – this makes up 56% of our NHS Carbon Footprint. Our emissions from electricity consumption make up an additional 26% of our footprint – resulting in a total 82% of emissions coming from our estate. We recognise the opportunities to reduce our use of fossil fuels, and the Trust has an estate decarbonisation scheme that includes low carbon heating replacements, LED lighting, window and insulation improvements and building management system upgrades that will reduce our emissions significantly.

We also recognise that our emissions will be impacted as our estate evolves, for example, the new Emergency Departments (EDs), Same Day Emergency Care (SDEC) and Acute Assessment Units (AAU). However, we will continue to make sure net zero carbon and sustainability principles are incorporated into the design of all future developments by ensuring they are built to Net Zero Hospital Standards.

As outlined previously, emissions from anaesthetics has reduced as a result of reduced use of desflurane and sevoflurane due to reductions in activity in planned/elective procedures. The 716 tCO_2e emitted in 2020/21 is over a 50% reduction in emissions from 2019/20 and whilst it is expected that planned/elective procedures at the Trust return to capacity levels, the increased awareness around the impact of desflurane and sevoflurane on carbon emissions should help keep these emissions at lower levels.

Water and waste emissions make up a small proportion of our NHS Carbon Footprint, however continued appropriate water and waste management are key to ensuring the delivery of sustainable healthcare.

To date, we have not calculated our emissions from inhalers, but will ensure subsequent years account for this activity and associated emissions.

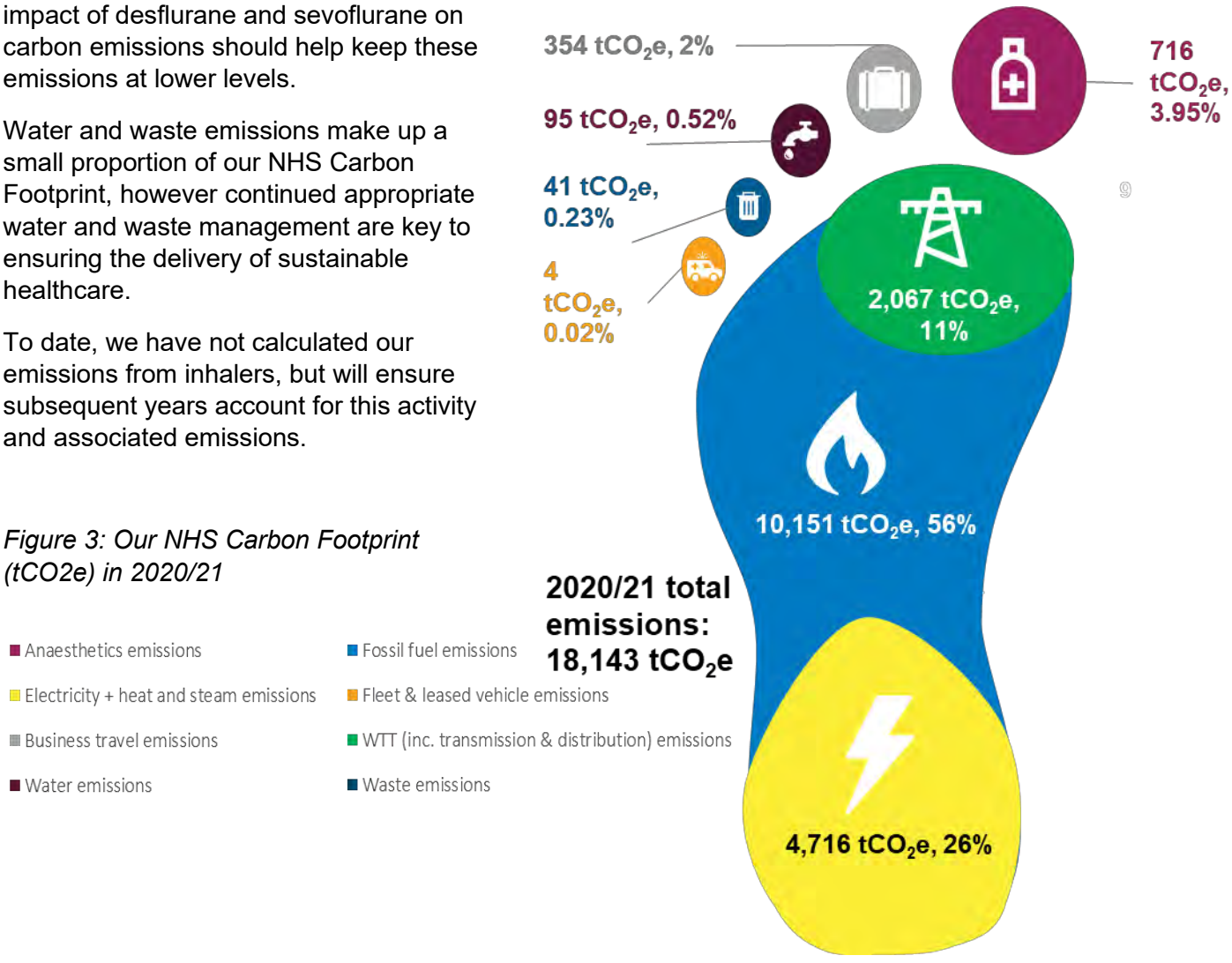


Figure 3: Our NHS Carbon Footprint (tCO2e) in 2020/21

Progress made since 2018/19

NHS Carbon Footprint

As seen in Figure 4, our NHS Carbon Footprint has steadily decreased between 2018/19 and 2020/21. In the last year, our footprint decreased by 10%, with the biggest reductions attributed to reductions in anesthetics and business travel as well as reductions in electricity consumption combined with the decarbonisation of the grid. Progress on total emissions can only be dated back to 2018/19 as a result of data availability, however we will continue to monitor progress in a structured way that enables future analysis to be undertaken.

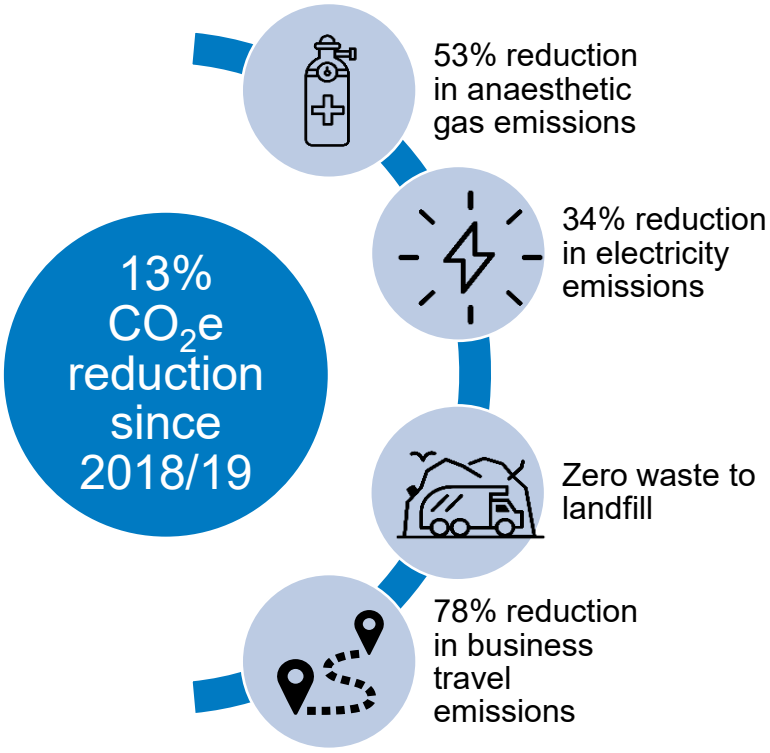
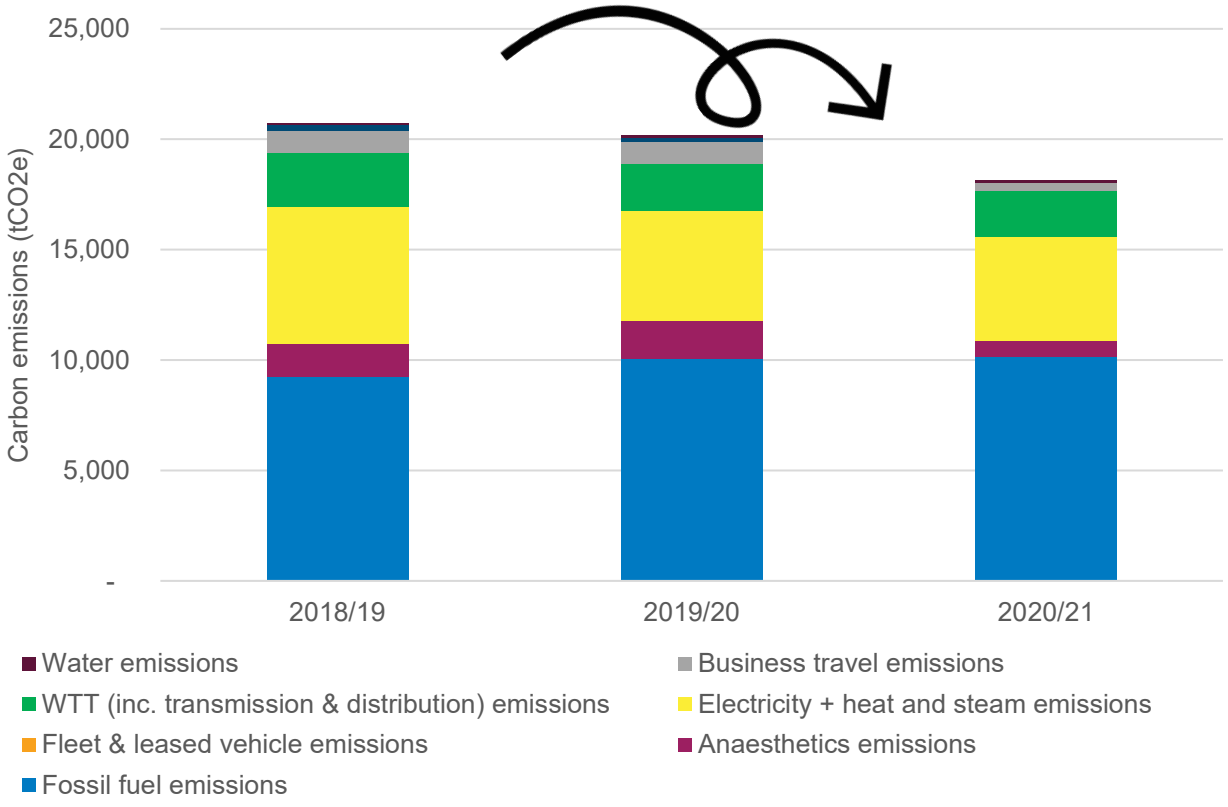


Figure 4: Our NHS Carbon Footprint between 2018/19 and 2020/21 (tCO_2e)



NHS Carbon Footprint Plus

NHS Carbon Footprint Plus accounts for 62% of the NHS' total carbon emissions. We have taken a sample of our procurement emissions from 2020/21 to provide a breakdown of emissions sources for our NHS carbon footprint plus – as seen in Figure 5 this equates to 7,843 tCO_2e, making up approximately 30% of our total footprint.

Due to data limitations, we have used a sample of spend data that is not reflective of the entirety of our procurement footprint. However, we are committed to understanding the full impact of procurement on Trust emissions and will seek to improve data collection and subsequently calculate associated emissions in future years.

Though we do not have a complete breakdown of procurement emissions, Figure 5 shows that patient and visitor travel, staff commuting, and construction and business services contribute the largest of our NHS Carbon Footprint Plus. The Trust continues to identify opportunities to reduce the impact of staff, patient and visitor travel through a range of initiatives including the introduction of a salary sacrifice scheme that only allows for the purchase of ULEV and ZEVs, as well as upgrading cycling facilities including cycle storage improvements. Additionally, the Trust expects travel associated emissions to reduce as we continue to improve our smart working practices.

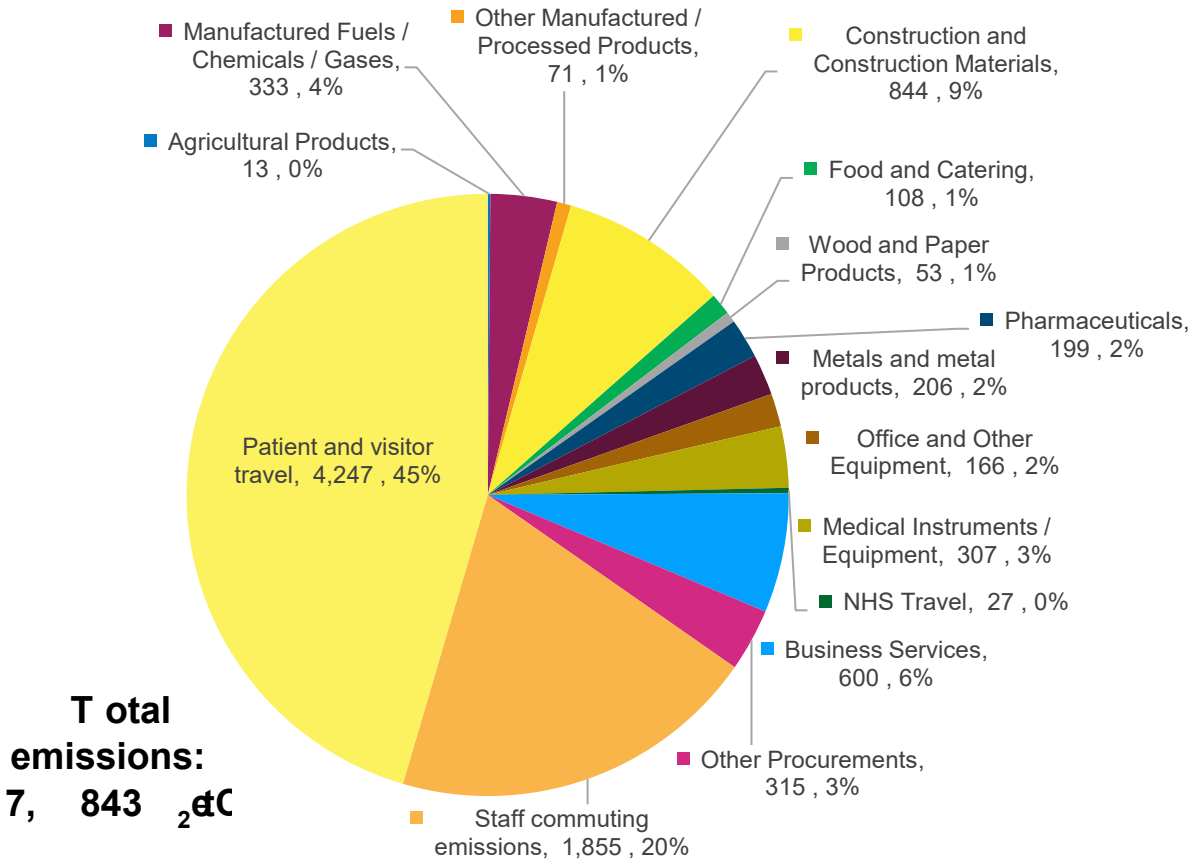


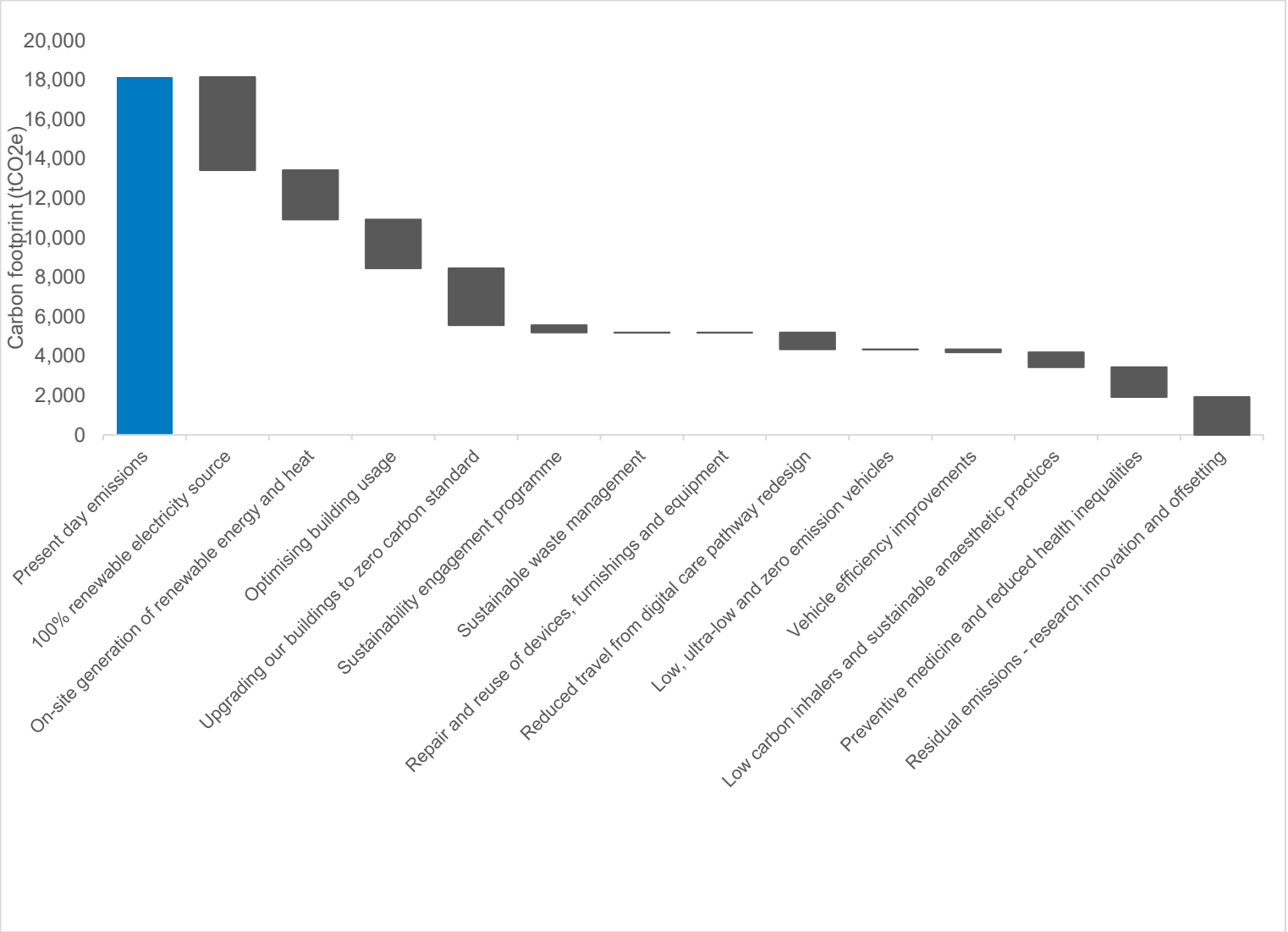
Figure 5: Our NHS Carbon Footprint Plus (tCO_2e)

Our Carbon Emissions

NHS Carbon Footprint

Figure 6 below depicts our pathway to achieving a net zero NHS Carbon footprint. As the figure shows, by switching to a REGO certified renewable energy tariff we are able to reduce over 4,700 tonnes of CO2. By utilising existing roof space and adjacent ground space we will support a shift to on-site renewable energy and heat generation to further reduce our NHS Carbon Footprint. Further upgrades to our buildings such as interventions focused on lighting, air conditioning and cooling, building fabric, space heating, ventilation and hot water would also lead to large reductions in our NHS Carbon Footprint.

Figure 5: Our NHS Carbon Footprint Plus (tCO_2e)



Stakeholder feedback

To develop this plan, we have engaged with a range of staff across our workforce via a sustainability survey, workshops and focus groups.

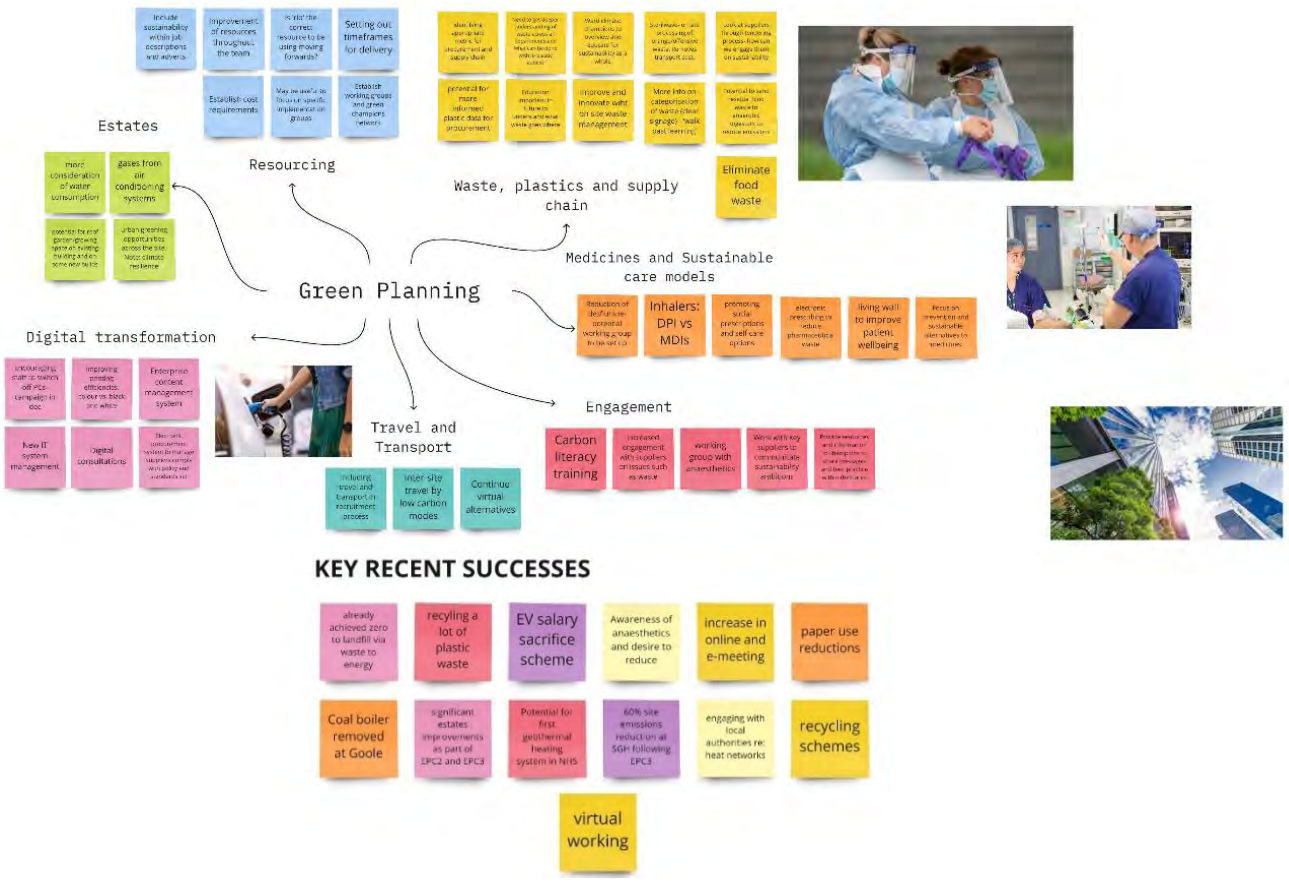
Based on the feedback provided within these sessions and survey responses, we have identified the following key areas of priority among our staff:

1. Improving recycling and reducing single-use plastics
2. Cutting emissions
3. Enhancing biodiversity and greenspace
4. Delivering energy efficiency and renewables
5. Adopting new ways of working

Alongside these priorities, we have gained an understanding of key areas of improvement for the Trust which we can focus on over the next three years. For example:

- **Sustainable medical gas practices**: switching to low carbon alternatives and actively reducing the use of Metered Dose Inhalers (MDIs) and nitrous oxide where possible.
- **Engagement**: communicating with staff and providing them with resources and tools to deliver change within their departments.
- **Air quality**: gain an understanding of current air quality on site and identify areas for interventions to be focused, e.g. through an anti idling campaign.

Figure 6: Green Plan action planning workshop summary



Our action plan

The following section sets out our actions for the next three years with the aim of working towards net zero carbon emissions by 2040 for the emissions we control directly, and 2045 for those we can influence (such as those embedded within the supply chain).

Our action plan is aligned to the main drivers of change and sources of carbon emissions across the NHS. The key themes are:

- Engaging and developing our workforce and system partners plays a crucial role in defining and delivering carbon reduction initiatives and broader sustainability goals.

Workforce and system leadership

- It is our aim to embed net zero and sustainable development principles across all clinical services. We have a clear focus on prevention and reducing health inequalities, but this must continue to be reflected in the way we provide care to the patients we serve.

Sustainable models of care

- Digital is a key enabler in the decarbonisation of our Trust. At NLaG, we aim to focus on ways of harnessing existing technology and systems to streamline our service delivery and supporting functions whilst reducing resource use and associated carbon emissions.

Digital transformation

- The NHS accounts for 5% of all road traffic in England and travel is responsible for 18% of the NHS carbon footprint in England. Through reducing our travel activities and adopting active or low carbon alternatives, we aim to reduce our carbon footprint and improve local air quality simultaneously.

Travel and transport

- Decarbonising our estate has been a key priority for us over the past few years. We have made significant progress and will continue to reduce our utility use and waste generation to improve resource efficiency and building performance across the Trust's sites.

Estates and facilities

- Prescribing and the use of medicines and medical products can have adverse effects on our environment, including from plastic use and greenhouse gas emissions. We will initially focus on the key areas of action, inhalers, nitrous oxide and anesthetic gases, as set out in the 2021/22 NHS Standard Contract.

Medicines

- The NHS supply chain accounts for approximately 62% of total carbon emissions. We will embed sustainability and net zero credentials within purchasing decisions to not only reduce carbon embedded within our supply chain, but to enhance the social value provided as part of our contracts.

Supply chain and procurement

- NHS England estimates that hospital food and catering produces 1.5 kilotonnes of carbon dioxide equivalent, 6% of the NHS' total greenhouse gases. Sustainable diets can improve wellbeing and help to prevent diet-related illness while reducing our environmental impact.

Food and nutrition

- The effects of climate change are already being felt, and so we must adapt more quickly and comprehensively. We will focus on developing and rolling out adaptation solutions to help reduce climate-related risk, increase climate protection and safeguard the provision of our services.

Adaptation

Workforce and system leadership

Engaging and developing our workforce and system partners plays a crucial role in defining and delivering carbon reduction initiatives and broader sustainability goals.

Progress to date

In 2021 we established a Sustainability Working Group, comprised of key service lead representatives spanning across the core chapters of this Green Plan.

We have appointed a lead for Sustainability, and this role will combine the technical experience within the Energy and Information team, Logistics, Waste, Procurement, and Clinical colleagues to embed sustainability into the Trust. It will be an objective of the Sustainability team to not only deliver technological solutions to reduce carbon, but to encourage an approach to service delivery which recognises the Green agenda and its positive impact on health, communities, and earth.

Additionally, we are working in partnership with Local Authorities, other NHS organisations and the voluntary sector to progress our sustainability ambitions (e.g. Heat Networks and travel plans).

Additionally, all our policies and procedures are accessible to staff on the Trust intranet as well as dedicated staff wellbeing groups, workforce policies, organisational development and workforce strategies which focus on developing staff, advancing the Trust and improving the patient experience.

Targets

- Establish a Net Zero Heroes network and grow to 500 staff by 2025/26; a minimum of one staff representative within each department
- Ensure 100% of job descriptions include a sustainability clause
- Achieve annual increases in number of staff receiving climate literacy training

Measuring progress

- Number of staff undertaken sustainability training
- Number of staff with sustainability objectives within their job descriptions and annual review
- Number of Net Zero Heroes

Action	Timeframe
Engage staff and system partners in sustainability ambitions	Ongoing
Engage with Humber, Coast and Vale Health and Care Partnership ICS partners in regional sustainability forum	Ongoing
Encourage staff to identify carbon reduction opportunities	Ongoing
Include sustainability KPIs in Annual Report	Annually
Expand Green Champions / Net Zero Heroes network for sharing ideas and initiatives	2022/23
Complete SDAT tool, or similar benchmarking tool, to understand baseline progress	2022/23
Introduce sustainability within PDR, job descriptions, staff induction and training	2022/23
Implement process for upkeep and regular review of Green Plan and associated requirements	2022/23
Establish working groups across each key theme to develop detailed annual delivery plans	2022/23
Set aside a ring-fenced budget for sustainability annually	
Future projects and business cases will include an analysis of their sustainability impact	2022/23

Sustainable models of care

It is our aim to embed net zero and sustainable development principles across all clinical services. We have a clear focus on prevention and reducing health inequalities, but this must continue to be reflected in the way we provide care to the patients we serve.

Progress to date

The Trust's Directorate of People and Organisational Effectiveness supports our continuing commitment to improving the health and wellbeing of patients, staff and the wider community, which in turns helps build a sustainable and healthy community. Activities include health promotion initiatives, educating staff, using websites, social media platforms and contributing to national and local awareness campaigns. The overall purpose of such activities is, for example, to promote the positive health benefits of stopping smoking and monitoring alcohol intake, eating healthily to tackle obesity and ill health conditions likes to poor eating habits.

We are committed to continuous quality improvements throughout bespoke networks and endeavouring to drive quality, innovation, safety and sustainability into all it does.

Targets

- Where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely
- Improve PLACE scores – feedback relating to the care environment (e.g. temperature, light, services using PLACE surveys)
- Increase number or % of medical devices reduced or recycled year-on-year
- Achieve recognition and awards for quality improvements in sustainable care
- Reduction in hospital admissions and delayed discharges

Measuring progress

- % of social prescriptions provided
- Number of sustainable care models and susQI projects
- Patient feedback scores (PLACE)

Action	Timeframe
Explore sustainable innovative suppliers to support clinical carbon reduction initiatives	Ongoing
Optimise location of care and support closer to home via coordination with primary care	Ongoing
Introduce social prescribing where clinically appropriate	Ongoing
Develop sustainable quality improvement projects that focus on prevention and health inequalities	2023/24
Calculate the carbon footprint of specific care pathways e.g. respiratory, to identify hotspots for targeted reduction	2024/25

Digital transformation

Digital is a key enabler in the decarbonisation of the Trust. At NLaG, we aim to focus on ways of harnessing existing technology and systems to streamline our service delivery and supporting functions whilst reducing resource use and associated carbon emissions.

Progress to date

We have introduced Microsoft Teams, which enables meetings to take place virtually negating the need for colleagues to travel across sites for meetings saving the trust time and money on travel and helping us to reduce our carbon emissions.

Locally, we are reducing office wastage by moving to electronic and paperless files where possible, for example all purchase requisitions and ordering will turn to digital.

As part of the NHSX Digital Aspirant Programme, we have been awarded £5 million to help us to invest in the technology and digital infrastructure we need. This includes improving our digital infrastructure to support mobile working, ward boards and clinical monitoring systems as well as upgrades to digital systems to better support patient care. These foundational improvements will allow us to conduct virtual outpatient appointments for 30% of our patients and make it easier and more efficient for our staff to record observations. By working with our partners across the Humber Coast and Vale region, we are also ensuring that our systems will allow clinicians to access patient records in a variety of care settings.

We will also create a Single Point of Access (SPA) for patients, which will empower them to get involved in their own care. As we continue to pilot and develop more patient access, we are looking to improve the digital literacy and access to digital solutions for those in our community. Working with the Humber Acute Services Review, our Integrated Care System, Yorkshire Humber Care Record and other partners, we are looking forward to a future where digital is making engagement with the healthcare system more patient friendly.

Targets

- 90% of observations being digitally recorded
- Printing for meetings will be eradicated or by exception e.g. for accessibility reasons only by 2023/24

Measuring progress

- % of outpatient care delivered remotely
- % of observations digitally recorded

Action	Timeframe
Support digitisation of records, communications and workflow	Ongoing
Review digital use and efficiency of technologies to reduce energy consumption	2022/23

Travel and transport

The NHS accounts for 5% of all road traffic in England and travel is responsible for 18% of the NHS carbon footprint in England. Through reducing our travel activities and adopting active or low carbon alternatives, we aim to reduce our carbon footprint and improve local air quality simultaneously.

Progress to date

NLaG is in the process of introducing a salary sacrifice scheme that only allows for the purchase of ULEV and ZEVs. Our fleet also continues to become more carbon efficient following the addition of new electric pool cars and an electric van. The new ED schemes are designed to encourage the use of sustainable transport, with a focus on maintaining excellent links to public transport and increased secure cycle parking on both sites. They also provide new single-storey decked car parks at both Grimsby and Scunthorpe, which include several charging points for EVs and E-ambulances.

Additionally, NLaG's cycling facilities have been consistently upgraded with secure cycle storage for staff in place across all three sites. Scunthorpe has most recently benefit from an increase in cycle parking spaces following new development.

Smart working practices have been increased with Microsoft Teams now widely used and this has led to reduced travel with the introduction of working from home, especially for non-clinical staff, and the HR department is working on policy to affirm the future of agile working among our staff.

Targets

- All key contracts include CO2e and/or NOx reduction KPIs
- End business travel reimbursement for any domestic flights within England, Wales and Scotland
- All fleet vehicles purchased or leased by the organisation support the transition to low and ultra-low emission (ULEV)
- Cut business mileages and fleet air pollutant emissions by 20%
- At least 90% of the NHS fleet will use low-emissions engines (including 25% Ultra Low Emissions)
- 50% of vehicles used to deliver the contract are of the latest emission standards, ultra-low emission vehicles (ULEV) or zero emission vehicles (ZEV) from 2023

Measuring progress

- % fleet ULEVs and ZEVs
- Number of cycle storage facilities per member of staff
- Number and % of staff travelling by active and public modes of transport
- Carbon footprint (tCO2e)
- Business travel mileage and % reduction annually

Action	Timeframe
All new purchased and leases are for ULEV or ZEV (90% by 2028)	Ongoing
Run an annual travel survey	Ongoing
Review transport contracts to identify low carbon opportunities	Ongoing
Improve facilities that encourage active travel e.g. cycle storage, lockers and showers	Ongoing
Review staff parking, business travel and home working policies to reflect our environmental ambitions and priorities	Ongoing
Create a plan for electrifying fleet and charging infrastructure	2022/23
Introduce a plan to reduce the carbon emissions of our grey fleet over a 5 year strategy aligning to ULEV carbon levels	2022/23
Install air quality monitors across our sites to identify areas of improvement and measure impact of our air quality initiatives	2022/23
Run an anti-idling campaign for staff, patient, visitor and ambulances to improve air quality across site	2022/23
Sign up to the Clean Air Hospitals Framework	2022/23
Work with NEPTS and other transport service providers to consolidate deliveries to the site	2023/24
Explore the provision of electric cargo bikes for transporting goods and services across/between sites	2023/24

Estates and facilities

Decarbonising our estate has been a key priority for us over the past few years. We have made significant progress and will continue to reduce our utility use and waste generation to improve resource efficiency and building performance across the Trust's sites.

Progress to date

We will reduce our carbon footprint year-on-year by removing outmoded power supplies and upgrading our infrastructure across our estate. In 2020/21 the Trust made significant progress in achieving these objectives, securing grant funding to finance the programme and work is already well underway.

Sustainability has also been at the forefront in our plans for both Emergency Department schemes. Modern construction methods and materials have been utilised to minimise the environmental impact of the builds and ensure their future energy efficiency performance is as high as possible. In addition to this, £10,127,599 has been secured from the Public Sector Decarbonisation Scheme, the coal-fired boilers at Goole have been replaced with a low-carbon gas CHP system and a variety of other energy efficiency measures – such as improved insulation, windows, and LED lighting – this will reduce the carbon emissions at Goole alone by 60%.

The same additional improvements will also be made at our sites in Grimsby and Scunthorpe, where we will also increase the number of solar panels. At Scunthorpe, we will also continue to explore replacing the aging steam system that is currently in operation and upgrade the ventilation plant.

From April 2021, we have purchased 100% REGO backed renewable energy, enabling us to report market-based electricity as net zero carbon. We're also investing in upgrading our water infrastructure and fitting new fire security systems across our three sites. In 2020/21, we have achieved a recycling rate of 23% by introducing a number of recycling and reuse schemes to reduce waste and the use of single-use plastics.

Future success

The Trust's digital ecosystem is anticipated to be a significant contributor to achieving our sustainability targets. A truly Smart hospital – one in which its building systems are interconnected, yield insight into the real-time operation of the estate, and can be dynamically and automatically controlled and adjusted, or tested in a Digital Twin model, promises to radically optimise the use of energy across the estate.

However, in order for these opportunities to be explored and realised as part of our sustainability initiatives, it is vital that due consideration is given to the role played by the Estates and Digital teams. A sustainable, smart hospital is heavily reliant on a Digital, Data and Technology strategy that can accommodate these new connected systems and infrastructure that have been hitherto unconnected or siloed. This paper recommends that an initiative is undertaken to understand the following:

- The interdependencies between our sustainability programmes and our digital and estates strategies, in terms of connectivity, data management, security and operational management
- The implications for future capital developments; for example, the considerations required during the design and construction process

Targets

- Phase out oil and coal for primary heating, replacing with low carbon alternatives
- All new builds and refurbishment projects delivered to net zero carbon standards

- Electricity consumption benchmark of 90 kWh/m2 by 2026
- Fossil thermal consumption benchmark of 420 kWh/m2 by 2026
- Water consumption benchmark of 0.90m3/m2 by 2026
- Increase our municipal waste recycling to 55% by 2025

Measuring progress

- Tonnes and % of waste per stream per year
- kWh and % renewable energy generated on site
- kWh and % energy purchased from renewable sources
- BREEAM score of new builds and refurbishments
- HTM benchmarks for energy use (kWh/m2)

Action	Timeframe
Replace all lighting with LED bulbs	Ongoing
Improve waste management and recycling processes	Ongoing
Enhance greenspace on site e.g. green walls, tree planting etc.	Ongoing
Continue to implement carbon reduction programmes and explore low carbon heating alternatives e.g. heat networks	Ongoing
Maximise smart building systems (BMS) to reduce electricity consumption when not in use	Ongoing
Adhere to the “ Carbon Net Ze ro Playbook” : obligations for new build and leased buildings, aligned to RIBA work plan	Ongoing
Improve waste segregation practices among staff via the provision of training and resources e.g. posters or labelling	2022/23

Medicines

Prescribing and the use of medicines and medical products can have adverse effects on our environment, including from plastic use and greenhouse gas emissions. We will initially focus on the key areas of action, inhalers, nitrous oxide and anaesthetic gases, as set out in the NHS Long Term Plan[3].

Progress to date

From 2018/19 to 2020/21, we have successfully reduced our carbon footprint from medical gases by 53%, from 1,512 tCO2e to 716 tCO2e.

Awareness around volatile anaesthetic gases, Desflurane and Sevoflurane, and the impact it has on our carbon footprint has increased. The reduction in Desflurane and Sevoflurane has largely been due to COVID-19, which has led to a reduction in activity in planned/elective procedures in the trust rather than a change in clinical practice.

Targets

- Reduce the carbon impact of anaesthetics by at least 40% by 2028
- Appropriately reducing the proportion of Desflurane to Sevoflurane used in surgery to less than 20% by volume
- Clinically appropriate prescription of lower greenhouse gas emitting inhalers, and the appropriate disposal of inhalers (MDIs to DPIs)
- No more than 45% non-salbutamol inhalers prescribed are metered-dose inhalers by 2023/24

Measuring progress

- Ratio of DPIs to MDIs
- Ratio of Desflurane to Sevoflurane
- Annual carbon emissions (tCO2 and % reduction)

Action	Timeframe
Explore recycling initiatives at a Trust and ICS level	Ongoing
Establish a lead to address nitrous oxide waste (NOX)	2021/22
Prescribe lower carbon inhalers (50% less by 2028 and 6% less in 21/22)	2022
Introduce gas capture and reuse technologies	2023/24
Expand desflurane reduction initiatives via a staff behavioural change campaign	2022/23
Monitor NOX use at a trust and ICS level and deliver a reduction project	2023/24
Reduce highly wasted pharmaceutical products and identify products with unnecessary packaging; feeding back to suppliers	2023/24
Work with national team to ensure schemes for green disposal of inhalers are rolled out across the region	2022/23

[3] NHS Long Term Plan

Supply chain and procurement

The NHS supply chain accounts for approximately 62% of total carbon emissions. NLaG will embed sustainability and net zero credentials within purchasing decisions, to not only reduce carbon embedded within our supply chain, but to enhance the social value provided as part of our contracts.

Progress to date

Our Procurement team is committed to delivering sustainable procurement. This involves reviewing current processes and ensuring we adapt, factoring in the economic, environmental and social considerations when procuring Goods and Services. This involves looking beyond the short-term and looking at the longer-term impacts when conducting Procurement processes.

Life Cycle Costing is an efficient tool used that enables the review of all elements of the cycle including but not limited to:

- Purchase price and associated costs including delivery, transportation etc.
- Operating and maintenance costs including maintenance, utilities etc.
- End of life costs including disposal etc.

We review all tender documentation including Pre-Qualification Questionnaires (PQQs) and Invitations to Tenders (ITTs) to ensure that sustainable issues are considered within future procurement decisions.

Targets

- For the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039
- No longer purchase from suppliers that do not meet or exceed NHS' commitment to net ze ro
- Switch to 100% recycled content paper for all office-based functions in 2022/23
- Reducing reliance on office paper by 50% across secondary care through increased digitalisation
- Signing up to and delivering the NHS ' Plastics Pledge' which commits organisations to phase out procurement of single-use plastic items throughout the NHS supply chain

Measuring progress

- % contracts with social value
- Carbon footprint tCO2e
- % contracts with net zero targets aligned with NHS 2040
- Number and % of local suppliers (first 3 postcode digits)
- % and value of equipment reused

Action	Timeframe
Continue to improve compliance and monitoring for procurement processes i.e., the Procure to Pay policy stipulates that we should look to reuse before buying new	Ongoing
Reduce paper usage by 50% in offices	2022/23
Introduce a remanufacturing device collection and reuse programme	2022/23
Establish a walking aids reuse programme	2022/23

Food and nutrition

NHS England estimates that hospital food and catering produce 1.5 kilotonnes of carbon dioxide equivalent, 6% of the NHS's total greenhouse gases. Sustainable diets can improve wellbeing and help to prevent diet-related illness while reducing our environmental impact.

Progress to date

Within our three main sites, our fresh food produce is all locally sourced, all suppliers we work with are reviewed in full based on their sustainable procurement policies to ensure that we share the same approach. We ensure our suppliers meet all requirements when it comes to ethical farming, waste and nutritional content including meeting all of the national and food safety standards.

We will continue to improve the quality, locality and sustainability of food across the Trust and adopt this approach in other areas of food procurement. A Task and Finish Food Wastage Group has also been established whose aim is to reduce food waste through the Trust.

Targets

- By 2028, so far as clinically appropriate, to cease use at the Provider's Premises of single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxodegradable plastics.
- 50% of our menus will be meat-free by 2030

Measuring progress

- Food waste (tonnes)
- % menu vegetarian or vegan options

Action	Timeframe
Continue to maximise the use of seasonal ingredients in our menus	Ongoing
Aim for sustainable production methods such as organic, free range and methods that allow soils to recover, have more mixed native hedging between	Ongoing
Ensure food which cannot be used is efficiently composted	2022/23
Redistribute surplus food that would otherwise be thrown away via food banks or food sharing apps	2023/24

Adaptation

The effects of climate change are already being felt, and so we must adapt quickly and comprehensively. We will focus on developing adaptation solutions to help reduce climate-related risks such as flooding, drought, hot weather and freezing temperatures that threaten the provision of our services.

Progress to date

To date, we have undertaken maintenance and introduction of green spaces around the site. Trees and open spaces in urban areas can be successfully used to manage urban temperatures by providing shading and helping to dissipate heat through evaporation and controlling air movement. Alongside this, we are seeking ways to improve the air quality at our sites.

The following resilience plans have been produced with partners to deal with projected changes in climate and extreme weather events:

- Major Incident Plan
- Significant Incident Plan
- Incident Coordination Centre Manual
- Adverse Weather Manual
- Heatwave Plan

Targets

Adhere to targets and requirements set out in Building engineering in the health sector (HTM 00)[4], the Climate Change Act[5] and the National Adaptation Programme (NAP)[6] to put plans in place to address both the causes and consequences of climate change.

Measuring progress

- Number of overheating cases per year
- Staff attending climate adaptation working group sessions
- Number of climate risks identified in risk assessment
- Number of people trained in climate adaptation

Action	Timeframe
Collaborate with local Councils and partners to align mitigation measures and enhance adaptation approach	Ongoing
Establish climate change adaption working group	2022
Identify climate projections (particularly flood risk) on Trust sites	2022/23

[4] (HTM 00) Building engineering in the health sector

[5] Climate Change Act 2008

[6] Department for Environment Food & Rural Affairs *The National Adaptation Programme and the third strategy for climate adaptation reporting*, 2018

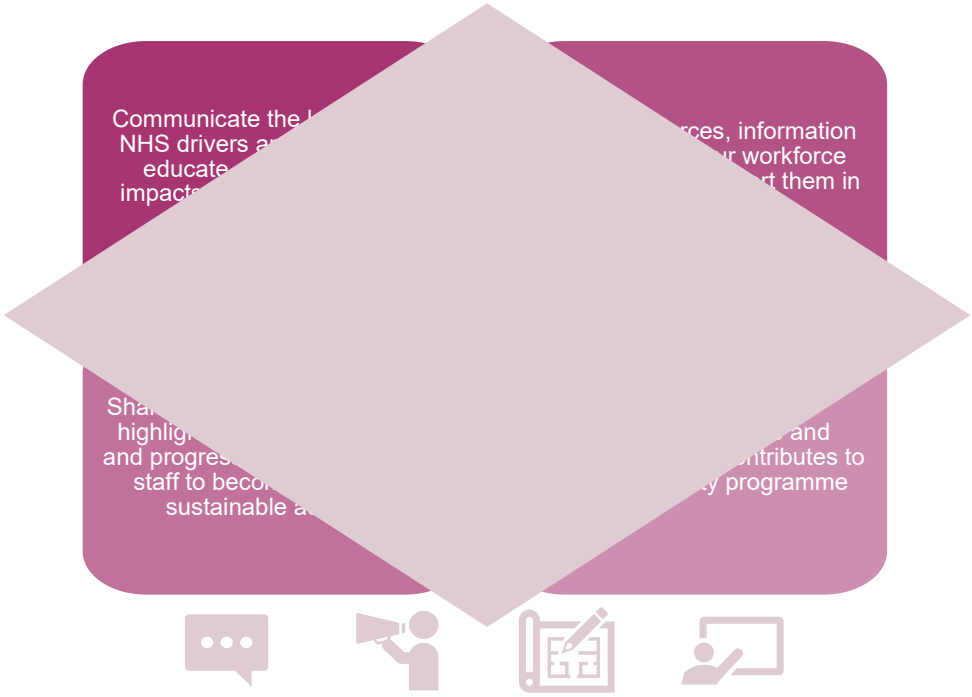
Resources and delivery

Communications and partnership engagement

Take action now!

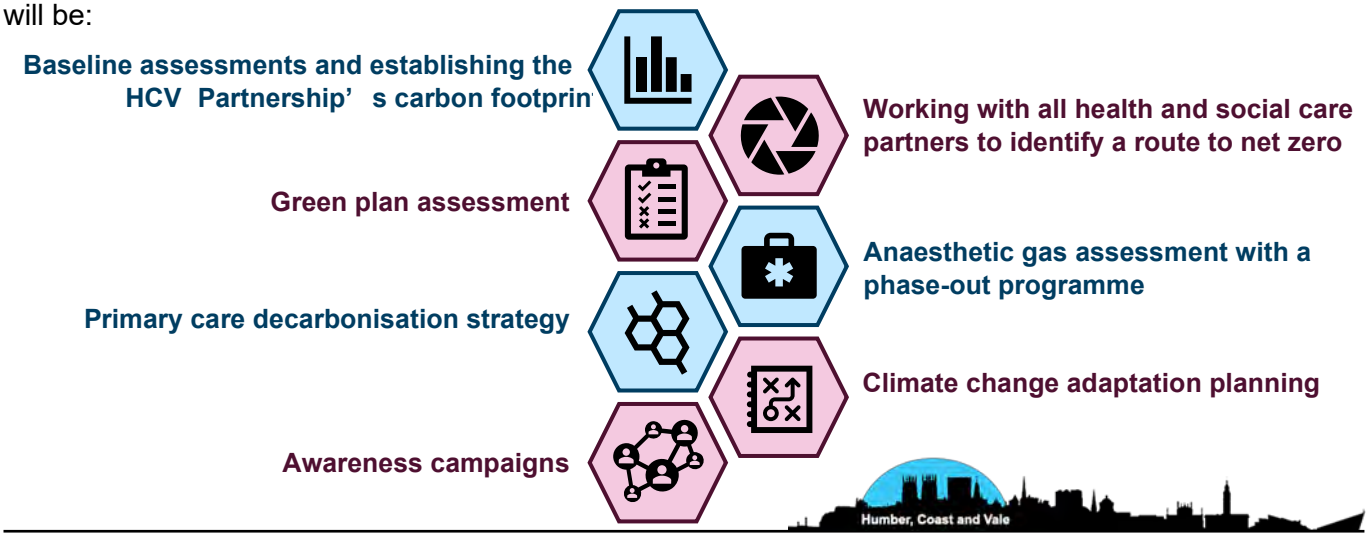
Climate change threatens the core purpose of the NHS – putting the health and wellbeing of the patients and communities we serve at risk now and in future. We are part of the challenge and the solution. We have a collective responsibility to act and to do that, the Trust is encouraging all staff, partners and the wider community to take action.

Communication plays a key role in enabling Green Plan delivery. The main objectives of communications set out by the Greener NHS are **raising awareness**, **building understanding** and **inspiring action**. Further details of our actions will be outlined in a Communications Plan to be developed in 2022/23. The key areas of focus for engaging our community are highlighted to the right.



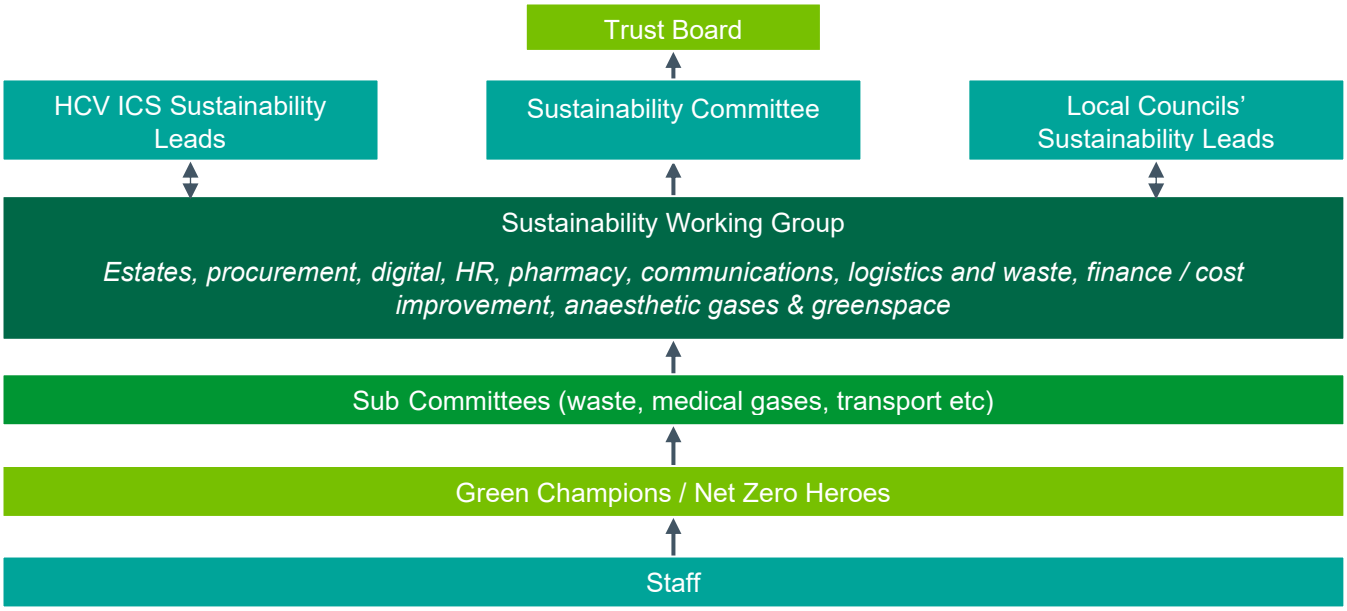
Humber, Coast and Vale Health Integrated Care Partnership (ICS)

Our Partnership's ambition is for everyone in our area to start well, live well and age well. This means shifting the focus of our work from picking people up when they fall to helping to prevent them from becoming unwell in the first place and supporting more people to manage their health and wellbeing at home so they can get on with living happy and fulfilling lives. The ICS is still establishing a target date for net zero, which will be considered as part of future plans. Sustainability within our care and reducing our impact on the local environment play a key role in this ambition. The key areas of work that will be looked at with our ICS partners in this coming year as part of the net zero and climate change agenda will be:



Governance and responsibility

Our sustainability governance structure is outlined below:



All staff

All staff have a role to play in delivering this Green Plan. We will continue engagement and dialogue, further building understanding and support for both practical action and deepening ambition.

Staff Champions / Net Zero Heroes

A staff network will be established to attract all environmentally-minded staff across all Trust departments. Champions are ambassadors for sustainability and green initiatives within in their work area and the wider trust. They act as a conduit between the Trust's sustainability group and wider staff in order to disseminate information, provide feedback and generate ideas. They support in gaining excitement and further engagement with sustainability across our workforce.

Sub-Committees

We will establish task groups to develop delivery plans against each of the Green Plan key areas. These delivery plans will provide a pipeline of projects for each year alongside setting responsibilities, timeframes for delivery, and metrics for monitoring.

Sustainability Working Group

A sustainability group has been engaged to deliver the implementation of the green plan. The sustainability group meets monthly to progress actions and is responsible for formalising an annual report to be submitted to the board by the lead Director. The sustainability group will be further supported by dedicated sub-committees to assist implementation of the Green Plan across its various sectors.

Trust Board

Strong leadership and support from decision makers is required to embed sustainability across the organisation. The delivery of our Green Plan will be overseen by our designated board-level net zero lead, who will report progress annually to the Board.

Dedicated sustainability resource

We will continue to resource sustainability and environmental programs across our sites, establishing an annual budget for sustainability. This may include the establishment of a dedicated team, for example a sustainability manager and/or officer in post. When required, we will continue to work alongside our sustainability partners, ETL, in delivering upon the actions set out in this plan.

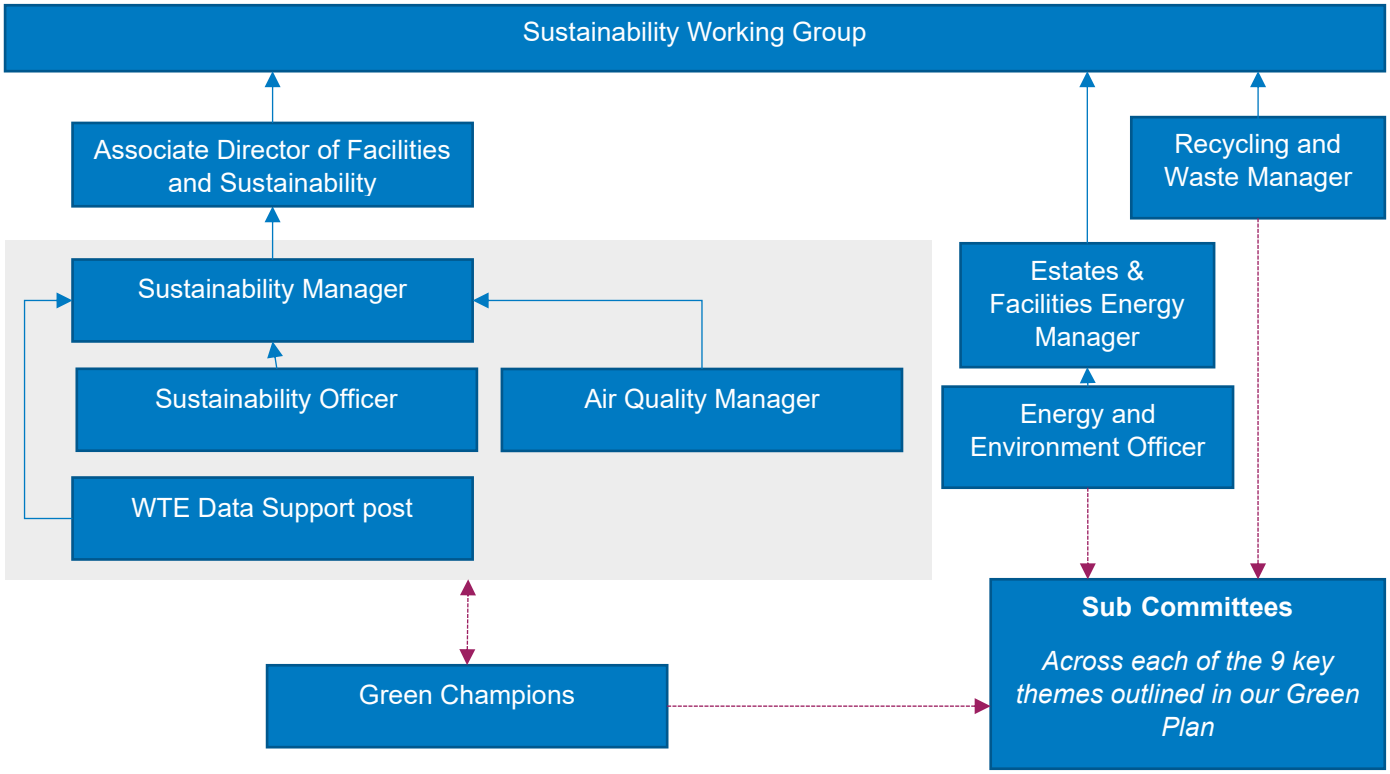
Our proposed plans to grow the sustainability team include:

- A Band 4 WTE Data Support post
- A Band 6 Sustainability Officer
- A Band 6 Energy and Environmental Officer
- A Band 7 Air Quality Manager
- A Band 8a Recycling and Waste Manager
- A Band 8a Sustainability Manager

The Sustainability Manager will feed into the Associate Director of Facilities and Sustainability to lead the integration and coordination of sub-committees. They will act as the connection between groups, identifying synergies and linkages to accelerate progress and ensures they are managing to deliver upon projects and targets set out in this Green Plan.

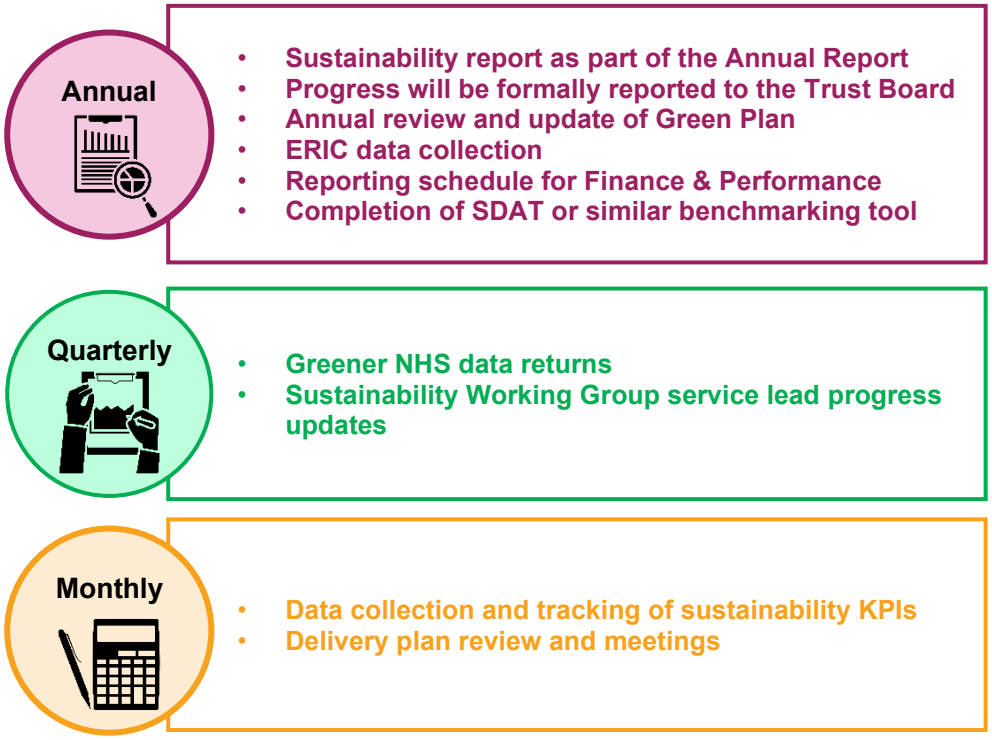
Alongside a full-time Sustainability Manager, a Recycling and Waste Manager will drive the reduce, reuse, recycling and remanufacture agenda to generate waste savings and improve the circular economy of the Trust.

Various support roles would be beneficial to provide dedicated resource against key priorities set out in this Plan, including data and analytics, energy management, air quality and transport.



Tracking and reporting progress

This Green Plan is approved by the Trust's Board and reported by the Estates and Facilities Governance Group. The implementation of this plan is to be overseen by the Sustainability Working Group. Progress towards the objectives, commitments and targets contained within this action plan will be monitored through a structured approach that will produce outputs on an annual, quarterly and monthly basis.



Finance

Delivering a net zero National Health Service makes clear that many of the interventions described are either cost-neutral or can provide an immediate cost benefit. Many of the actions set out in this plan are aligned with existing priorities, such as the digital transformation agenda, where quick progress should be made.

Additional capital investment will be required to deliver the Green Plan. We will:

Continue to integrate net zero principles within all business-as-usual upgrades and maintenance.

Integrate sustainability within business case requirements to ensure our projects are contributing to our Green Plan priorities and objectives.

Continue to explore grant funding opportunities, as seen with the Public Sector Decarbonisation Scheme (PSDS).

There may also be funding schemes for active travel whereby the Trust will work alongside suppliers and local councils to identify low or zero carbon alternatives and encourage active travel e.g. through improvements to infrastructure.

U tilise the Greener NHS Programme's Future NHS workspace ɒ review details of new schemes and funding available across the UK, including eligibility criteria, and support navigating the application process.

How to get involved

Everyone's contribution is required in order to meet our goals set out in this Green Plan; however, it is important that our people are empowered to be able to take action. There are a number of simple actions that collectively can make a big difference. At NLaG, we encourage our staff to get involved using the following mechanisms:

Staff pledges

We encourage staff to take their own sustainability and net zero pledges. These could include:

Go digital

Cycle to work

Reduce, reuse and recycle

Eliminate single-use plastic

Net zero heroes

A network of staff, suppliers and volunteers who are involved in raising sustainability awareness at the Trust, encouraging others to join NLaG's Greener NHS ambition.

If you would like to understand your own carbon footprint and make sustainable changes visit footprint.wwf.org.uk.

Suggestions and ideas

Staff are encouraged to suggest any projects that will directly impact our environmental performance.

Communicate success and ask for support

When exemplar change is recognised, staff should share case studies with the communications team to highlight success and share with the wider workforce and Greener NHS Community.

Email xxxx@nhs.net to become a Net Zero Hero today

Visit our website to learn more about sustainability at NLaG

Visit the staff intranet page, the Hub

References

- NHS England *For a greener NHS*
- NHS England. *2019/20 NHS Standard Contract*, 2020
- NHS England. *The NHS Long Term Plan*, 2019
- Climate Change Act 2008
- Civil Contingencies Act 2004
- Public Services (Social Value) Act 2012
- Department for Environment Food & Rural Affairs *The National Adaptation Programme and the third strategy for climate adaptation reporting*, 2018
- NHS England *NHS Operational Planning and Contracting Guidance 2020/21*
- *Health Technical Memorandum 07-02: EnCO2de 2015 – making energy work in healthcare*
- *Health Technical Memorandum 07-04: Water Management and Water Efficiency*
- *(HTM 00) Building engineering in the health sector*

Glossary

- BREEAM — Building Research Establishment Environmental Assessment Method
- CCRA — Climate Change Risk Assessment
- CHP — Combined Heat and Power Plant
- CO2 — Carbon Dioxide
- CO2e — Carbon Dioxide and equivalent Green House Gases
- DPI — Dry Powder Inhalers
- ED — Emergency Department
- EMS — Environmental Management System
- ERIC — Estates Returns Information Collection
- F-gases — Fluorinated greenhouse gases
- HCV — Humber, Coast and Vale
- HTM — Health Technical Memoranda
- ICS — Integrated Care System
- ITTs — Invitations to Tenders
- KPI — Key Performance Indicator
- kWh — Kilowatt hours
- LED — Light-emitting diode
- MDI — Metered Dose Inhalers
- NAP — National Adaptation Programme
- NHS — National Health Service
- NLaG — Northern Lincolnshire and Goole NHS Foundation Trust
- NO2 — Nitrogen dioxide
- NOx — Nitrogen oxides
- PDR — Performance and development review
- PLACE — Patient-Led Assessments of the Care Environment
- PQQs — Pre-Qualification Questionnaires
- Procurement — The process used to purchase goods and services
- PSDS — Public Sector Decarbonisation Scheme
- REGO — Renewable Energy Guarantees of Origin
- SDAT — Sustainable Development Adaptation Tool
- SDGs — United Nations Sustainable Development Goals
- SDU — NHS Sustainable Development Unit
- Solar PV — Solar Photovoltaic cells
- tCO2 — Tonnes of carbon dioxide
- WEE — Waste Electrical and Electronic Equipment recycling
- WTE — Whole time equivalent employee
- VOCs — Volatile Organic Compounds
- ULEV — Ultra Low Emissions Vehicles
- ZEV — Zero Emissions Vehicles

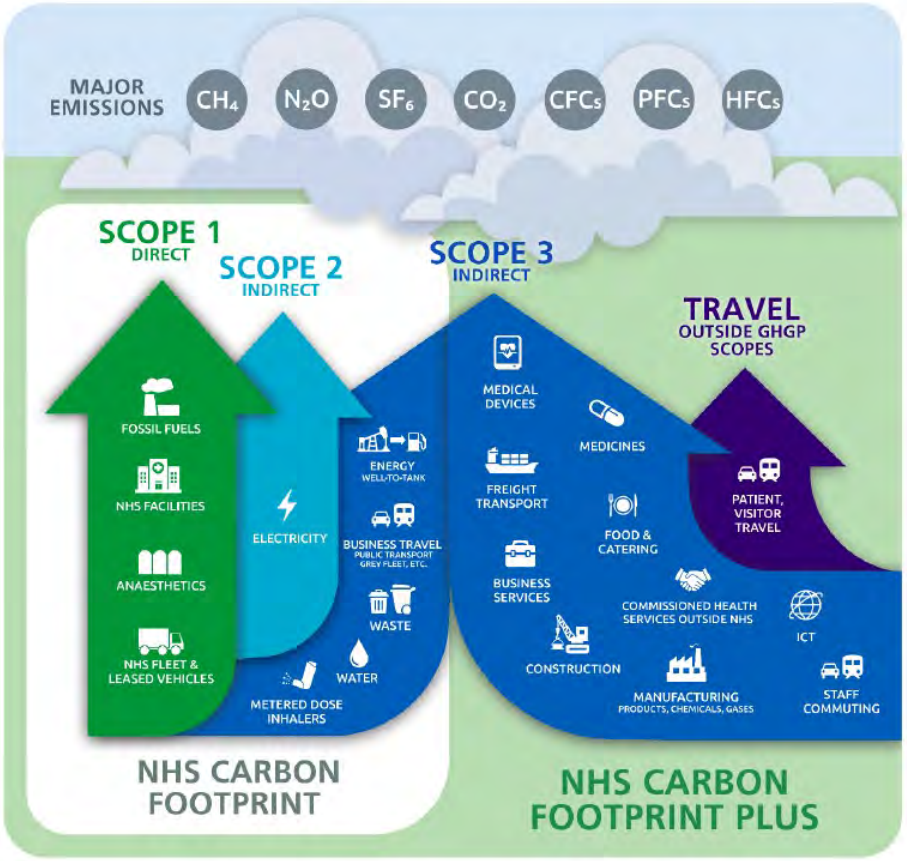
NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Green Plan

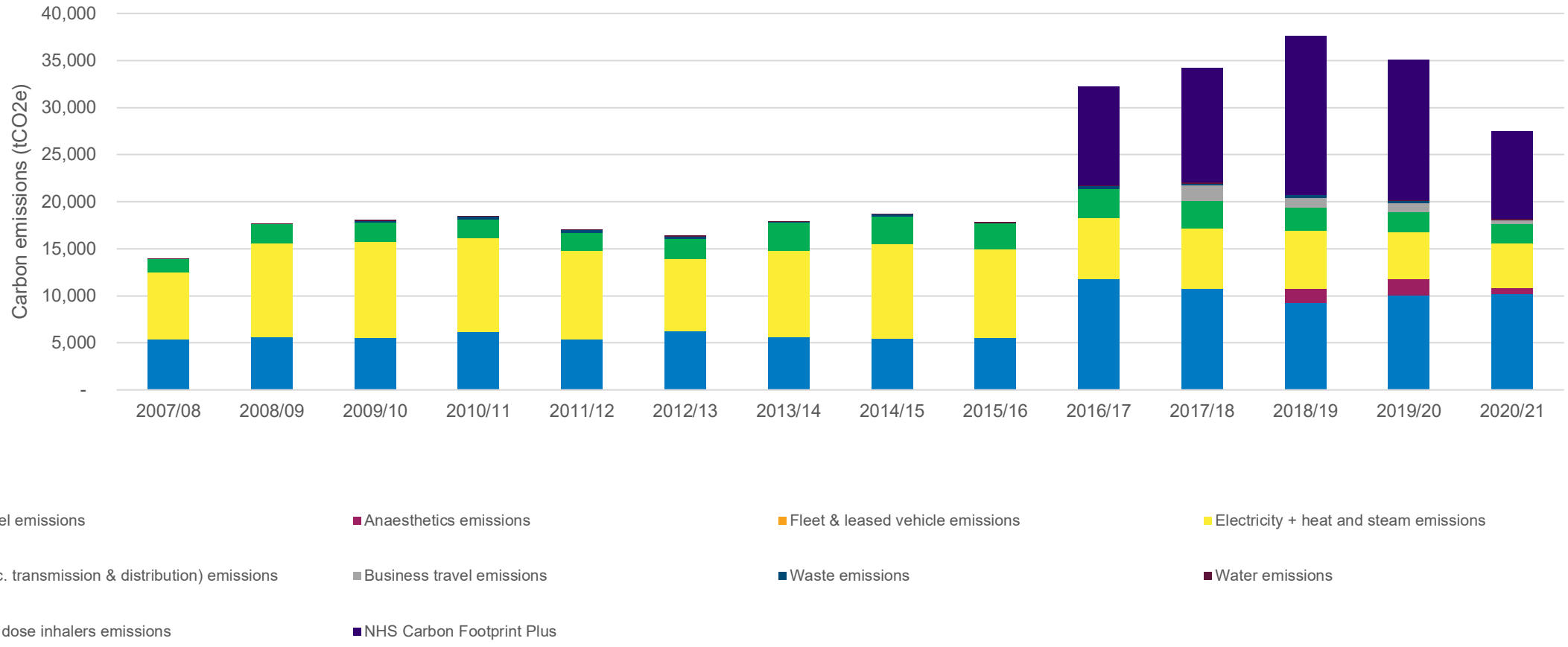
2022-2025

Our Green Plan

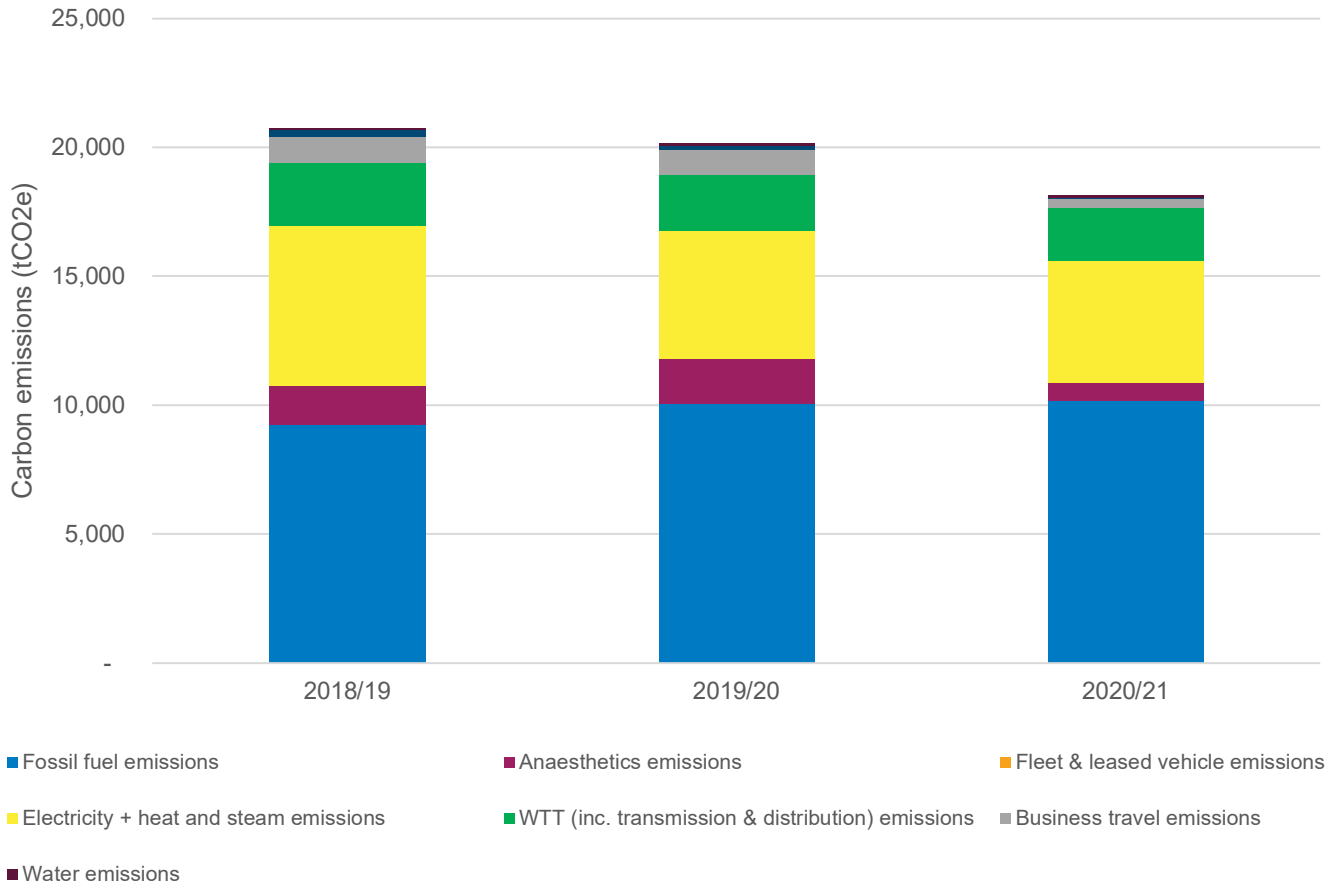
- The Greener NHS's 'Delivering a net zero National Health Service report highlights that **left unabated, climate change will have devastating effects on human health** and subsequently the NHS. The report set out the trajectories and actions required for the NHS to achieve its net zero targets.
- The 2021/22 NHS Standard Contract set out the requirement for Trusts to develop a Green Plan to detail their approaches to reducing their emissions.
- Trusts are now required to submit quarterly data returns to the Greener NHS programme who will review the sustainability performance of the Trust against a range of themes.



Our carbon emissions



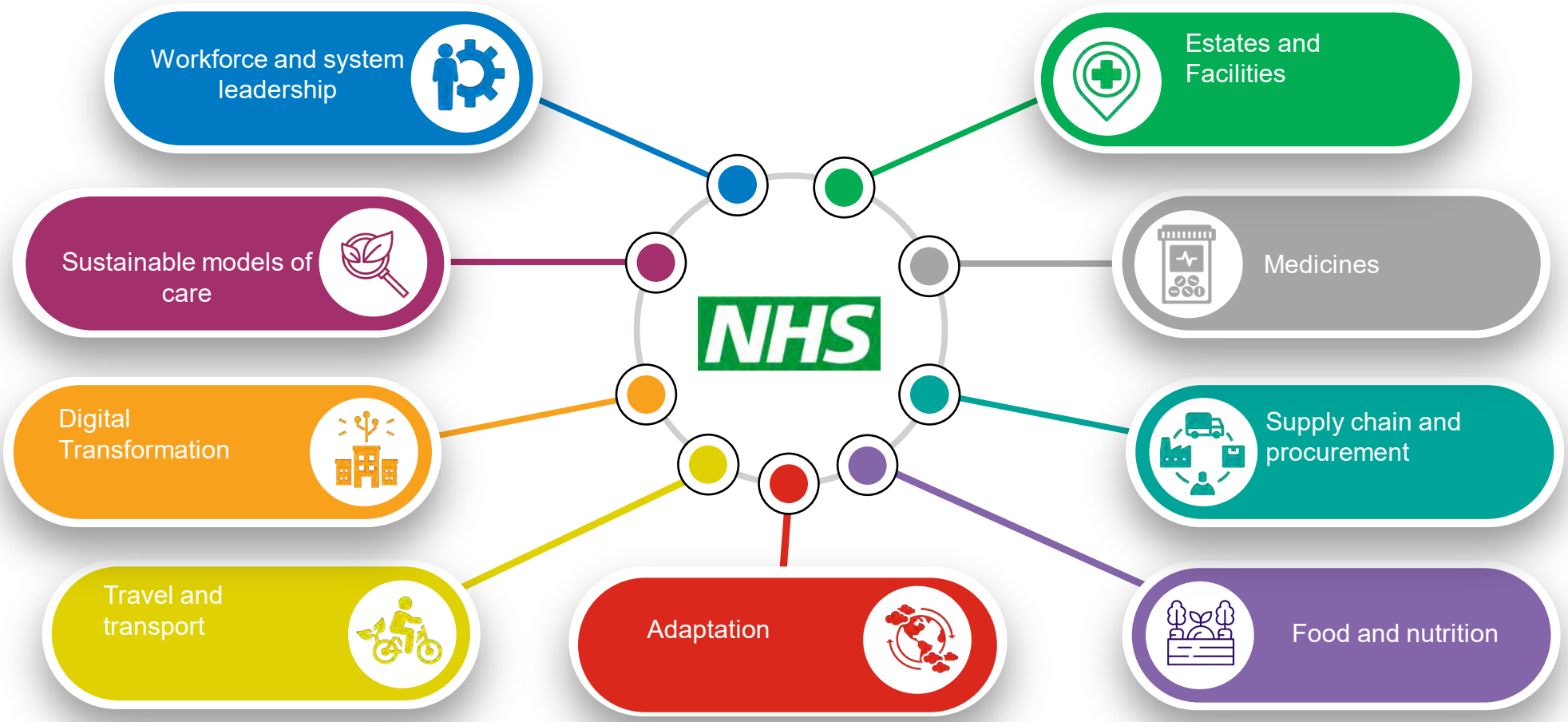
Our carbon emissions



- Our NHS Carbon Footprint has steadily decreased between 2018/19 and 2020/21.

- In the last year, our footprint decreased by 10%, with the biggest reductions attributed to reductions in anesthetics and business travel as well as reductions in electricity consumption.

What are the key areas of focus?

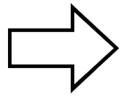


Targets and Next Steps

Our ambitions

- Net zero by 2040 for our direct Carbon Footprint
- Net zero by 2045 for Carbon Footprint Plus
- Reduce carbon, waste and water
- Improve air quality
- Reduce the use of avoidable single-use plastics
- Protect our services from climate change
- Encourage sustainable behaviours

Next steps



- Allocate an annual sustainability budget
- Employ a Band 4 data support officer and build a dedicated sustainability team
- Establish annual reporting requirements against KPIs
- Progress delivery of the action plan laid out within the Green Plan
- Review Greener NHS quarterly data submission progress and target areas for improvement

NHS
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Green Travel Plan

2022-2025

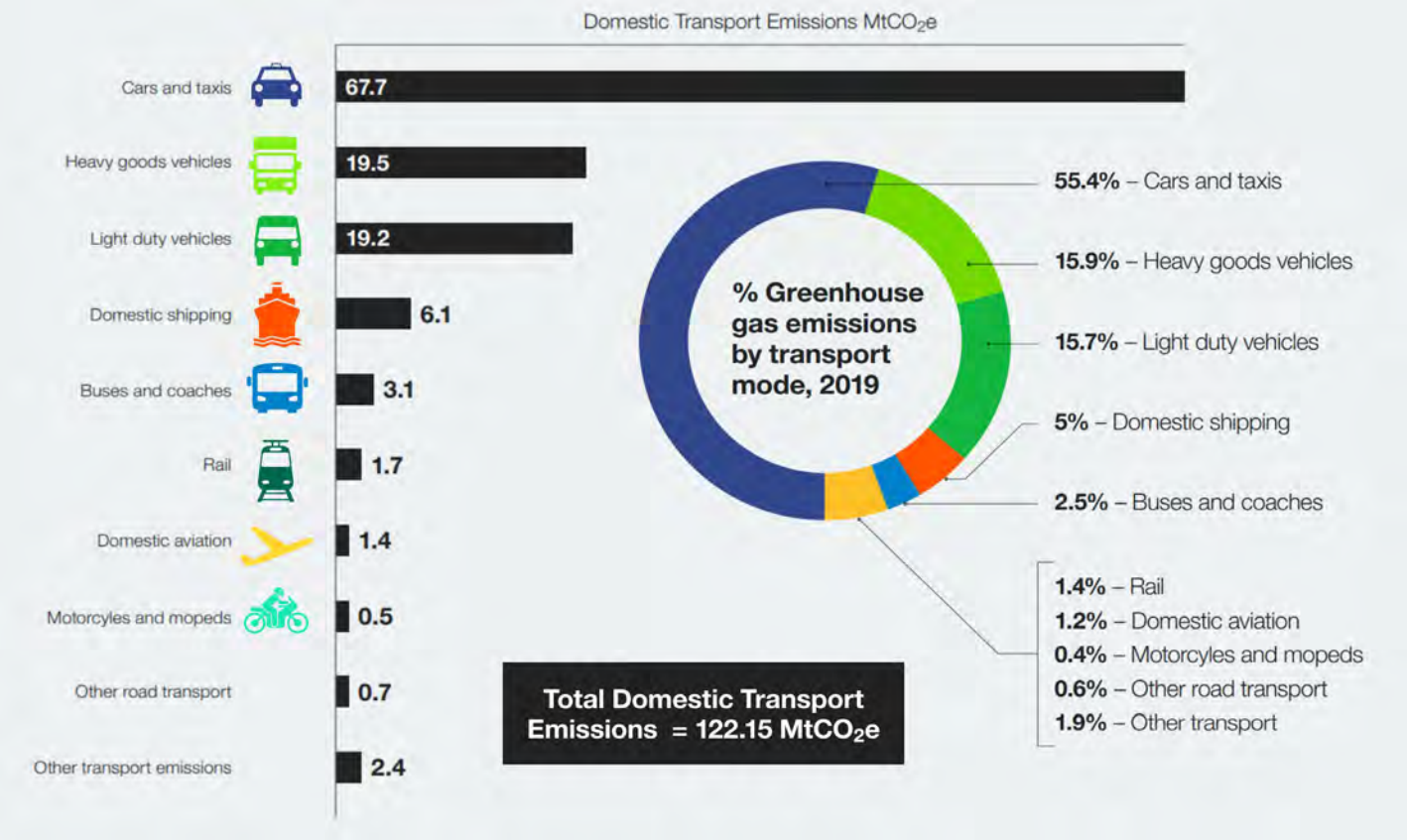
Green Travel Plan

What is a Green Travel Plan?

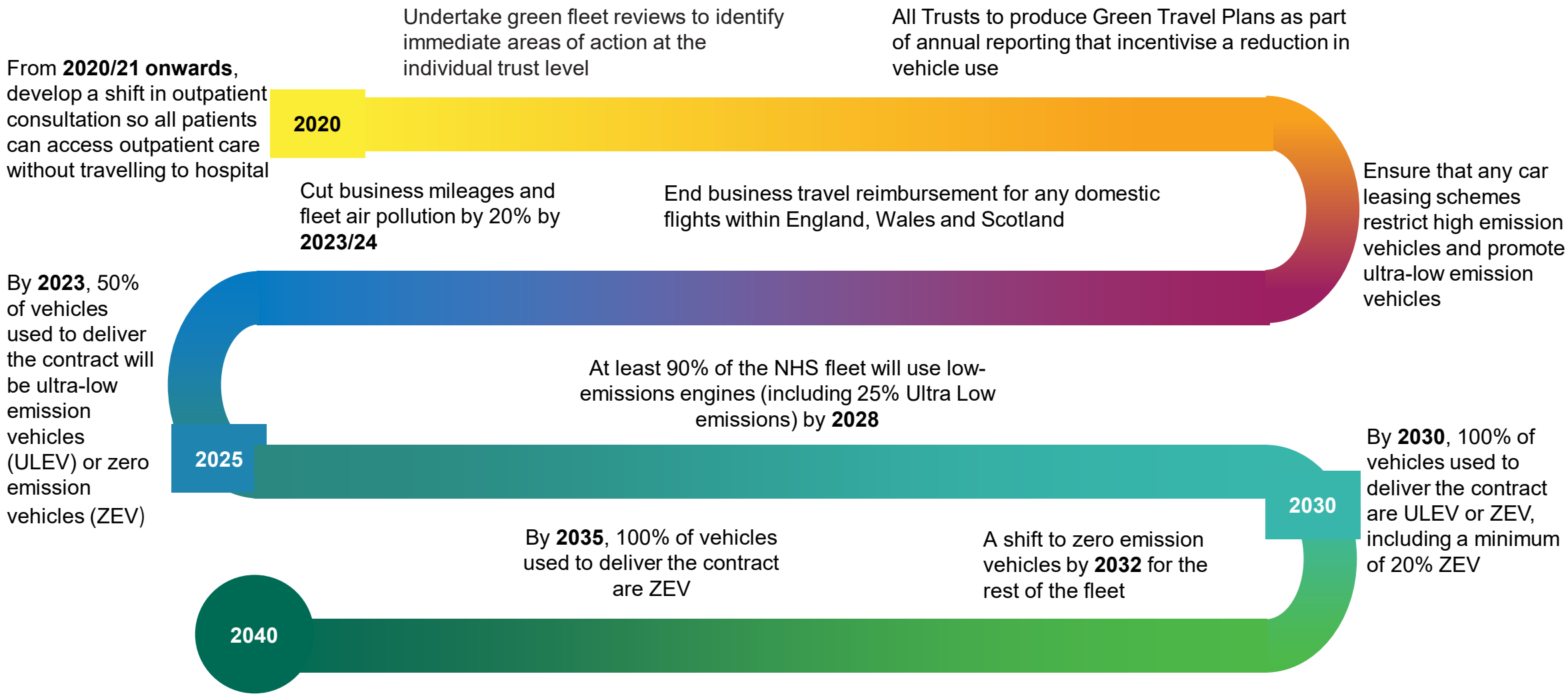
- A Green Travel Plan is a document that aims to assess the current travel trends within an organisation and aims to encourage a behavioural shift which will lead to the use of more sustainable modes of travel to and from the site.

Why is it necessary?

- In 2019, transport became the largest contributor to UK domestic greenhouse gas emissions responsible for a total of 27%.
- The NHS is responsible for 9.5 billion road miles each year which equates to 3.5% of all road travel in England. Travel is also responsible for 14% of the NHS' total emissions.



NHS route to net zero travel



Where we are now

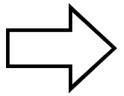
- The table below shows the results of our travel surveys conducted since 2015.
- As shown by the table, currently we are not on track to meet our targets tied to reducing our travel and transport carbon footprint.

Target	Measure	2015 baseline	2018 target	2018 result	2021 target	2021 result	On track?	2024 target
1: Decrease in single occupancy vehicle use by staff	Number of staff driving to work by themselves	77%	73%	73%	68%	70%	×	65%
2: Increase in numbers of staff walking or cycling to work	Number of staff walking or cycling	17%	19%	10%	13%	9%	×	15%
3: Increase the percentage of staff regularly car sharing or using public transport to work	Number of staff car sharing or using public transport	9%	17%	10%	12%	9%	×	15%

Targets and next steps

Our ambitions 

- Decrease single occupancy vehicle use
- Convert fleet and pool vehicles to fully electric
- Increase percentage of active travel to site
- Encourage uptake of electric vehicles
- Increase percentage of staff car sharing to commute to site
- Encourage uptake of public transport

Next steps 

- Increase current travel budget
- Undertake annual staff/visitor travel surveys
- Undertake green fleet reviews to identify immediate areas of action
- Continue to improve active travel facilities across all sites
- Improve EV charging infrastructure at all sites
- Work with the local council and additional partners to improve active travel options (e.g. green routes between major sites)

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	Tuesday 6 December 2022
Director Lead	Jug Johal – Director of Estates and Facilities
Contact Officer/Author	Keith Fowler – Associate Director of Facilities and Sustainability
Title of the Report	**NLaG Green Plan and Travel Plan**
Purpose of the Report and Executive Summary (to include recommendations)	The NLaG Green and Travel Plan sets out how NLaG will work to achieve the NHS Net Zero Carbon emissions target. The Green Plan provides information on the challenge Net Zero presents the NHS and details how NLaG contributes to that carbon footprint. The Green Plan and Travel Plan provides information on sources of carbon as a result of our operations, and projects how we can work as an organisation to reduce carbon from utilities, procurement, medicines, gasses, and travel, as examples of carbon emitting functions. The Green Plan and Travel Plan sets out a strategy towards 2025 to reduce carbon and embed sustainable changes for the future improvements to our business for the benefit of our healthcare communities. Recommendation – The Trust Board is asked to approve the Strategic Trust Green Plan and Travel Plan 2022 – 2025.
Background Information and/or Supporting Document(s) (if applicable)	NLaG Green Plan 2022 – 2025, NLaG Travel Plan 2022 - 25
Prior Approval Process	✓ TMB ☐ PRIMs ✓ Divisional SMT ✓ Finance and Performance Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	Allocation of salary sacrifice benefits for EV charging Infrastructure. Band 4 Sustainability Officer 2023 Business Plan

Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	✓ Approval ✓ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Green Travel Plan

2022-2025

Northern Lincolnshire and Goole Hospital (NLAG) was established as a combined hospital and community trust on 1st April 2001 and achieved foundation status in 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates across all NHS hospitals in Scunthorpe, Grimsby and Goole. The considerable geographical distance that separates each of the three hospitals poses a significant service delivery challenge yet also allows for the trust to provide acute care to a wide population of over 450,000.

Figure 1: Diana Princess of Wales Hospital

Based in Grimsby, Diana Princess of Wales (DPoW) provides a wide variety of inpatient and outpatient services. Whilst providing planned patient care, DPoW also provides access to one of the most advanced emergency care centres in the region as well as a modern en-suite maternity facility and a £4.4 million oncology, haematology and rheumatology unit.

Figure 2: Scunthorpe General Hospital

Scunthorpe General Hospital also provides a wide range of inpatient and outpatient services as well as a busy emergency centre that receives over 60,000 attendances each year. It also features state-of-the-art Blue Sky Imaging Suite providing a seven day scanning/diagnostic service for CT, MRI and non-obstetric ultrasound scans.

Goole and District Hospital is the trust's smallest hospital. The hospital provides non-acute medical care, elective surgery, outpatients and diagnostic imaging and midwifery led maternity services for children, young people and adults primarily in the North East Lincolnshire

Figure 3: Goole and District Hospital

In total NLAG are responsible for 77 community sites across the North Lincolnshire, North East Lincolnshire and the East Riding of Yorkshire. All sites operate 24 hours a day, 7 days per week, with staff working various shift patterns. Due to staff specialisms and resourcing there is a requirement for some staff to work across more than one site in NLAG's area. In total, NLAG employees around 6,800 staff across the trust.

ETL

A healthier perspective

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Executive summary

Existing travel patterns

Updates to NLaG's previous staff surveys were conducted in February 2021. Of 181 responses, analysis of this survey found that:

- 70% of staff respondents travel to work via a single occupancy vehicle (a 3% decrease since 2019)
- 9% travel to work via bicycle (a 4% decrease since 2019)
- 9% travel to work via public transport (a 1% increase since 2019)
- 12% work from home

Aims and objectives

- NLaG continues to recognise its responsibilities in regard to creating a greener and more sustainable future for patients, visitors and staff. This Green Travel Plan provides a timely update on our aims and objectives following significant infrastructural development across our key sites.
- The aims and objectives laid out in this Green Travel Plan have been developed by evaluating the previous Travel Plan and updating them according to NLaG's Trust priorities laid out in the supplementary Green Plan as well as developments in key national policy.
- Our aims continue to be centred around the reduction of single-use occupancies to get to and from our sites, and the promotion of more sustainable modes of travel including public transport and active travel. The overarching aim is to promote a healthier environment whilst simultaneously reducing the emissions we, as a Trust, our responsible for.

Actions for the next 3 years

Page 23 of this Green Travel Plan sets out a number of measures and bespoke interventions broken down by mode of travel. These interventions and measures act to update NLaG's previous Green Travel Plan with the aim of achieving the Trust's new travel and transport targets outlined on page 25.

Monitoring and Review

This Green Travel Plan is the third to be produced by the Trust and continues the formal review process to update on the Trust's travel progress. This Green Travel Plan should therefore be next updated in 2025. This plan includes a monitoring and review strategy on page 31 to ensure the successful delivery of the actions and measures laid out in the plan.

Foreword

"With NHS travel and transport accounting for 3.5% of all UK road traffic, reducing journeys and adopting greener transport is critical if we are to reduce harmful emissions, clean up our air, and improve health now and for future generations. Air pollution alone contributes to 1 in 20 deaths in the UK. At NLaG, we recognise our role in reducing emissions to support the reduction of cases of asthma, cancer and heart disease. Travel forms a core part of our strategies and everyday operations and we will continue to promote low carbon alternatives to our patients, staff, visitors and wider communities.

The Board and I are wholly committed to embedding sustainability within NLaG's daily behaviours and choices and encourage every single member of staff to take the necessary 'steps' to reduce the impact of their travel on their health and the environment."

Jug Johal – Director of Estates and Facilities

Contents

Introduction

As defined by the Department for Transport (DfT), a Travel Plan is

"a package of measures tailored to the needs of individual sites and aimed at promoting greener, cleaner travel choices and reducing reliance on the car".

The overarching purpose of a Green Travel Plan should therefore be to encourage behaviour change which will lead to the use of more sustainable modes of travel and reduce overall travel to and from the site in question.

A Travel Plan should function as a live document that should be reviewed over time in response to changing circumstances. Travel Plans should include objectives, initiatives and targets that can be implemented to reduce the impact of travel and transport on the local environment. The benefits of implementing a Green Travel Plan are not strictly environmental but also include reduced congestion, increased road safety as well as economic, social and health benefits.

At NLaG, we recognise the importance of a robust travel plan in fulfilling our responsibilities to contribute towards a greener environment. The value of a successful Green Travel Plan cannot be underestimated and can provide a variety of benefits to both staff and the wider local community. These include a physically and mentally healthier environment which can lead to increased motivation and productivity, reduced congestion and shorter journey times as well as emissions reductions, enhanced air quality and reduced noise pollution.

In partnership with ETL, this Green Travel Plan builds on our Travel Plans from 2015 and 2018, monitoring, reviewing progress and evaluating the sustainable travel developments made across the Trust's main sites.

It will ensure that progress has been made towards the overarching aims, as well as reviewing whether the original travel objectives and targets are still relevant, or whether they should be expanded given the development of new national policy and changes in site infrastructure across our hospital sites.

The purpose of this Green Travel Plan is therefore highlighted below:

1. A review of new developments in travel related national and local policy to realign Trust commitments, targets and the rationale for change.
2. To provide an overview of site infrastructure development, staff travel survey results and describe the achievements completed to date.
3. To revise existing travel targets and provide an updated action plan to support progress towards sustainable travel goals.
4. To establish the next steps to be taken to ensure the implementation of the action plan and the further engagement of a variety of Trust stakeholders.

Whilst this travel plan is predominantly focused on influencing the behaviour of Trust staff it remains important to acknowledge the importance of patients and visitors travel behaviour. The policies put forward in this document therefore attempt to influence the behaviour of staff, patients and visitors across the following three sites:

- Diana, Princess of Wales Hospital, Grimsby (DPoW), Scartho Road, Grimsby, North East Lincolnshire, DN33 2BA
- Scunthorpe General Hospital (SGH), Cliff Gardens, Scunthorpe, North Lincolnshire DN15 7BH
- Goole and District Hospital (GDH), Woodland Avenue, Goole, East Riding of Yorkshire, DN14 6RX

Policy Review

National Policy

The Climate Change Act 2008 (2050 Target Amendment) Order 2019

The original Climate Change Act of 2008 committed the UK to an 80% reduction of greenhouse gas emissions compared to 1990 levels. Its amendment in 2019 has furthered that commitment ensuring that by law, the UK's greenhouse gas emissions must be net zero carbon by 2050.

Decarbonising transport- A better greener Britain (2021)[1]

As of 2019, transport became the largest contributor to UK domestic greenhouse gas emissions responsible for a total of 27%. Over half of these transport emissions were attributable to cars. In order to reach net zero carbon, there is an urgent need to not only decarbonise transport, but to encourage less carbon intensive modes of travel. The following targets have been set as a result:

- Increase provisions to promote active travel
- Deliver a green bus revolution
- Railway and maritime decarbonisation by 2050
- Jet zero strategy for net zero aviation by 2050
- All cars and vans to be 100% zero emission by 2035

Gear Change: A bold future vision for a new era (2021)[2]

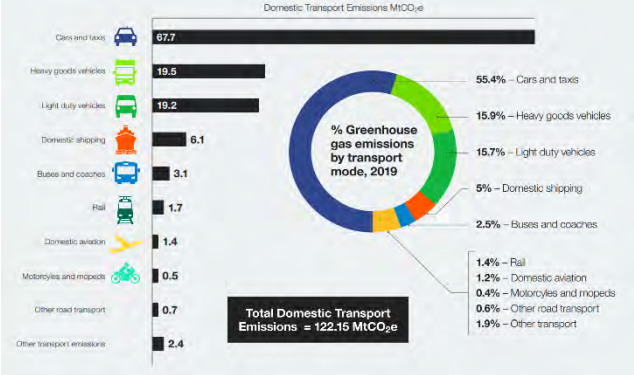
To deliver net zero carbon transport in the UK, decarbonisation of transport must go handinhand with the promotion of active modes of travel. In 2020, the government announced a £2 billion investment into walking and cycling before 2025. The subsequent 'Gear Change' report laid out the following targets:

- Half of all journeys in towns and cities will be cycled or walked by 2030
- England will have a world class walking and cycling network by 2040
- A long-term cycling and walking programme

The Environmental Act 2021

By 2035, air quality is estimated to cost health and social care £5.3 billion in England alone. Transport remains one of the largest sources of air pollution in the UK. Plans to reduce air pollution were initially laid out in the 'Clean Air Strategy' published in 2019. The recent Environmental Bill delivers upon key aspects of the strategy including a legallybinding duty on the government to bring forward the following two air quality targets by October 2022:

- An annual target to reduce the level of fine particulate matter (PM2.5) in the air
- A long-term target for reduction of key air pollutants over a period of at least 15 years



1. Decarbonising Transport – A Better, Greener Britain (publishing.service.gov.uk); 2. Gear change: a bold vision for cycling and walking

Local Policy

The geographical distance between our sites extends the range of the Trust over three unitary authorities including North East Lincolnshire, North Lincolnshire and East Riding of Yorkshire. Each of these authorities have produced bespoke transport strategies for their respective local areas:

Northern Lincolnshire Local Transport Plan 2011-2026[3]

This travel plan sets out how strategic transport improvements will be delivered in the local areas. It sets out a number of key goals including the reduction of carbon dioxide emissions and the protection of the natural environment through sustainable transport solutions. It also establishes the key objectives of enhancing people's health and wellbeing through the promotion of healthy modes of travel and provision of a high-quality integrated transport system that contributes towards long term sustainable regeneration.

North East Lincolnshire Local Travel Plan 2013-2032[4]

North East Lincolnshire's Local Travel Plan sets out its vision and strategy for the borough's future development. Key priorities and objectives within the plan were the promotion of sustainable travel choices in order to reduce congestion, improve environmental quality and encourage more active and healthy lifestyles. The strategy for achieving this includes prioritising pedestrian and cycle access to and within the site, ensuring appropriate provision for access to public transport as well as electric vehicle charging, car clubs and car sharing.

East Riding of Yorkshire Council's Local Transport Plan 2021-2039[5]

The East Riding of Yorkshire Council's local travel plans sets out the strategic objectives, challenges and priorities for local transport in the future. Sustainability is engrained within the future transport strategy of the Council with their key priorities based upon valuing the environment and promoting healthy lifestyles through the promotion of active modes of transport.

NHS

In 2020, the NHS launched committed to be the first net zero health service. To support this the Greener NHS Campaign published the 'Delivering a 'Net Zero' National Health Service' which set out two clear targets:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039

Figure 5 below is taken from the same report and highlights the emissions sources that contribute to the NHS' overall footprint of which travel is a large contributor.

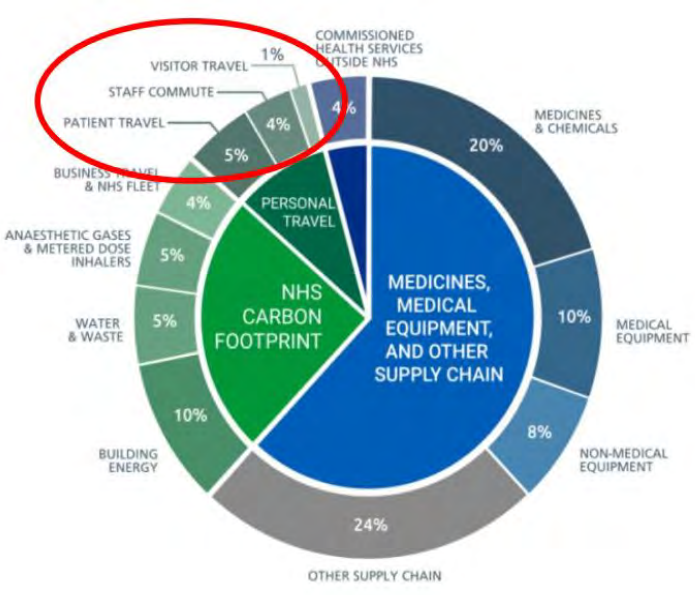
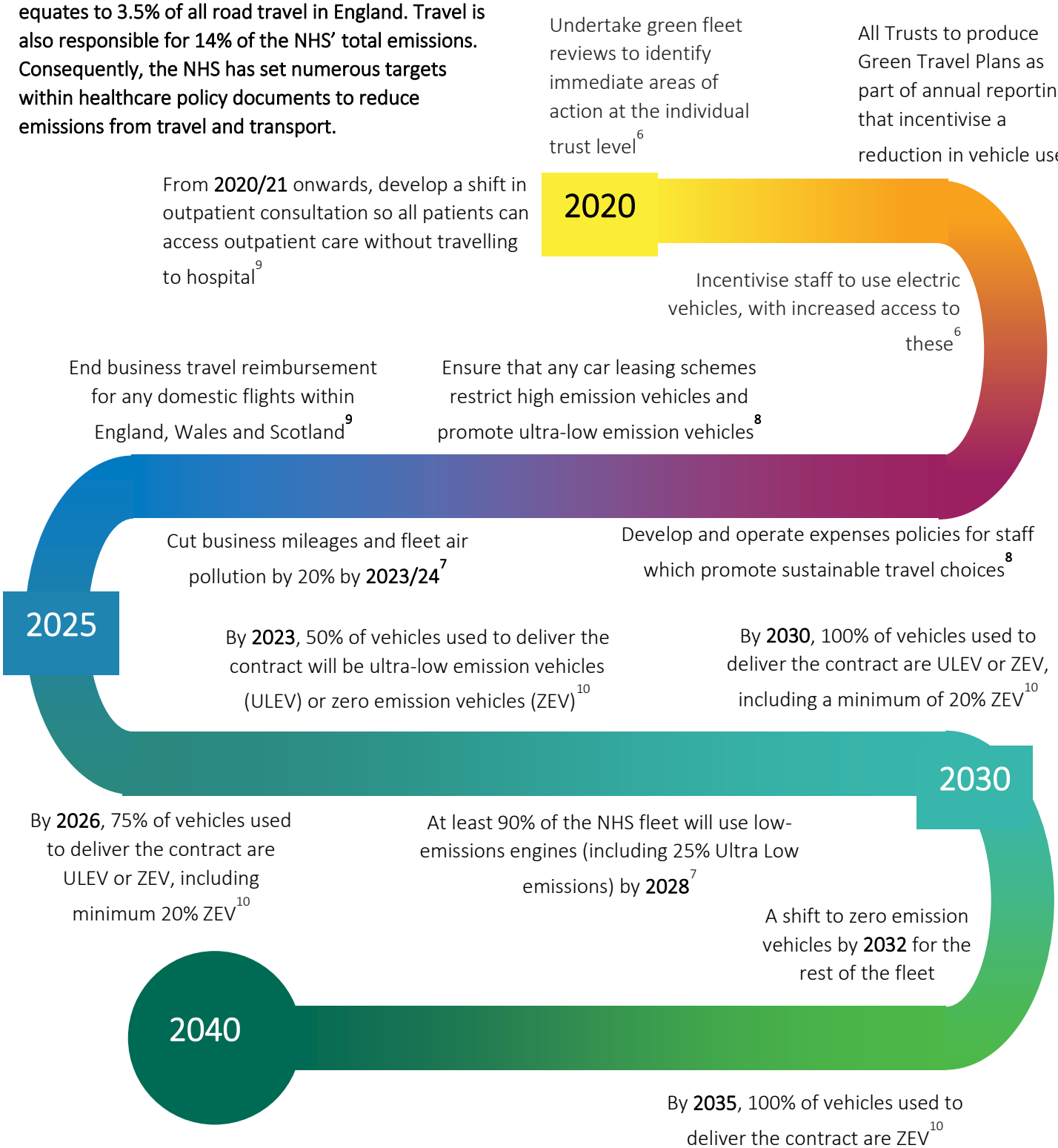


Figure 5: Sources of carbon emissions by proportion of NHS Carbon Footprint Plus from the Delivering a 'Net Zero' National Health Service' report

3. Local Transport Plan 2011-2026 - North Lincolnshire Council (northlincs.gov.uk); 4. 2018 - New Local Plan 2013 to 2032 (nelincs.gov.uk);
5. Local transport plan (eastriding.gov.uk) 6. delivering-a-net-zero-national-health-service.pdf (england.nhs.uk)

Policy Review

Travel and transport are significant contributors towards the NHS' overall emissions footprint. The NHS is responsible for 9.5 billion road miles each year which equates to 3.5% of all road travel in England. Travel is also responsible for 14% of the NHS' total emissions. Consequently, the NHS has set numerous targets within healthcare policy documents to reduce emissions from travel and transport.



7. The NHS Long Term Plan; 8. 2020/21 NHS Standard Contract; 9. NHS Operational Planning and Contracting Guidance 2020/21; 10. NHS Non-Emergency Patient Transport Services (NEPTS) review

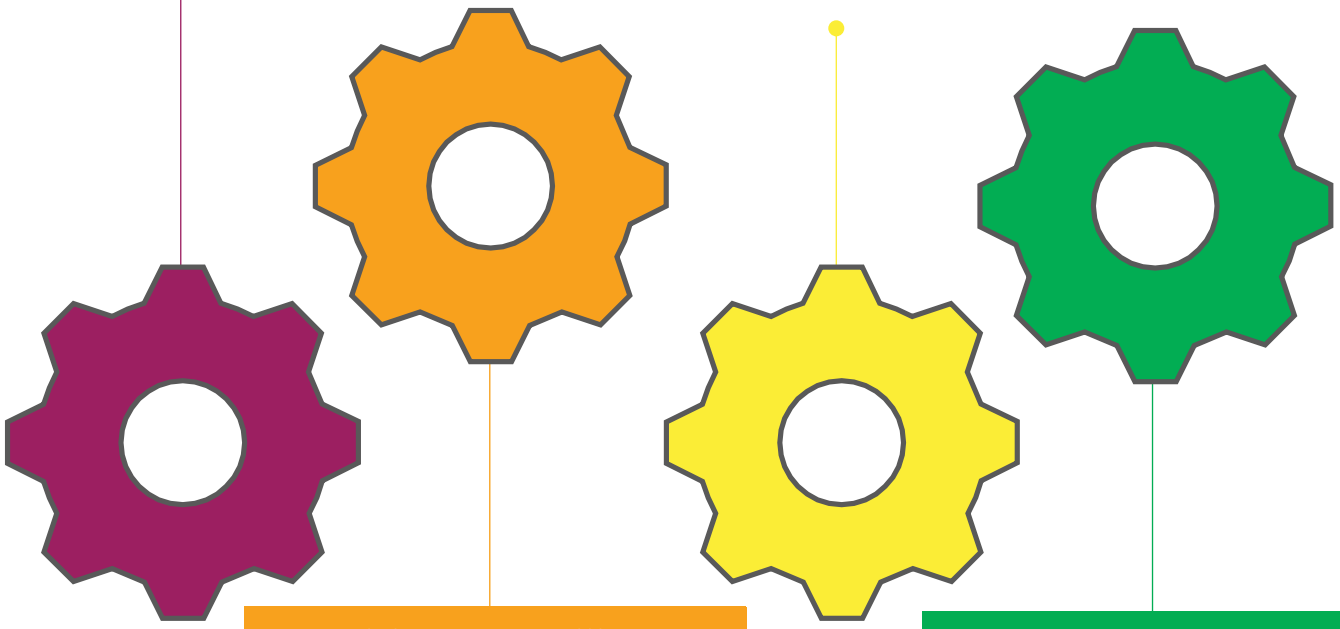
Context and Drivers

National, Regional and Local Policy

The Greener NHS campaign set a net zero target of 2045 across all emissions linked to NHS activity. With travel accounting for 14% of the NHS' total emissions, the decarbonisation of travel is a key factor in achieving the world's first net zero national health service. Beyond the NHS, transport remains the largest contributor to UK domestic emissions prompting the release of £2 billion investment into active travel at a national level. Locally, both North East Lincolnshire Council and the East Riding of Yorkshire Council have declared climate emergencies and North East Lincolnshire, North Lincolnshire and East Riding of Yorkshire have all published independent travel plans.

Trust Strategies

This Green Travel Plan is the third produced by the Trust and acts to assess progress made on NLaG's previous sustainable travel targets and their continued relevance. The Green Travel Plan will also support the delivery of the Trust's newly updated Green Plan by providing an updated action plan focused specifically on the reduction of the Trust's transport emissions.



Health and Wellbeing

Physical inactivity costs the NHS up to £1.8 billion per annum with further indirect costs calculated at £8.2 billion. Active and sustainable travel incorporates physical activity that can significantly improve both mental and physical health leading to reduced economic costs for the Trust through reduced employee absence and lifestyle related disease.

Environment and wider benefits

In 2020, the NHS set out the target of a fully net zero national health service by 2040. Decarbonising travel and providing measures to facilitate the modal shift to active transport represent one of the cost-effective methods of reducing emissions. Meeting national targets to double cycling and increase walking will also lead to reduced congestion, as well as improved air quality within the local region.

Carbon emissions

In 2020/21, our emissions from travel totalled 6,459 tCO_2e, 23% of our total footprint. Figure 6 below provides an overview of the emissions tied to the Trust's travel and transport activity. As the graph highlights, the vast majority of travel emissions are associated with patient and visitor carbon emissions highlighting the need to encourage sustainable travel modes for not only staff, but also patients and visitors.

As can be seen in the graph, emissions related to transport have decreased annually over the last three years. The more drastic reaction in transport emissions can be largely attributed to the reductions in patient and visitor travel as well as business travel, likely due to the Covid-19 pandemic and the increased take up of virtual meeting software, agile working and non-clinical staff working from home on a permanent basis. The Trust are currently in the process of developing policies to entrench agile working for staff across NLaG.

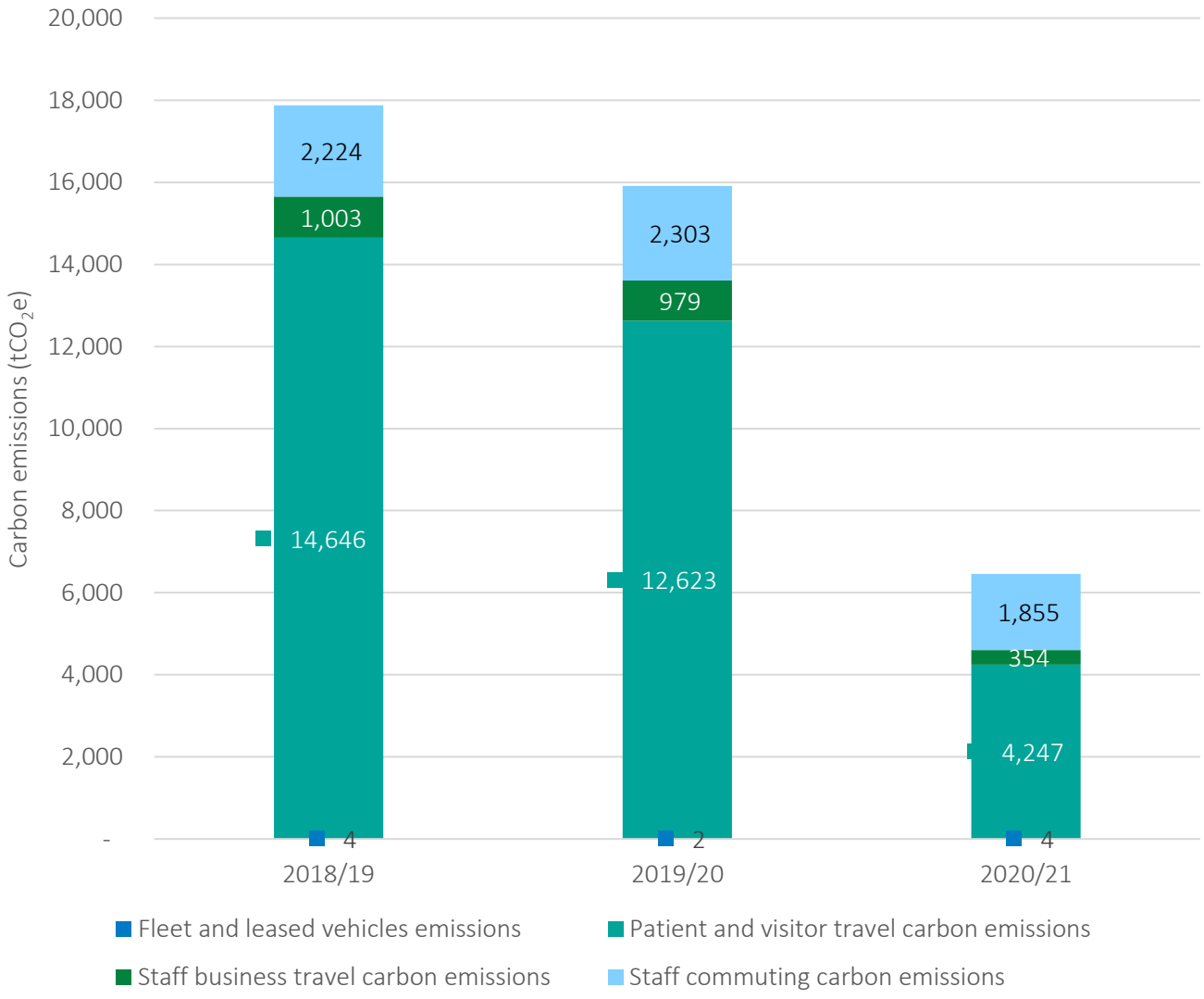
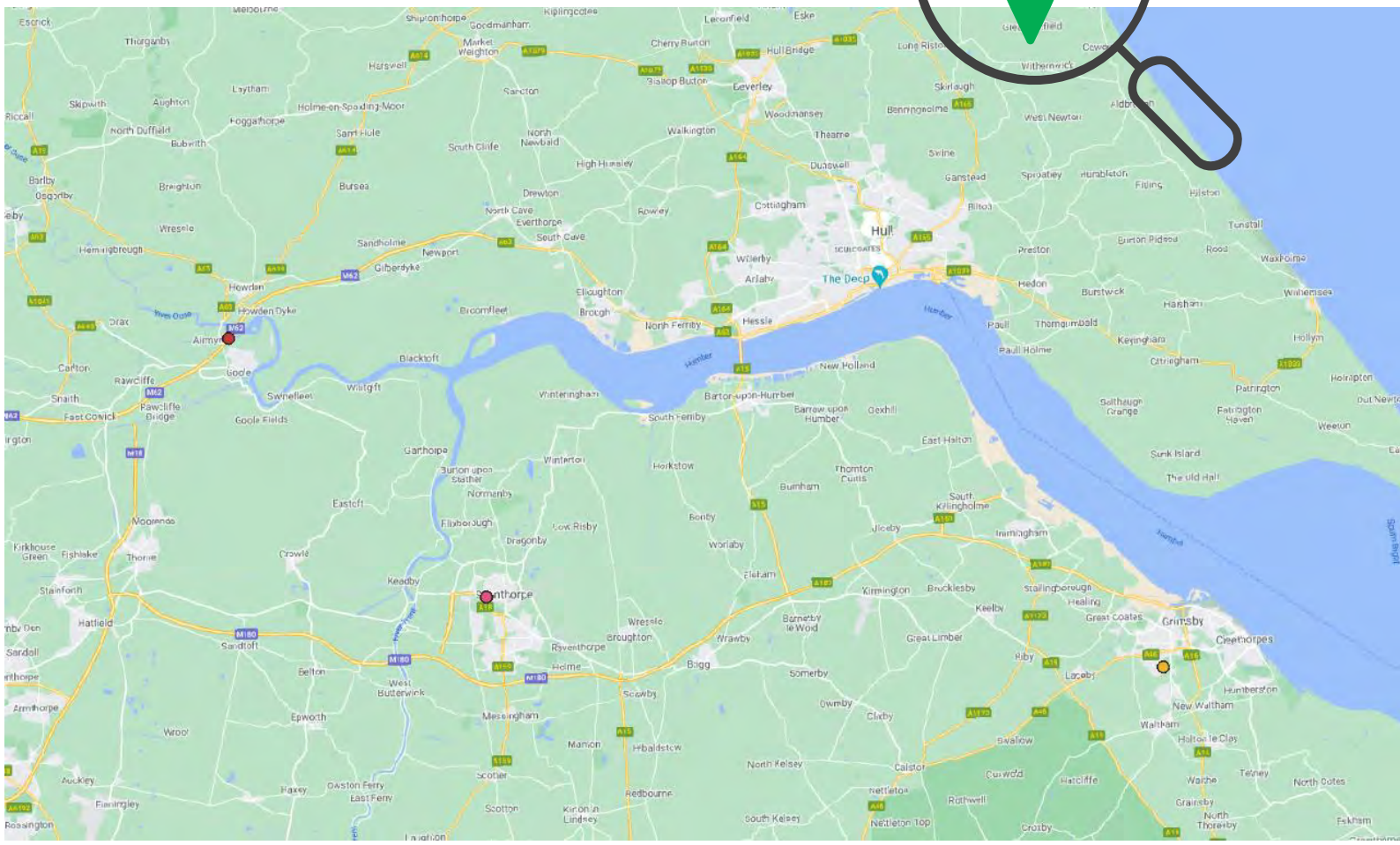


Figure 6: Breakdown of NLaG's travel related emissions

Site Audits



The following section provides an overview of the current transport infrastructure for each of our three main sites. This includes public transport, parking, active travel accessibility and community transport services. The audit of sustainable travel infrastructure is a crucial element of the Green Travel Plan. The key objectives of the audit are:

To identify the current infrastructure and travel options for staff, patients and visitors;

To identify the potential for promotion of sustainable modes based on existing infrastructure; and

To identify gaps in provision (which will form the basis of the Green Travel Action Plan).

Site audits

Diana Princess of Wales, Grimsby

Overview

Diana Princes of Wales (DPoW) Hospital is situated off the A1243 Scartho Road, approximately 2 miles south of Grimsby town centre and four miles west of the town of Cleethorpes.

The site is open 24 hours a day, seven days a week and employs just over 3,000 staff working either full time or part time.

DPoW is located in a broadly residential area with vehicular access points on both the east and west of the site (depicted by the blue dots in Figure 7). The main access to DPoW is on the east via Forsythia Drive, off the A1243 Scartho Road which provides vehicles with access to the hospital's estate road. Visitors, patients and staff can also access the hospital from the west via Second Avenue which also provides access to the hospital's estate road.

Since the release of our previous 2019 Travel Plan, significant funding has been secured and work has begun on the development of a new Emergency Department building, a public deck car park over the site's main visitor car park as well as an expansion to an existing visitor car park and the construction of two new staff car parks. These developments have altered the site's infrastructure causing implications on transport. The following site audit therefore marks an important update on our previous travel plans.

Figure 7: Diana Princess of Wales Site Overview

11. Guidelines for Planning Public Transport in Development

Site audits

Diana Princess of Wales, Grimsby

Public Transport

Bus

The Institute of Highways and transportation recommend that the maximum walking distance to a development is 400m[11]. DPoW hospital has four bus stops situated within 400m of the site and a further three stops within 650m of the hospital's main entrance. The site is therefore well connected to the local bus service which provides the public with wider access as far as Louth, Mablethorpe Lincoln and Hull (see Appendix 1 for Grimsby Bus Map). Staff at NLaG are also able to travel between sites via a contracted staff minibus that provides an hourly service between DPoW and SGH. DPoW benefits from a bus stop within the site's grounds providing visitors, patients and staff with direct access to the hospital's facilities. The on-site bus stop is located opposite the new deck public car park on the one-way clockwise system. The new developments at DPoW include a designated entrance/exit route for ambulances to access the new emergency department meaning ambulances will no longer use the same one-way system as public transport. This will reduce congestion around the hospital's main entrance and increase public safety when accessing DPoW's services.

Bus Service	Operator	Duration (minutes)	Nearest Stop	Weekday Services	Weekend Services	Price
8 (Grimsby-North Sea Lane)	Stagecoach	30	DPoW	Half-hourly (06:45- 23:18)	Hourly on Sundays (09:05 22:18)	£1.80
9 and 10 (Waltham-North Sea Lane)	Stagecoach	70	DPoW	Half-hourly (07:03- 18:03)	No service Sundays	£1.80
51 (Grimsby-Louth Bus station)	Stagecoach	63	DPoW	Hourly (07:00-19:30)	No service Sundays	£4.10
25 (Grimsby-Market Rasen)	Stagecoach	80	Scartho, St Helens Avenue	Once on Tuesdays and Fridays (13:30	No service	£4.10

Table 1: Bus Services from Grimsby

Rail

Grimsby Railway Station is located in the town centre approximately 2 miles north of DPoW. From the station, DPoW can be reached in approximately 10 minutes by bike, 11 minutes by bus or 35 minutes by walking. The station offers 56 sheltered cycle spaces as well as cycle hire, car parking and a taxi rank. Bus services are also provided with the number 8 bus, providing a direct route to DPoW.

Destination	Operator	Duration (minutes)	Frequency
Scunthorpe	Transpennine Express	35	Hourly
Doncaster	Transpennine Express	65	Hourly
Manchester Piccadilly	Transpennine Express	150	Hourly
Leicester	East Midlands	150	Every two hours

Table 2: Rail Services from Grimsby

Site audits

Diana Princess of Wales, Grimsby

Community Transport

Where physical illness or disability prevents the use of public transport, non-emergency patient transport (NEPTS) is available to patients who require help getting to, or from, their hospital appointments.

Wheels 2 Work Scheme

Wheels 2 Work North Lincolnshire is a moped, electric bicycle and e-scooter, pay as you go scheme. It can help hospital staff without means of transport to access sustainable modes of travel as both electric and petrol mopeds are included within the fleet.

Voluntary Car Service

The Humber and Wolds Rural Community Council operates a voluntary car service. The aim of this service is to provide a safe, reliable and affordable voluntary transport service to residents of rural North Lincolnshire with genuine transport difficulties. The service uses volunteer drivers, who use their own cars, to take individual passengers on journeys to destinations of their choice, both within and beyond North Lincolnshire.

Phone n Ride

The 'Phone n Ride' service is provided by North East Lincolnshire Council on a demand-responsive basis. Patients who are unable to access forms of public transport can call and book up to 14 days in advance. The service has no fixed routes or timetables and is flexible to patient travel requirements. It runs from 6:30am to 6:30pm on each day of the week and provides patients with an affordable mode of accessible transport.

Dial a Ride

Dial a ride is a similar service providing accessible transport for the elderly, sick and disabled. Passengers can book any number of journeys with one phone call and the service can be used for any purpose. Following a phone call from a passenger, the booking clerk will work out the most efficient route of travel, collecting those in the same area with a similar travel request.

Site audits

Diana Princess of Wales, Grimsby

Car Parking

New developments at DPoW have seen the improvement of car parking facilities for both visitors and staff. A public deck car park (A in Figure 8) has been built over the existing main visitor car park and extensions have been made to existing public car parks (B, C and D in Figure 8). The developments have led to an increase in both visitor parking with 387 visitor spaces available as well as an improvement in sustainable infrastructure with the provision of two new EV charging points in the new deck car park.

Development at the site also includes the construction of two staff car parks at DPoW towards the site entrance of Second Avenue at the east of the site (E and F in Figure 8). This has led to an increase in staff parking with 999 available spaces for employees.

Car Sharing

NLaG has set up a car sharing scheme which enables internal staff working regular office hours or shifts to share the journey to and from work and/or business trips. Staff can apply for a car sharing scheme permit via an online database and although the car sharing scheme has been impacted by the Covid-19 pandemic, the scheme will resume once restrictions are lifted and ensuring elimination of any infection control risks.

Figure 8: Car Parking at DPoW

Site audits

Diana Princess of Wales, Grimsby

Cycling

Road infrastructure surrounding the site accommodates cycling as feasible mode of transport to DPoW. The A1243 Scartho Road that provides access to the site's main entrance is a local cycle route with an off-carriageway cycle route south of the site's entrance point on Forsythia Drive.

The development at DPoW has led to the increase in site cycle parking. Patients and visitors now have access to 41 cycle spaces whilst staff have access to 52. Further improvements to on-site cycle facilities has ensured that staff cycle parking is secure, with a further provision of storage lockers, as well as access to showers and changing rooms.

There is currently no statutory guidance on a reasonable cycling distance to work. According to the most recent pre-pandemic National Travel Survey, the average length of each UK cycle journey was 3.3 miles[12]. It is therefore assumed that cycle journeys up to 3.3. miles are considered a reasonable distance to commute to work. Assuming that the average cyclist travels at a speed within the ranges of 8-12mph, a 3.3 mile journey would take on average 20 minutes. Figure 9 therefore displays proximity to DPoW based on journey time of up to 20 minutes. It highlights that DPoW is reachable in 20 minutes or less from a number of surrounding localities including Grimsby town centre, Scartho, Bradley and Waltham.

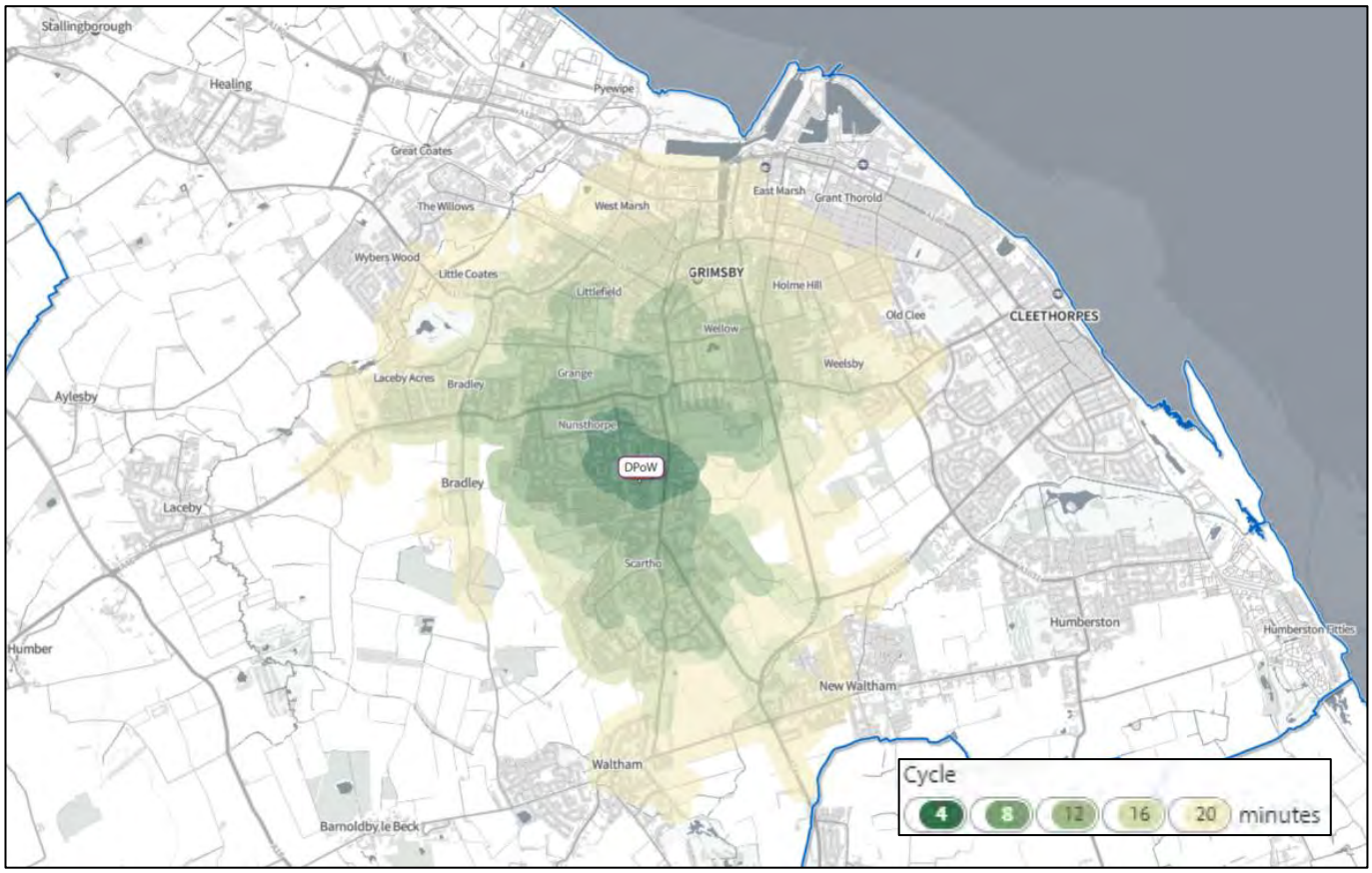


Figure 9: Cycling distances to DPoW (minutes)[13]

12. NTS0303: Average number of trips, stages, miles and time spent travelling by main mode: England; 13. SHAPE | Strategic Health Asset Planning and Evaluation (shapeatlas.net)

Site audits

Diana Princess of Wales, Grimsby

Walking

The site is well connected to surrounding pedestrian infrastructure. Recent developments have increased the safety and accessibility of walking to the hospital. A pelican crossing with dropped kerbs and a pedestrian crossing refuge has been installed at the crossroad junction that provides access to the main site entrance on Forsythia Drive. This has increased the safety and accessibility of the site via walking. The site also benefits from surrounding pedestrian infrastructure and is in close proximity to local amenities such as the nearby Nunsthorpe centre which has several food outlets as well as a post office.

DPoW also benefits from its own on-site amenities including a site shop, café, ATM and pharmacy. Internally, DPoW also benefits from wide and well-lit pedestrian walkways as well as good wayfinding signage and a number of crossing opportunities via zebra crossings, dropped kerbing and tactile paving.

The UK's National Travel Survey[12] reports that the average walking distance covered by each individual per journey is 0.7 miles. Government guidance published in 2001[14] suggested that people are prepared to walk just over a mile in order to get to work. Given that the average person walks at 4mph, a 1-mile journey would equate to 15 minutes. Figure 10 therefore provides areas that can be reached within a 15-minute walk of DPoW.

Figure 10: Walking distances to DPoW (minutes)[13]

12. NTS0303: Average number of trips, stages, miles and time spent travelling by main mode: England; 13. SHAPE | Strategic Health Asset Planning and Evaluation (shapeatlas.net); 14. Planning Policy Guidance

Site audits

Scunthorpe General Hospital

Overview

Scunthorpe General Hospital (SGH) is located one mile west of Scunthorpe town centre. The site is open 24 hours a day, seven days a week and employs just over 2,500 staff working either full or part time.

SGH is located in a broadly residential area with vehicular access points at the north and south of the site (depicted by the blue dots in Figure 9). The entrance at the north of the site is off Cliff Gardens, which provides one-way access to Accident and Emergency services. The entrance at the south of the site is off Church Lane and provides access to the main entrance at SGH.

There have also been new developments at SGH including the development of a new single storey Emergency Department building, the refurbishment of Adult Assessment Units (AAUs) and the construction of a new deck car park. These developments have altered the site's infrastructure, causing implications on transport. The following site audit therefore marks an important update on our previous travel plans.

Figure 11: Scunthorpe General Hospital Site Overview

Site audits

Scunthorpe General Hospital

Public Transport

Bus

SGH is well connected to local bus services with two bus stops located near the outpatient's entrance at the south of the site on Church Lane and two bus stops located near the main entrance at the north of the site on Cliff Gardens (see appendix 2 for detailed map). A further two sheltered bus stops are located on site which provide access to SGH's Park and Ride service (number 9). This shuttle service connects Scunthorpe bus station with the Hospital and Scunthorpe train station. It provides frequent services between 7am and 8pm from Monday to Saturday. The staff minibus also operates from onsite providing an hourly service between SGH and DPoW. Of these bus stops, four are within the recommended guidance of 400m from the ED's main entrance and all six are within 650m of the main entrance.

Bus Service	Operator	Duration (minutes)	Nearest Stop	Weekday Services	Weekend Services	Price
7 (Scunthorpe-Skippingdale)	Stagecoach	20	Cliff Gardens	Hourly (09:00-18:00)	No Service Sundays	£1.50
8 (Scunthorpe-Crosby/ Skippingdale)	Stagecoach	20	Cliff Gardens	Half-hourly (07:40-18:30)	No service Sundays	£1.50
90 (Scunthorpe-Crowle)	Stagecoach	35	Cliff Gardens	Every two hours (07:55-17:55)	No service Sundays	£1.50
360/361 (Scunthorpe bus station- Goole)	East Yorkshire	90	Church Lane	Every two hours (07:30-13:00)	Reduced Saturday service. No service Sundays.	£4.00

Table 3: Bus Services from SGH

Rail

The hospital is closely located to Scunthorpe's railway station with a short walking time of 15 minutes between the two. The train station at Scunthorpe is equipped with a car park, taxi rank and cycle storge. Customers using railway services into Scunthorpe can also request to take a bicycle on the train with them, so long as a cycle reservation has been made prior to travel.

Scunthorpe train station is managed by TransPennine Express and provides wider access to the following locations:

Destination	Operator	Duration (minutes)	Frequency
Doncaster	Northern Rail	35	Twice an hour
Manchester	Transpennine Express	120	Hourly
Cleethorpes	Transpennine Express	50	Hourly

Table 4: Rail Services from Scunthorpe

Site audits

Scunthorpe General Hospital

Community transport

Where physical illness or disability prevents the use of public transport, non-emergency patient transport (NEPTS) is available to patients who require help getting to, or from, their hospital appointments.

CallConnect

CallConnect is an on-demand bus service providing rural transportation for anyone who requires it across Lincolnshire and neighbouring counties. CallConnect transportation can be booked by phone or online from 1 hour's notice and home pick-ups and drop offs are viable for people unable to use conventional bus services due to age, disability or mobility impairment.

Wheels 2 Work Scheme

Wheels 2 Work North Lincolnshire is a moped, electric bicycle hire scheme, and e-scooter, pay as you go scheme. It can help hospital staff without means of transport to access sustainable modes of travel as both electric and petrol mopeds are included within the fleet.

JustGo North Lincs

JustGo is an on-demand bus service operating for people travelling in North Lincolnshire. Travel services can be booked through the JustGo North Lincs mobile app which further provides real-time tracking of your bus to the meeting point of choice. For those that are not comfortable using apps, help and support is provided.

justgo north lincs

Voluntary Car Service

The Humber and Wolds Rural Community Council operates a voluntary car service. The aim of this service is to provide a safe, reliable and affordable voluntary transport service to residents of rural North Lincolnshire with genuine transport difficulties. The service uses volunteer drivers, who use their own cars, to take individual passengers on journeys to destinations of their choice, both within and beyond North Lincolnshire.

Site audits

Scunthorpe General Hospital

Car Parking

The development of the new Emergency Department (ED) building at SGH is located in the north of the site over a pre-existing admin block and surrounding staff car park. A deck car park has therefore also been built over an existing visitor car park to replace the spaces lost following the construction of the new ED building. Access to the new deck car park will be available from the sites' main entrance on Church Lane with visitor parking on the lower level and staff parking on the upper deck. The result of this development will see an increase of 13 on-site spaces for staff however of a loss of 25 onsite visitor spaces.

In total SGH has 747 car parking spaces for staff and 261 for visitors including 30 accessible parking spaces. To further the green transport ambitions of the Trust, two electric vehicle chargers have been added to the lower-level visitor deck of the new parking facility.

Car Sharing

NLaG has set up a car sharing scheme which enables internal staff working regular office hours or shifts to share the journey to and from work and/or business trips. Staff can apply for a car sharing scheme permit via an online database and although the car sharing scheme has been impacted by the Covid-19 pandemic, the scheme will resume once restrictions are lifted and ensuring elimination of any infection control risks.

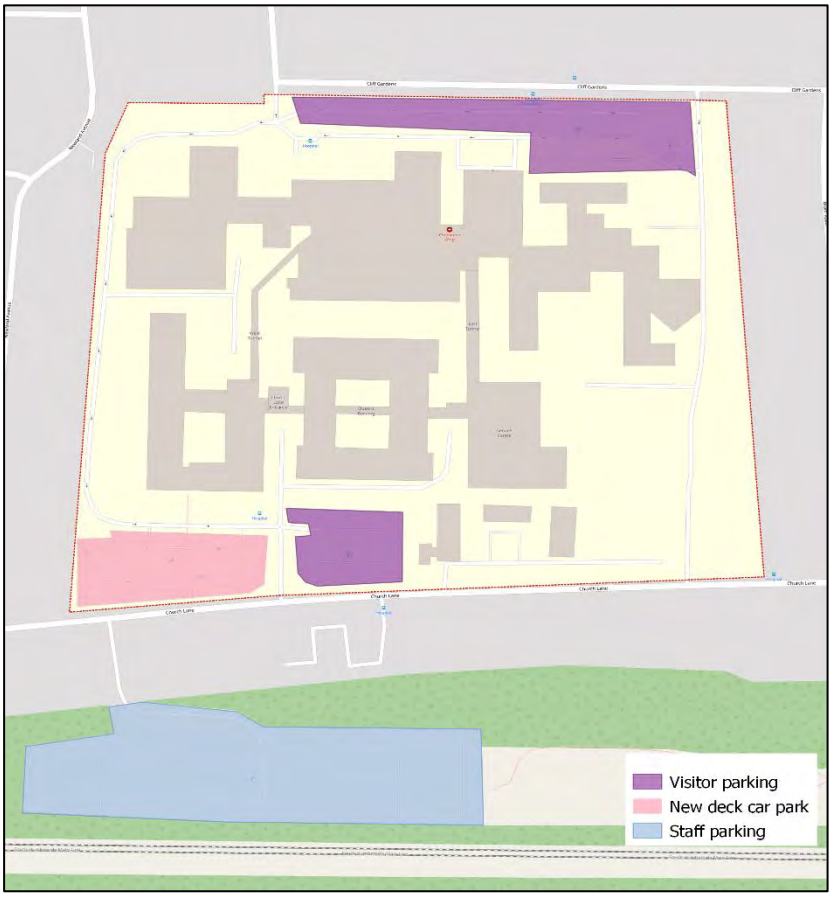


Figure 12: Car Parking at SGH

Site audits

Scunthorpe General Hospital

Cycling

Cycle infrastructure is well developed surrounding SGH providing staff and visitors with a feasible route of transport to the site. National Cycle Network route 169 is situated 1km west of SGH. It is a 5 mile, mainly traffic free route which provides local communities with a safe way of accessing Scunthorpe via a form of active travel. Along sections of busier road, a segregated cycle lane is provided.

The existing cycle storage at SGH was also demolished as a result of new development work. The secure cycle shed has however been relocated to the site's main entrance on Church Lane and its relocation has been accompanied by the provision of increased cycle parking. Further cycle parking provision is provided in the car park outside the pathology department. As a result of the development SGH now has 65 cycle parking spaces for staff and a further 35 for visitors.

Based on assumptions made by utilising available data from the UK's National Travel Survey[12], a 20 minute cycle journey is considered reasonable for commuting to and from work. Figure 13 demonstrates that SGH is accessible by bike from the majority of wider Scunthorpe including Lincoln Gardens, Ashby, Westcliffe, Gunness and Crosby.

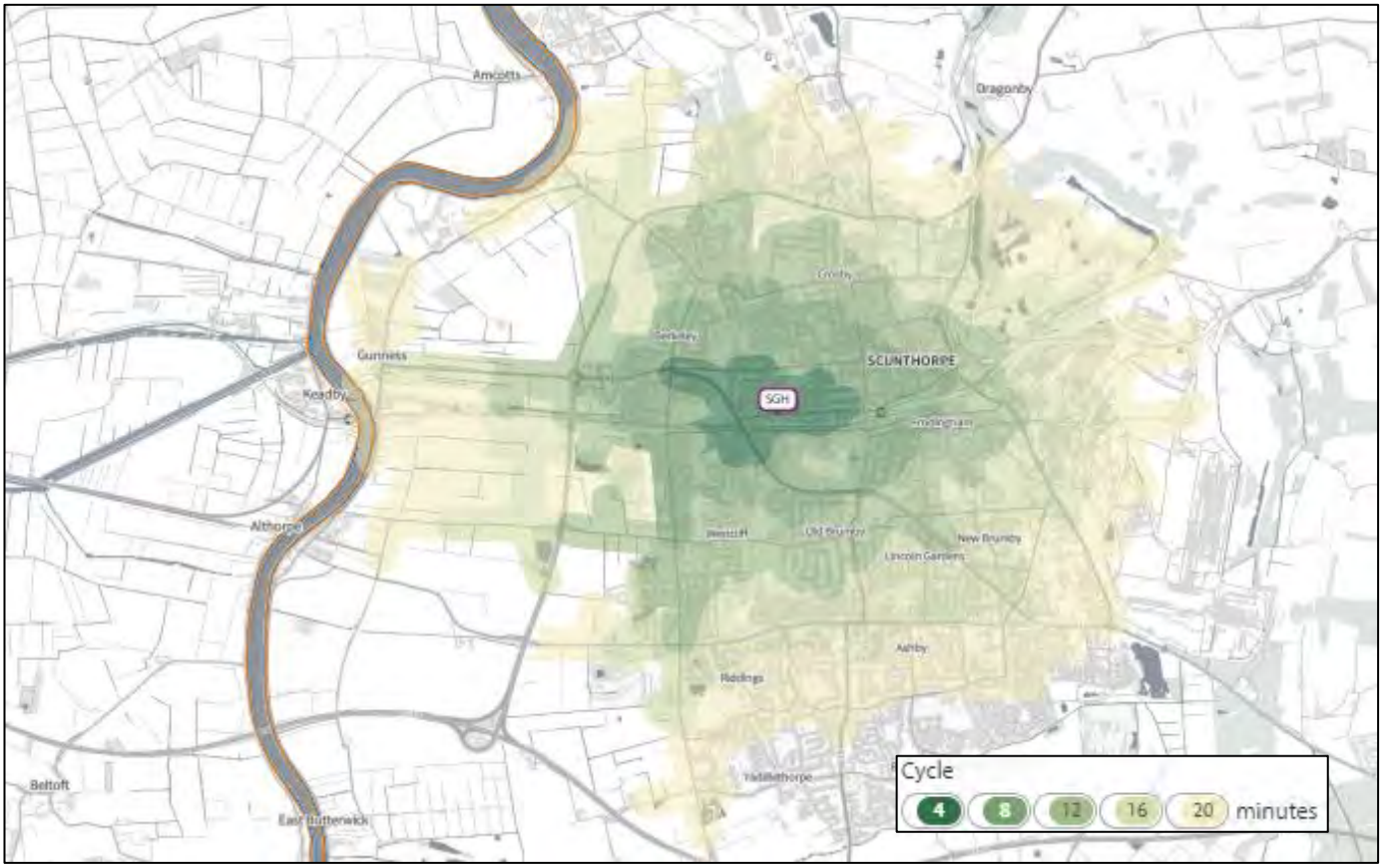


Figure 13: Cycling distances to SGH (minutes)[13]

12. NTS0303: Average number of trips, stages, miles and time spent travelling by main mode: England; 13. SHAPE | Strategic Health Asset Planning and Evaluation (shapeatlas.net)

Site audits

Scunthorpe General Hospital

Walking

The site is well supported by a network of surrounding pedestrian footways. There are footways on either side of Church Lane and dropped kerbs to facilitate pedestrians crossing the entrances at the site's access points. Cliff Gardens also has footpaths on either side of the road with signage that directs pedestrians to a separate pedestrian entrance in the north of the site. All local roads leading to SGH have adequate street lighting.

Within the site's own grounds, there are also a network of pedestrian footways that connect the north of the site with the south. SGH also benefits from a number of on-site amenities including a restaurant, coffee shop, an ATM and pharmacy.

Based on available Government guidance[14] as well as the UK's National Travel Survey[12], a 15-minute journey is considered a reasonable time and distance to walk to work. Figure 14 therefore highlights the areas within the proximity of a 15-minute walk from SGH.

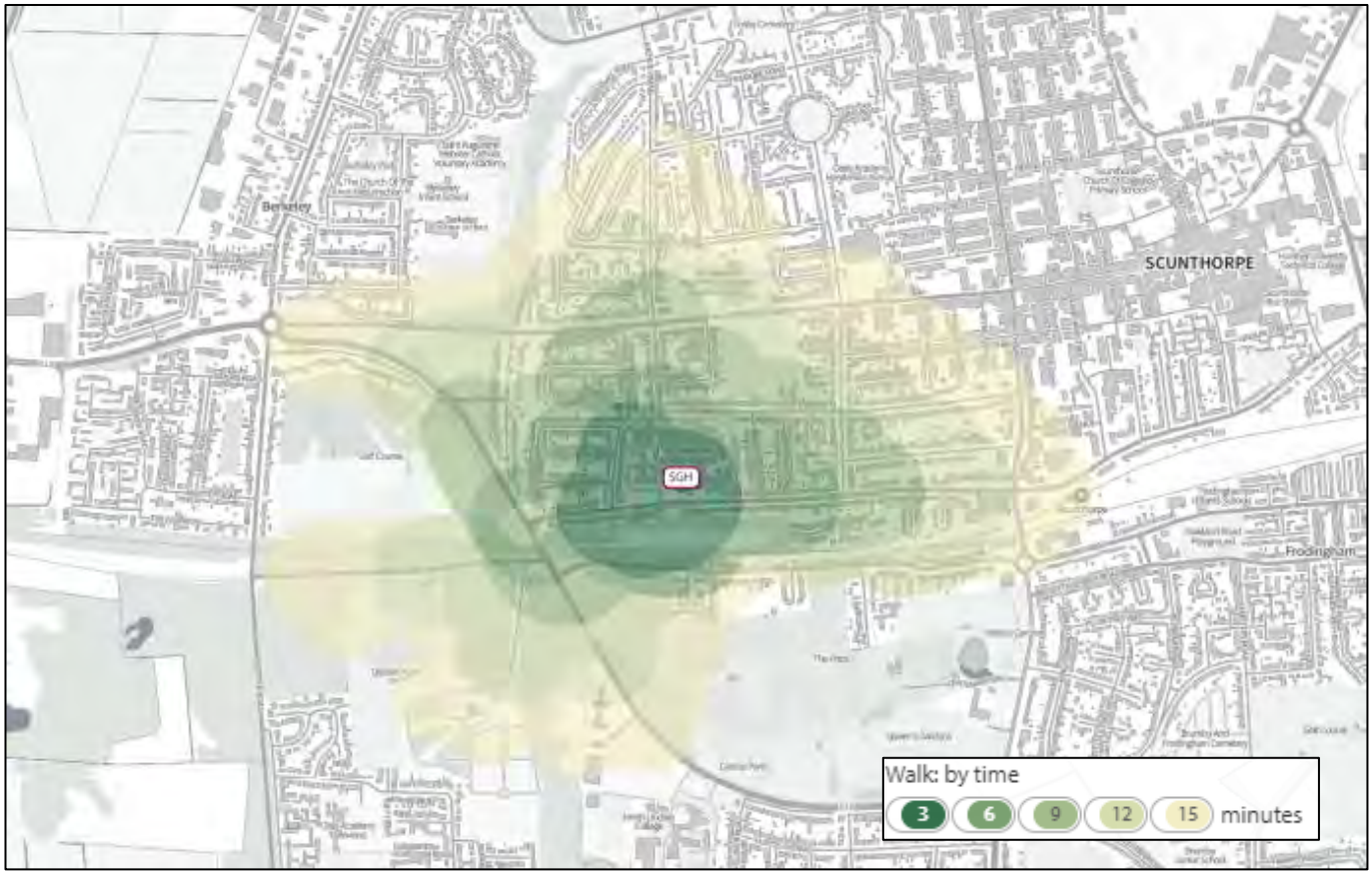


Figure 14: Walking distances to SGH (minutes)[13]

12. NTS0303: Average number of trips, stages, miles and time spent travelling by main mode: England; 13. SHAPE | Strategic Health Asset Planning and Evaluation (shapeatlas.net); 14. Planning Policy Guidance

Site audits

Goole and District Hospital

Goole and District Hospital (GDH) is situated approximately one mile north of Goole town centre. The site is open 24 hours a day, seven days a week and employs 224 staff either full or part time.

GDH is located in a broadly residential area and with vehicular access points at the south of the site (blue dots in Figure 11). The entrance at the south of the site is off Woodland Avenue which provides access to GDH's one-way private estate road which allows vehicles to loop around GDH's site before exiting back onto Woodland Avenue.

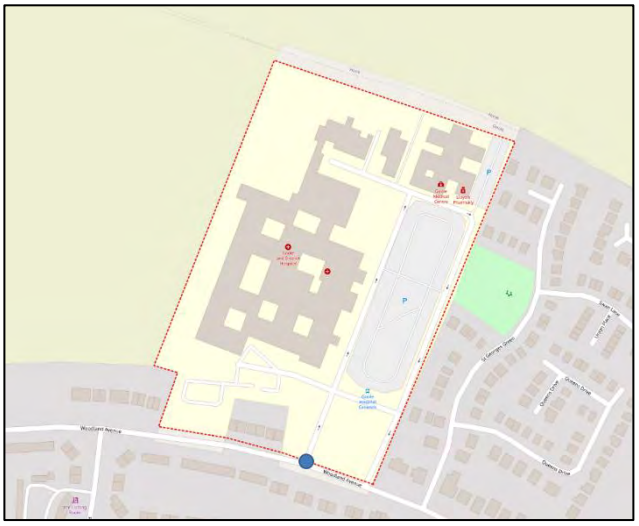


Figure 15: Goole and District Hospital Site Overview

Public Transport

Bus

GDH benefits from good on-site public transport facilities including two sheltered bus stops. The first of these is located on the hospital's private estate road just beyond the ophthalmology department. The second is located to the south of the visitor's car park opposite the main entrance. Externally, the hospital has no other bus stations within the recommended walking distance guidance of 400m.

Bus Service	Operator	Duration (minutes)	Nearest Stop	Weekday Services	Weekend Services	Price
G3 (Goole town centre- circular)	East Yorkshire	35	On site	Every 45 mins (09:20-15:20)	No Service Sundays	£1.50
G4 (Goole morning workers circular)	East Yorkshire	60	On site	Hourly (06:30-07:30)	No service weekends	£1.50
G5 (Goole evening workers circular)	East Yorkshire	60	On site	Hourly (16:15-18:50)	No service Weekends	£1.50
55 (Elloughton-Goole)	East Yorkshire	60	On site	Three times a day (11:55-16:05)	Reduced Saturday service. No service Sundays.	£1.50
3 (Selby- Thorne)	Arriva Yorkshire	85	On site	Twice a day (07:45-16:40)	No service weekends	£4.00

Table 5: Bus Services from GDH

Rail

GDH is located just over a mile north of Goole's train station with a walking time of approximately 20 minutes between the two. The train station includes 20 cycle parking spaces equipped with CCTV monitoring as well a 40 space public car park with 3 additional accessible parking spaces. Gooletrain station is managed by Northern and provides wider access to the following locations:

Destination	Operator	Duration (minutes)	Frequency
Hull	Northern Rail	40	Every half an hour
Doncaster	Northern Rail	30	Every half an hour
Sheffield	Northern Rail	55	Every half an hour
Scarborough	Northern Rail	115	Hourly

Table 6: Rail Services from Goole

Site audits

Goole District Hospital

Community Transport

Where physical illness or disability prevents the use of public transport, non-emergency patient transport (NEPTS) is available to patients who require help getting to, or from, their hospital appointments.

Goole GoFar

Goole GoFar is a community transport group with a fleet of minibuses and community cars available for hire to voluntary and community groups in Goole and the surrounding area. Trips are available to members of the community who through age, illness or ability may not be able to access regular transport.

Medibus

Medibus services provide residents living within East Riding and Yorkshire with transport from their front door to local hospitals, doctor's surgeries, clinics and dentists. Medibus services can be booked via telephone or email.

MEDiBUS

Door to door accessible transport for your medical appointments

MiBus

MiBus is a demand responsive transport service for those unable to access existing bus services. Journeys are determined on a first come, first served basis. Bookings can be made by phone or email. Once confirmed, the driver will be in contact with you the night before the journey is due to take place to confirm your home address pick–up location.

Car parking

In total GDH has 94 parking spaces for staff including 2 bays for electric pool cars and 200 car parking spaces for visitors including 8 accessible spaces for visitors.

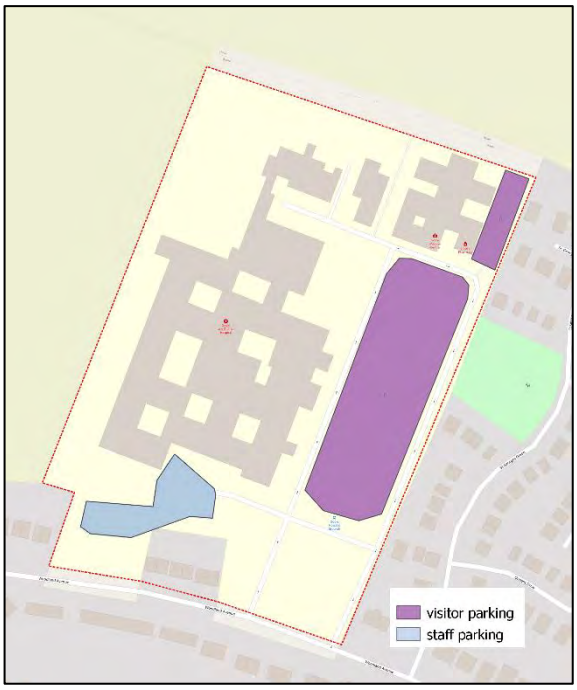


Figure 16: Car Parking at GDH

Car Sharing

NLaG has set up a car sharing scheme which enables internal staff working regular office hours or shifts to share the journey to and from work and/or business trips. Staff can apply for a car sharing scheme permit via an online database and although the car sharing scheme has been impacted by the Covid-19 pandemic, the scheme will resume once restrictions are lifted and ensuring elimination of any infection control risks.

Site audits

Goole District Hospital

Cycling

GDH is accessible by bike from Goole's town centre with the site only a 6-minute cycle from Goole railway station. The site is also made more accessible via bike due to the segregated cycle path A614 (Boothferry Road) which is approximately half a mile west of GDH. The A614 provides cyclists with an independent cycle lane from the south of Howden to Goole town centre. Please see Appendix

To accommodate cycling on site, GDH has 30 secure cycle parking spaces for staff and a further 22 for visitors.

Based on assumptions made by utilising available data from the UK's National Travel Survey[12], a 20-minute cycle journey is considered reasonable for commuting to and from work. Figure 17 demonstrates that GDH is accessible by bike from a number of localities including old Goole, Airmyn and Hook.

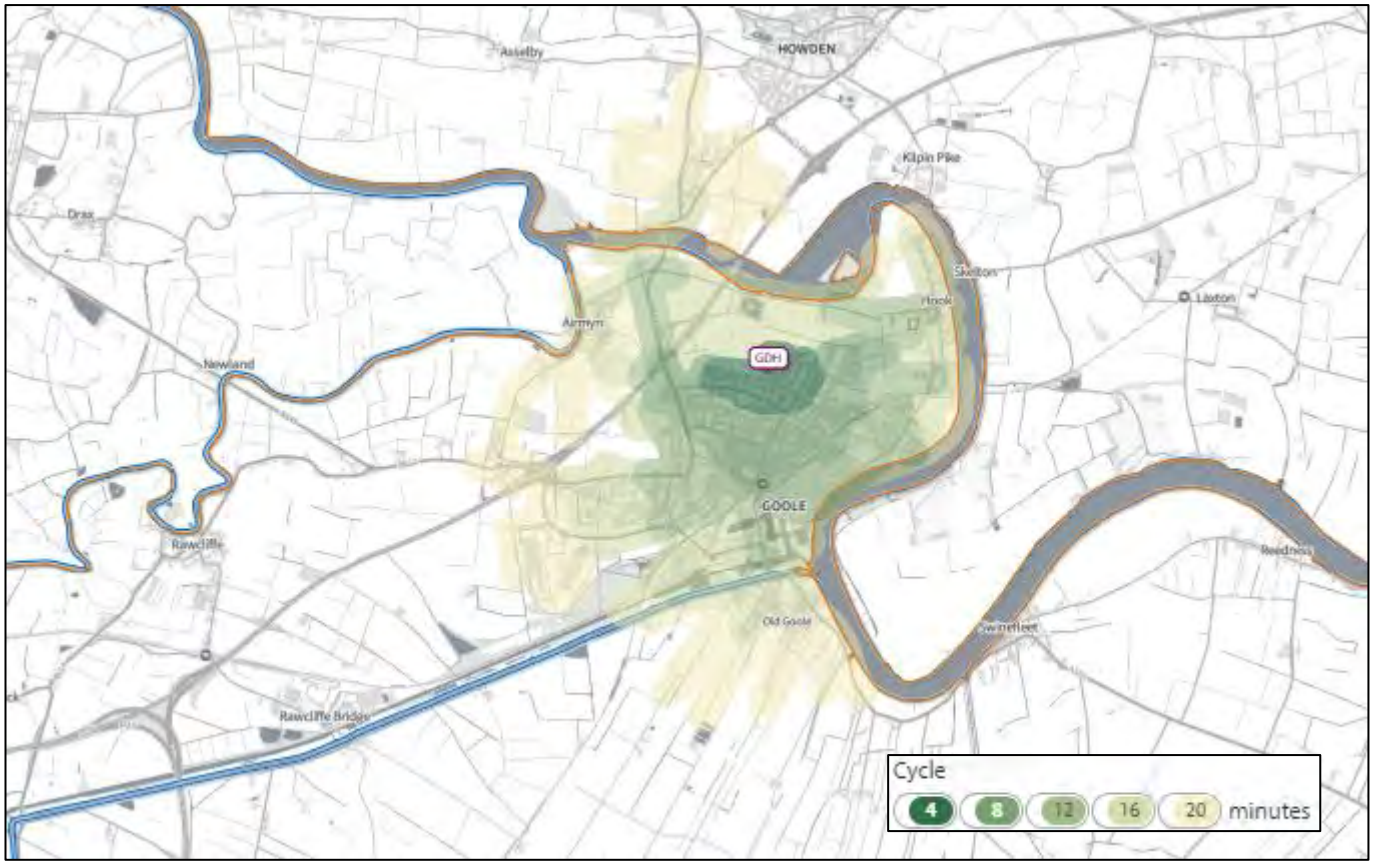


Figure 17: Cycling distances to GDH (minutes)[13]

12. NTS0303: Average number of trips, stages, miles and time spent travelling by main mode: England; 13. SHAPE | Strategic Health Asset Planning and Evaluation (shapeatlas.net)

Site audits

Goole District Hospital

Walking

As GDH is located just off Woodland Avenue in a broadly residential neighbourhood, the site benefits from an urban network of pedestrian footways which accommodate staff and visitors walking to the hospital.

The site itself also benefits from an extensive network of pedestrian footways connecting all departments on site as well as a number of crossing points via zebra crossing, dropped kerbing and tactile paving. GDH also provides visitors with access to on-site facilities including a coffee shop.

Based on available Government guidance[14] as well as the UK's National Travel Survey[12], a 15-minute journey is considered a reasonable time and distance to walk to work. Figure 18 therefore highlights the areas within the proximity of a 15-minute walk from GDH.

Figure 18: Walking distances to GDH (minutes)[13]

12. NTS0303: Average number of trips, stages, miles and time spent travelling by main mode: England; 13. SHAPE | Strategic Health Asset Planning and Evaluation (shapeatlas.net); 14. Planning Policy Guidance

Travel survey results

Trust wide

A staff travel survey was carried out in February 2021 and received 181 responses from staff across NLaG's three main sites. At this point in time, the UK was at the height of its third national lockdown in order to prevent the further spread of the Covid-19 pandemic and this may have influenced survey results and limited the number of responses.

The table below provides the staff survey results on the normal mode of transport staff use to travel to work. Due to the Covid-19 pandemic, working from home was added as an option within the 2021 travel survey.

Guidance from National Planning Policy Guidance (PPG 13)[12] suggests that individuals are typically prepared to cycle up to 8km (5 miles) to work. Figure 13 shows the number of miles staff travel to work. As shown in the graph, 93 of the 181 staff surveyed travel 5 miles or fewer to get to work each day. This represents over 50% of the respondents. Although the low survey sample limits the ability to generalise these results across the NLaG workforce, it does provide evidence that there is significant potential to promote active travel as a feasible mode of transport for staff at NLaG.

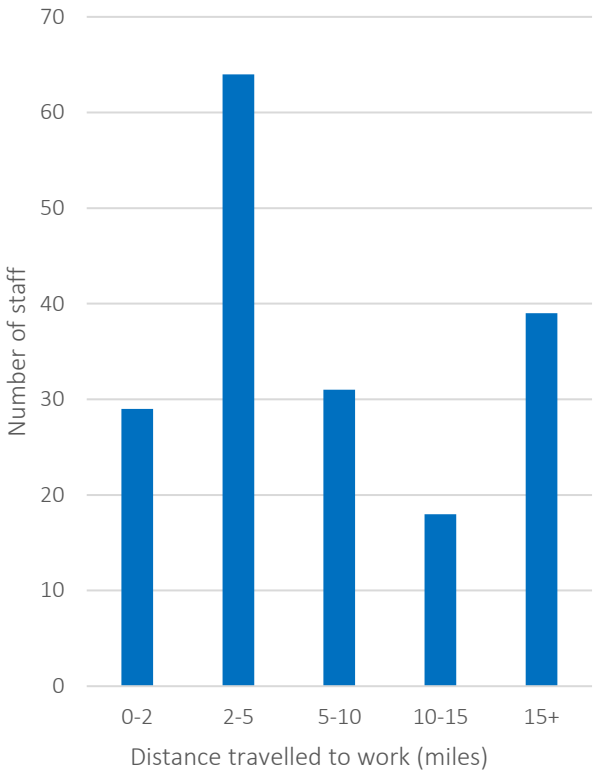


Figure 19: Survey results showing how many miles staff travel to work (on average)

Normal mode of travel to work	2015 Travel Plan baseline	2018 Travel Plan update	2021 Travel Plan results	Change from 2015 (%)
Car (solo)	77%	73%	70%	-7%
Cycle/walk	13%	10%	9%	-4%
Public Transport / Car share	8%	10%	9%	+1%
Work from home	N/A	N/A	12%	-
Other	2%	7%	N/A	-

Table 7: Travel Survey Results

14. Planning Policy Guidance

Travel survey results

Trust wide

The pie chart below displays the time it takes staff members to commute from home to work. It shows that over 75% of the survey respondents have a work commute less than half an hour which also reinforces the potential of staff to switch to more sustainable forms of travel including walking, cycling or avoiding the commute by working from home.

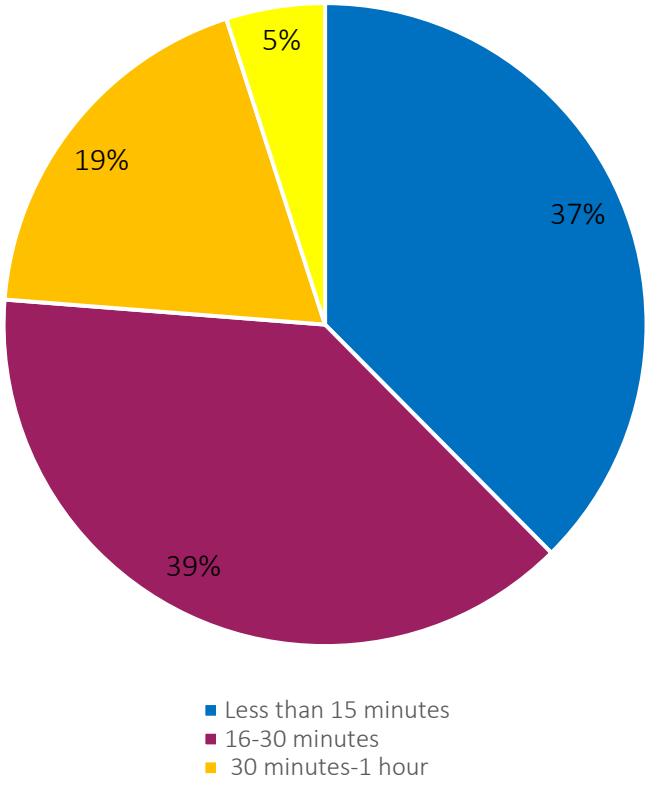


Figure 20: Survey results showing the typical duration of staff commutes (on average)

Whilst the survey results demonstrate the potential to increase sustainable modes of transport for future staff journeys, the survey also highlighted the following barriers to active travel:

- 19% of responses highlighted that they felt it was too far to cycle or walk and a further 7% responded they do not feel safe cycling.
- Large proportions of staff also reported the poor standard of public transport service as a reason for travelling by car. 14% said public transport was unavailable to them with a further 11% stating that public transport takes too long for it to be a feasible mode of travel.
- Survey participants were also provided with a list of initiatives to encourage active travel or the use of public transport:
  - 71% staff reported 'Nothing would encourage me to walk to work'
  - 55% staff reported 'Nothing would encourage me to cycle to work'
  - 49% staff reported 'Nothing would encourage me to use the bus'
- There are barriers and behaviours preventing staff from transitioning away from single car occupancy. To change this, we will introduce an awareness campaign to help staff understand the multiple benefits of active transport including increased physical and mental health, cleaner air and a healthier environment.

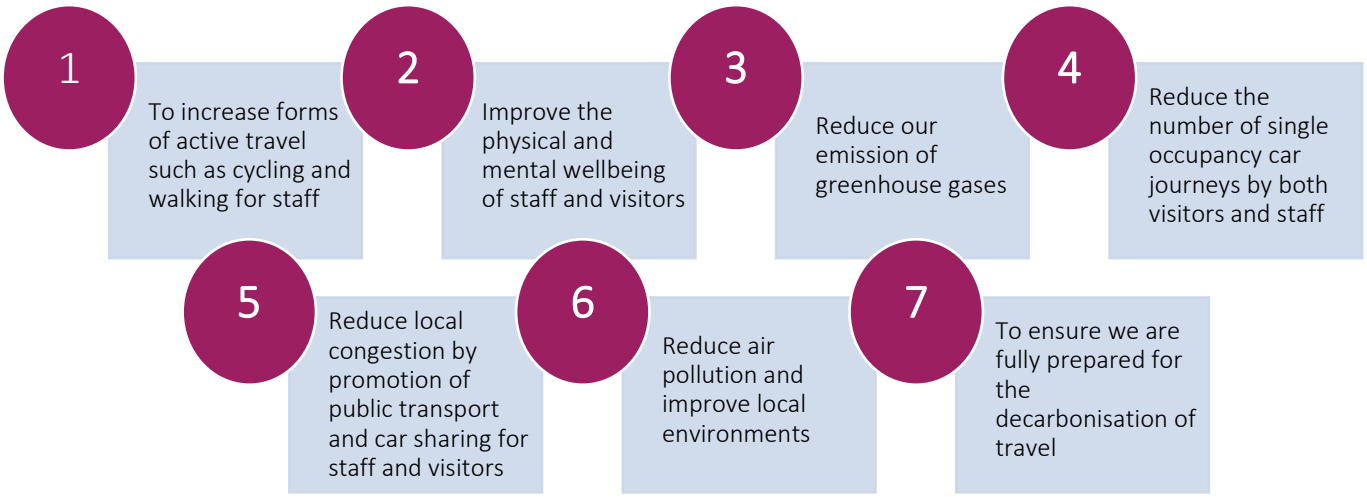
When given the opportunity to provide further information on travel, the following were frequent comments raised by staff:

- The Covid-19 pandemic makes the public transport and car sharing not appropriate.
- Some staff want to invest in EVs but would not be able to charge them on site.
- The lack of cycling infrastructure makes cycling to work dangerous.
- It would not be fair to impose increased car parking charges on staff who travel from distance to get to work.

Aims and targets

Aims and objectives

The following aims and objectives have been developed by evaluating the previous Travel Plan and updating them according to NLaG's Trust priorities laid out in the Green Plan as well as key national policy developments.



Targets

The Trust's previous Travel Plans outlined SMART targets to aim for. These are target indicators that are Specific, Measurable, Achievable, Realistic and Time constrained. These targets were based on the responses to the staff travel survey and the following table provides an update on progress made:

Target	Measure	2015 baseline	2018 target	2018 result	2021 target	2021 result	On track?	2024 target
1: Decrease in single occupancy vehicle use by staff	Number of staff driving to work by themselves	77%	73%	73%	68%	70%	✗	65%
2: Increase in numbers of staff walking or cycling to work	Number of staff walking or cycling	17%	19%	10%	13%	9%	✗	15%
3: Increase the percentage of staff regularly car sharing or using public transport to work	Number of staff car sharing or using public transport	9%	17%	10%	12%	9%	✗	15%

Table 8: An update on NLaG's progress towards sustainable travel targets

Although the 2021 targets have not been met, the Covid-19 pandemic will have had implications on the survey data collected with 12% of the 2021 staff survey working from home and therefore not travelling at all. Reductions in the percentage of staff using public transport and car sharing to get to work is also to be expected as a result of the pandemic as the public were advised not to use public transport to prevent the risk of spreading the virus. Given these adverse conditions, there has still been a 3% decrease in staff using single occupancy vehicles since 2018. More ambitious targets have been set under the assumption that pre-pandemic 'normal life' will resume prior to the next travel plan update.

Progress since 2019 travel plan

Trust achievements

Since the last Travel Plan in 2019, significant progress has been made against the following outlined actions.

01 Public transport

- Realtime timetables have been installed at DPoW and public transport information has been provided on the staff portal and Trust website.
- An upgraded bus shelter has been installed at DPoW.
- The SmartCommute ticket has been promoted and has seen a good uptake at DPoW.

02 Policies & procedures

- The travel plan has been promoted via the staff portal and social media.
- 'How to find us' guides have been updated and are on the Trust website.
- An EV Chargepoint survey was completed in 2019.
- A staff travel survey was conducted in 2021.
- Usage of car and bike parking has been monitored with relevant reports published.
- A Sustainability Working Group has been introduced at the Trust.

03 Smarter working

- Smart working practices have been increased with Microsoft Teams now widely used across the trust to conduct virtual meetings and web conferences.
- The Covid-19 pandemic has led to the introduction of working from home- especially for non-clinical staff.

04 Active travel

- Information on walking routes around sites have been provided to staff on the team NLaG section of the staff portal.
- Walk to Work Week promoted via portal announcements and social media.
- Cycle to work scheme introduced and has seen successful take up.
- Cycling routes for both social and commuting have been provided to staff via the staff portal.
- Cycle facilities were improved following storage locker installation at DPoW.
- Pre-Covid-19, cycling maintenance, training and Dr Bike events were held at DPoW.
- Increased number of cycle parking spaces at SGH following new developments.

05 Fleet, EVs & infrastructure

- World Car Free day was promoted across via the staff portal and social media.
- New electric pool cars and electric van added to fleet.
- Two new EV chargers for visitors at DPoW and SGH following construction of new car parks.
- Walking infrastructure has been improved by ensuring a continuous route of tactile crossings following developments at DPoW and SGH
- The on-site road services have been reviewed at GDH.

Action plan

Trust wide

The action plan is the most important section of a travel plan as it identifies and outlines the steps that are required to transition to more sustainable forms of travel, decarbonise existing transport and therefore contribute to reducing the Trust's overall carbon footprint. The following action plan for NLaG has been developed by:

- Reviewing the developments in travel policy at a national and regional level.
- Evaluating the Trust's previous 2019 Travel Plan, whilst accounting for the infrastructure developments at Diana Princess of Wales Hospital and Scunthorpe General Hospital.
- Integrating staff feedback from the 2021 travel survey and extends the detail of the actions put forward in the Trust Green Plan.

The action plan recognises the differences between NLaG's three sites and provides site specific actions broken down by specific areas of focus. To assist Plan delivery, key metrics and timeframes are provided to prioritise action each year.

In addition to the Green Travel Plan, the Trust has also produced a Green Plan to set out future plans for emissions reduction initiatives across a range of Trust activities. This includes a specific workstream for travel, transport and air quality. The actions outlined in the Green Plan and their expected delivery dates are provided in the table on the right. These are actions that are applicable to all sites across the Trust.

The following action plan will provide details as to how the Trust will implement greener travel practices across the themes outlined below.

Action plan

Cycling

Action	Timeframe	Measure	Site
Review opportunities for installation of additional secure cycle storage for staff	2022/23	Number of secure cycle parking spaces	All
Improve cycling facilities including showers, changing sites and lockers	2023/24	Number of staff/visitors cycling to site	All
Purchase E-bikes for clinical teams doing community visits	2022/23	Number of Trust owned E-bikes	All
Trial a pool E-bike for staff personal use	2022/23	Number of pool E-bikes	All
Collaborate with Local Authorities to upgrade the safety of each site's surrounding cycle infrastructure	2023/24	Annual survey results	All
Implement and engage staff in staff cycling clubs	2022/23	Number of staff in a cycling club	All
Host cycle maintenance/training/Doctor Bike events across remaining sites.	2022/23	Number of participants	SGH, GDH

Walking and running

Action	Timeframe	Measure	Site
Implement and engage staff in a running and walking club	2022/23	Number of participates	All
Promotion of national events such as walk to work week	Ongoing	Number of participates	All
Introduce green walking routes around sites	2022/23	Annual survey results	All
Ensure site walking infrastructure is safe and pedestrian friendly	2022/23	Annual survey results	GDH

Public transport

Action	Timeframe	Measure	Site
Extend the staff travel bus to accommodate all three sites and increase capacity for peak travel times	2023/24	Number of bus passengers	GDH/All
Review transport contracts to identify low carbon alternative transport alternatives e.g. electric staff bus	2022/23	Number of low carbon travel suppliers	All
Work with local transport providers to identify potential opportunities to subsidise travel for staff	2022/23	Price of staff commute	All
Ensure real time information screens displaying bus time updates are available at all sites	2022/23	Number of bus passengers	SGH, GDH

Action plan

Car use/smarter driving

Action	Timeframe	Measure	Site
Raise local staff parking charges in line with public transport	2023/24	Number of local staff actively commuting	All
Run an anti-idling campaign via installation of signs at dop-off points and the provision of posters and communications	2022/23	Air quality on site	All
Continue the promotion and implementation of car sharing scheme after Covid-19	Ongoing	Number of car sharers	All

Fleet and EV infrastructure

Action	Timeframe	Measure	Site
Undertake an EV charging infrastructure review and set ambitious EV infrastructure targets e.g. 10% all visitor/staff parking to be equipped with EV charging infrastructure	2022/23	Percentage of spaces with EV charging points	All
Convert fleet and pool vehicles to fully electric	2024/25	Percentage of EVs in fleet	All
Introduce measures to decarbonise grey fleet e.g. restrict salary sacrifice scheme to only zero emission vehicles	2022/23	Number of EVs through scheme	All

Smart Working

Action	Timeframe	Measure	Site
Review the need for remote IT training for staff	2022/23	Number of staff working from home	All
Continue to increase the use of Smart working practices (e.g. web conferencing)	2022/23	Annual business mileage expenditure	All
Increase the use of flexible/ home working/hot desking	2022/23	Number of agile working staff	All

Action plan

Policies and Procedures

Action	Timeframe	Measure	Site
Submit further site specific travel plans to the relevant local authority after the newly constructed ED's have come into use	2022/23	Evidence of submissions	DPoW, SGH
Ensure a monitoring report on the impact of the travel plan is submitted to the local planning authority annually.	2022/23	Evidence of submissions	All
Establish a Travel plan working group and network of sustainable travel champions	2022/23	Evidence of group action	All
Establish a travel bureau at each site to coordinate pool bookings and plan travel routes for staff driving to visits	2023/24	Use of pool transport/ business mileage expenditure	All
Develop a green travel welcome pack for new staff	2022/23	Evidence of travel pack	All
Review potential for gamification/apps to inspire sustainable action	2023/24	Number of engaged staff	All
Climate training for staff to help understand the multiple benefits of active travel	2023/24	Number of staff enrolled in training	All

Promotion and Communication

Action	Timeframe	Measure	Site
Develop a communication plan to support NLAG's travel plan and ensure messages and opportunities are being received by staff	2022/23	Evidence of plan	All
Promotion of the travel plan to staff and visitors through the appropriate communication channels e.g. social media/ display posters	2022/23	Evidence of promotion	All
A section within the staff portal should be dedicated to information relating to the Green and Travel Plans.	2022/23	Evidence on staff portal	All
Update online site information (e.g. site maps) with relevant infrastructure development	2022/23	Evidence of completion	DPoW, SGH
Provide staff with internal newsletters to update them on sustainable steps taken and progress made by the Trust	2022/23	Annual number of newsletters	All
Promote sustainable travel activities and events as well as share important travel information to the wider public through social media platforms	2022/23	Evidence on social media	All

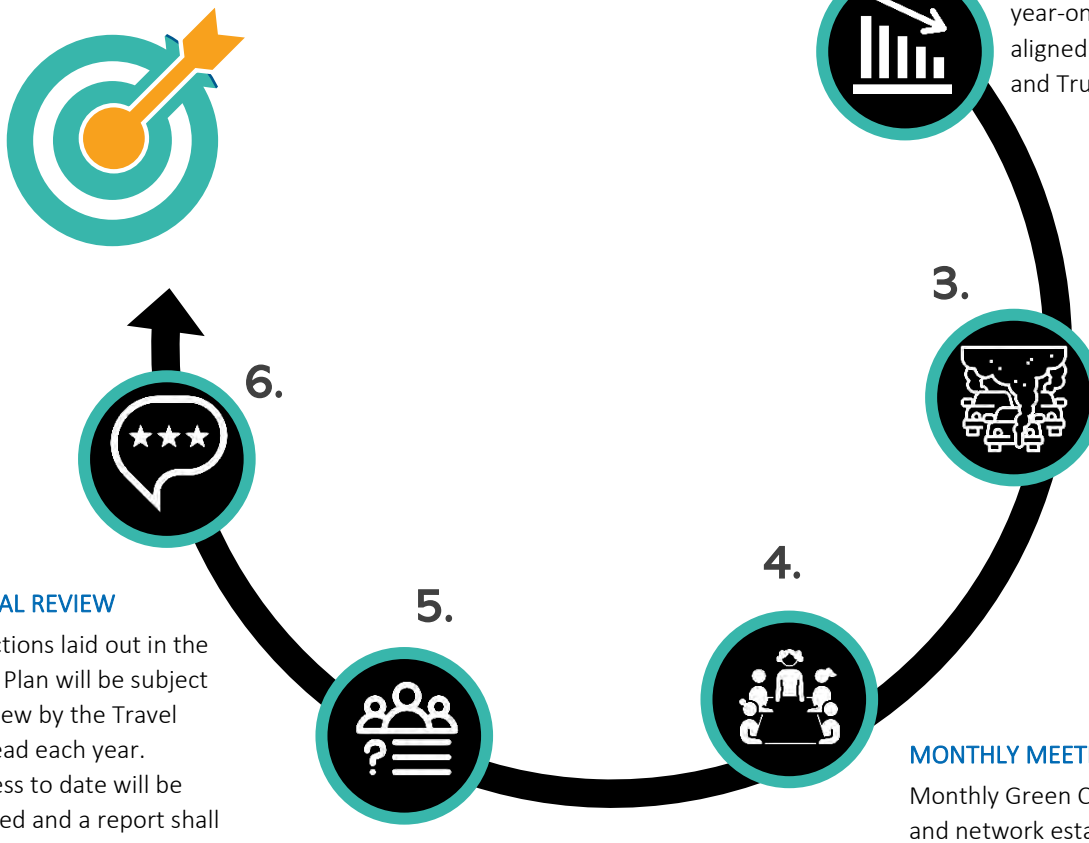
Monitoring and review

To ensure the actions laid out in the Travel Plan are implemented successfully, an effective monitoring and review process will be required to ensure progress is being made against the action plan. The following measures shall be put in place to monitor the plan:

1.

DATA COLLECTION

The collection of data will be an important process in monitoring the progress of actions. Data should be collected on fleet and business mileage to inform annual emissions calculations and track progress. Data should also be collected on the usage of car parks, bike parking facilities, car sharing and engagement with sustainable travel schemes and initiatives.



2.

EMISSIONS CALCULATIONS

Emissions calculations for travel should be conducted each year with the aim of year-on-year improvements aligned with the wider NHS and Trust targets.

3.

HEALTH OUTCOMES TRAVEL TOOL (HOTT)

The Greener NHS programme's HOTT helps the Trust measure the impact of our travel and transport in environmental, financial and health terms.

4.

MONTHLY MEETINGS

Monthly Green Champions meetings and network established- A dedicated Green Champions network and monthly meetings will keep the staff engaged and inspired. This will also give a chance for the Travel Plan lead to report on successes across the Trust.

5.

ANNUAL TRAVEL SURVEYS

In order to monitor progress against our targets, both staff and visitor surveys will need to be conducted each year. Since NLaG's last travel plan, there has been no travel survey on visitor travel behaviours. Collecting both staff and visitor data will help the next travel plan to monitor progress on key travel targets and use survey feedback to update subsequent travel plan action.

6.

ANNUAL REVIEW

The actions laid out in the Travel Plan will be subject to review by the Travel Plan lead each year. Progress to date will be assessed and a report shall be produced. This report will then be shared to the local planning authority as well as the green champions network as well as the online staff portal to update staff on progress made.

Priority actions for 2022/23

Appendices

1. Grimsby Bus Map

Figure 15. Bus route map- Grimsby[13]

Appendices

2. Scunthorpe Bus Map

Figure 16. Bus route map- Scunthorpe[14]

Appendices

3. Goole Local Cycle Routes

Figure 17. Local cycle map- Goole[15]

Appendices

References

1. Decarbonising Transport – A Better, Greener Britain (publishing.service.gov.uk)
2. Gear change: a bold vision for cycling and walking (publishing.service.gov.uk)
3. Local Transport Plan 2011-2026 - North Lincolnshire Council (northlincs.gov.uk)
4. 2018 - New Local Plan 2013 to 2032 (nelincs.gov.uk)
5. Local transport plan (eastriding.gov.uk)
6. delivering-a-net-zero-national-health-service.pdf (england.nhs.uk)
7. The NHS Long Term Plan
8. 2020/21 NHS Standard Contract
9. NHS Operational Planning and Contracting Guidance 2020/21
10. NHS Non-Emergency Patient Transport Services (NEPTS) review
11. Guidelines for Planning Public Transport in Development
12. NTS0303: Average number of trips, stages, miles and time spent travelling by main mode: England
13. SHAPE | Strategic Health Asset Planning and Evaluation (shapeatlas.net)
14. Planning Policy Guidance 13: Transport
15. EMID Grimsby Map July 2021
16. Scunthorpe Map.pdf
17. getresource.axd (eastriding.gov.uk)

NLG(22)223

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	6th December 2022	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance & Performance Committee Highlight Report**	
Purpose of the Report and Executive Summary (to include recommendations)	To highlight to the Board the main Finance areas where the Committee was assured and areas where there was a lack of assurance resulting in a risk to the delivery of the Trust's strategic objectives.	
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Executive Leads
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
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: Click here to enter text.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	6th December 2022
Report From:	Finance & Performance Committee – 19-10-22 and 23-11-22

Highlight Report:

Review of NLaG monthly Financial position (Finance Report) (SO3.1/SO3.2b)
Finance Report Month 6
The Committee received the September financial report and discussions were had around:

- **Monthly Performance**

The Trust had an in-month deficit of £1.42m, £1.17m adverse to plan and had a £4.01m year-to-date deficit, £4.91m worse than plan. The September deficit was primarily driven through funding shortfalls of the national pay award. If no mitigating actions were taken, initial forecast assessments projected a potential risk of a £9.6m end of year deficit, which would also worsen the underlying deficit position. The Committee questioned the actions in place to correct this and reassurance was given that all plans would be brought to the Committee as they were generated.
Pay was £4.65m overspent in month, again mainly due to the national pay award and non-pay was £0.17m overspent in month.
COVID-19 expenditure was £3.25m year-to-date which continued below plan.

- **CIP**

CIP continued slightly behind the year-to-date plan and forecast to be £1.3m adverse.

- **Capital Spend**

The Capital programme had seen slippage on both Emergency Departments but the Grimsby site was now open.

- **System Performance**

The ERF income plan was again recognised as fully achieved for H1, as per system requirements, despite the Trust only achieving 88% in September and 93% year to date against the 104% target and despite spending the Capacity Reserve set aside in the plan.

Finance Report Month 7
The Committee received the October financial report and discussions were had around:

- **Monthly Performance**

The Trust had an in-month surplus of £0.46m, £0.27m better than plan and now had a £3.55m year-to-date deficit, £4.63m worse than plan. The October surplus was supported through the release of £1.59m of non-recurrent technical reserves. The Trust was formally forecasting a balanced financial position but was highlighting a deficit risk of £8.5m, mainly due to temporary staffing, escalation beds and pay pressures. The Committee queried the full year forecast as the high vacancy rate would potentially warrant extra investment and the Committee were assured that there was a good pipeline of staff in place which would help reduce spend. The Committee also questioned the year end balanced forecast as that would be reliant upon the system achieving plan but the report did not state how the system was performing. It was agreed that system performance would need to be included in future iterations of the report.
Pay was £0.71m adverse in month.
COVID-19 expenditure was £3.72m year-to-date which continued below plan.

- **CIP**

At the end of October, the Trust had delivered £5.93m of savings against a core year to date plan of £6.4m, an under delivery of £468k.

- **Capital Spend**

The Trust had received notification of the additional funding of £5.83m relating to TIF funding for theatres at DPOW and SGH and further funding of £0.13m for MRI software upgrade and Endoscopy training simulator.

Recovery Support Programme for finance (RSPf)
The Committee received the letter in October and discussed the content, with no issues raised. There was no letter available for the November meeting.

Business Case Assurance
No Business Cases that fall under the remit of the Committee were presented.

Community Diagnostic Centres
The Committee received a presentation on the community diagnostic centres and assurance was requested around the timescales for Phase 2 of the programme. The Committee were assured that the programme was due to complete Phase 2 by the end of March 2023.

Confirm or Challenge of the Board Assurance Framework:

None

Action Required by the Trust Board:

The Trust Board is asked to note the key points made and consider whether any further action is required by the Board at this stage.
Gill Ponder
Non-Executive Director / Chair of Finance and Performance Committee

NLG(22)224

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	6th December 2022
Director Lead	Ivan McConnell, Director of Strategic Development
Contact Officer/Author	Kerry Carroll, Deputy Director of Strategic Development Claire Hansen, HAS Programme Director
Title of the Report	Key Issues - Strategic & Transformation
Purpose of the Report and Executive Summary (to include recommendations)	The attached report provides the Board with an update and overview of our progress against the delivery of: **Strategic Objective 1 - 1.3: To give great care** **Strategic Objective 4: To work more collaboratively** The Board is asked to note: The progress that is being made on the delivery of the Humber Acute Services critical milestones of Programme 2 Core Service Change. The progress that is being made on the development of a Capital Strategic Outline Case to support major capital investment within NLAG and HUTH and the associated capital financing risks we face: • Potential announcement of the New Hospitals Programme (NHP) for the remaining 8 Hospital Trusts by end October 2022 (delayed) • Residual capital risks we face even if we gain a place on the NHP, in particular within SGH Our continued participation in and leadership of collaborative ventures through partnership working, notably: • Membership of Place Boards • Leadership of Collaborative of Acute Providers (CAP) Strategy • Leadership of CAP Planned Care Strategy and Operational Planning/Delivery • Leadership of South Bank Community Diagnostic Centres Programme The Board is asked to note that whilst significant progress has been made in the delivery of the agreed milestones for Humber Acute Services there are potentially significant risks and key issues that still remain to future implementation and delivery: • The timing of consultation has moved to summer 2023 but could be impacted by wider system change in that time period • The risk of not being selected as one of the remaining 8 Trusts to become part of the New Hospitals Programme limiting our potential access to National funding and leaving us with a significant capital infrastructure and funding risk
Background Information and/or Supporting	N/A

Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Directorate SMT
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ✓ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Capital funding	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

***Board Assurance Framework (BAF) Descriptions:**

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk

	to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Strategic Service Development and Improvement – December 2022

Strategic Objective 1 (1.3) - To give great care

Strategic Objective 4 – To work more collaboratively

- With partners in the Humber Acute Services Review, we will engage fully in leading and supporting the development of a Pre-Consultation Business Case (PCBC) for the delivery of new models of care for ***(programme 2) linked to submission of a Capital Expression Of Interest (EOI) and Pre- Strategic Outline Case (SOC) (Programme 3) for:***

    - Urgent & Emergency Care
    - Maternity, Neonates & Paediatrics
    - Concepts of Planned Care and diagnostics

- We will play a full part in the development of the Humber and North Yorkshire Health & Care Partnership, including the:

    - Humber & North Yorkshire Integrated Care Board (H&NY ICB)
    - Acute Collaborative
    - Community Collaborative
    - Primary/Secondary Care Interface Groups – North and South Bank
    - Place Boards - North and North East Lincolnshire, East Riding of Yorkshire and working groups
    - HNY Cancer Alliance and associated professional networks
    - HNY Clinical and Professional Leaders Group
    - Community Diagnostic Centres

- We will play a full part in other national and regional networks, including professional, service delivery and improvement (e.g. Getting it Right First Time - GIRFT), and operational.

Highlights	Lowlights	Risks

Overall
• Continued engagement with the H&NY ICB re the HAS Programme – potential options and consultation approach/timeline, Clinical evaluation planning, and finance approaches.
• Continued engagement with the Overview Scrutiny Committees (OSC) and discussion re the timescale for setting up a Joint Health OSC to oversee the Consultation and Decision
• Review potential capital development options to include becoming one of the remaining 8 Trusts on the New Hospitals Programme (NHP) Place, or potential next steps should we not be a member of the NHP
• NHSE/I monthly assurance reviews continue with positive challenge and support
• Ongoing briefings of individual ICS Executive Team members, Place Directors and Primary/Secondary Care interface Groups
• Progression with joint PMO developments with Place Directors to support the design and implementation of the essential out of hospital programme changes
• Finance team engagement for revenue and capital costing planning
• Place Director x4 and wider system – ongoing briefings Doncaster/Lincoln
	• Complicated acute review spanning all programmes and aligning to out of hospital and community diagnostic changes
	  • Out of Hospital (OOH) programme requires new governance and leadership – HAS team to support Place Directors for next 6 months and set up Programme Management Office to govern
	• Challenges of continuous engagement and involvement / time commitments for busy operational staff (including key clinical leads during recovery phase)
	  • Associate Medical Director Strategy/Programme Director and Deputy Director Strategy undertaking and maintaining continuous Divisional engagement on ongoing basis – this will be an increased requirement given timescale changes
	• Potential media interest in emerging options as we continue to engage widely
	• Misunderstanding of wider staff groups in relation to HASR/Group structures and Interim Clinical Plan.
		• Potential further movement of consultation timelines – political
		• Pathways in P2 look beyond hospital boundaries and require out of hospital transformation – OOH programme governance is not sufficient to deliver
		• Potential options may be subject to OSC, Public challenge resulting in Independent Review, Judicial Review or Secretary of State review
		• Potential options may displace activity to neighbouring health economies
		• The delivery of changed pathways will require capital investment in digital as well as wider infrastructure – funding sources not yet known
		• Planned care pathways must align to wider ICS Elective recovery and Community Diagnostic Hub programme implementation
		• Potential further COVID wave and impacts on elective delivery and ability to continue with engagement and evaluation of key stakeholders
		• Potential impact on staff who have been engaged in process due to legislation delay – may lose interest and enthusiasm
		• Need for temporary service change as a result of quality/safety issues – perception/management/pre-determination

Programme 2 (P2):

- H&NY ICB briefings x 2
- Timeline reset against consultation change to summer 2023
- Finalisation of PCBC contents –chapters added – Travel/IIA/Displacement/Enablers/Workforce/Plan to Implement – finance and economic chapters in train
- Collaborative procurement of consultation and engagement external support with H&NY ICB – 2x contractors appointed, and planning for pre-consultation commenced.
- Staff engagement events arranged (inc. drop in sessions, speciality workshops) throughout Nov to Jan 23 that is based around Integrated Impact Assessment
- Specialty meeting's attended and focused workshops to go through the detailed modelling have been agreed
- Further targeted engagement with hard to reach groups through the support of the VCSE and Maternity Voices Partnership within the system and on the boundaries.

Programme 3 (P3)

- Awaiting announcements on final 8 Trusts selected to become part of New Hospitals Programme – potentially mid/end October 2022 (*delayed)*
  - If selected multiple business cases will be required to support funding applications
  - If selected will still require significant capital cover for Back Log Maintenance/Critical Infrastructure Risks – particularly in SGH during any design/build phase
- Capital options in support of Expression of Interest (EOI) Strategic Outline Case (SOC) developed:
  - Investment Objectives
  - Options – Business as Usual (BAU)/Do minimum/Do Maximum
  - Phasing considered
  - Risk analysis undertaken
  - Funding options considered

- Capital funding sources not yet agreed – raised issue with Regional Finance Director – funding sources and capital gaps

- Delays to capital submission outcomes and potential extension of timelines for delivery of NHP – impact on funding short term Back Log Maintenance and Critical Infrastructure Risks costs

- Lack of affordability from internal capital for priority capital investment in the short term

- Potential for developments in ICB Strategy, Place Strategies and Collaborative Acute Providers Strategies to change prioritisation and focus of effort

Partnership and System working

- We will play a full part in the development of the Humber and North Yorkshire (HNY) Health & Care Partnership
- We will play a full part in other national and regional networks, including professional, service delivery and improvement (e.g. GIRFT), and operational.

Highlights	Lowlights	Risks
Humber and North Yorkshire Health & Care Partnership: NLaG is an active member of a number of Boards/Groups across the Humber and North Yorkshire ICS: • Trust is member of HNY Partnership Board • The Trust is an active member of the Collaboration of Acute Providers Board and other members of the Trust leadership community participate in sub groups • The Trust is an active member of the Community Provider Collaborative • The Trust is actively involved various community collaborative (i.e. Outpatients Transformation, Planned Care Programme, Diagnostics, Urgent & Emergency Care Network, Community Paediatrics) • The Trust COO and Head of Cancer are members of the HNY Cancer Alliance Board • Senior leaders from across the Trust are active participants in HNY Clinical Networks • Linkages and alignment to the ICS Out of Hospital Programme Board as part of the HAS Programmes. • The Trust is an active participant in the emerging Place Based Partnerships • HAS leads are part of the primary/secondary care interface groups • The Trust is an active member of the HNY Clinical and Professional Leaders Group **National and regional networks:** • Members of the Trust Board and Senior Leadership Community are active members of national and regional networks. The Trust is an active participant in Getting It Right First Time (GIRFT) reviews • As part of the HAS Programme the Trust is actively engaged with National and Regional Network and GIRFT leads on Urgent Emergency Care, Maternity and paediatrics and a number of planned care specialties	• Pace of design and development of Place Base Partnerships – at different stages of development • Place Based Boards – lack of PCNs clarity of role	• Aligning the /strategies/ objectives/ priorities of the to HASR

NLG(22)225

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	6 December 2022
Director Lead	Lee Bond, Chief Financial Officer
Contact Officer/Author	Ellie Monkhouse, Chief Nurse; Joint Clinical Lead Dr Kate Wood, Medical Director: Joint Clinical Lead Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee; Author
Title of the Report	**HTF Trustees' Committee Highlight Report –** 3 November 2022
Purpose of the Report and Executive Summary (to include recommendations)	The highlight report summarises key issues presented to and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 3 November 2022. The Trust Board are asked to note the following: • HTF Team Changes • Approval of Wishes for The Pink Rose Suite • Improvement to Staff Rest Rooms • HTF Investments
Background Information and/or Supporting Document(s) (if applicable)	HTF Trustees' Committee Terms of Reference
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: HTF Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
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Highlight Report to the Trust Board

Report for Trust Board Meeting on:	6 December 2022
Report From:	Health Tree Foundation Trustees' Committee held on 3 November 2022

Highlight Report:

HTF Team Changes

- Trustees were advised of the following temporary personnel changes within the HTF Team, all taking immediate effect. Clare Woodard will be filling the Head of Smile Health role until December 2023, whilst Victoria Winterton takes maternity leave. Lucy Skipworth will assume responsibility for the HTF Charity Manager post for the same period and Michelle Soar has been recruited and appointed as the HTF Community Champion for Grimsby on a fixed term basis.

Approval of Wishes for The Pink Rose Suite

- A series of 3 linked Wishes for The Pink Rose Suite were approved by Trustees following a presentation by Consultant Radiographic Practitioner, Sarah Fox in support of the Wishes submission. The monies will fund 2 Tomosynthesis Biopsy Software Licences and 4 SecurView Tomosynthesis Option Licences, an additional software licence for the Affirm Breast Biopsy System and 2 Hologic 2D Software Options for new mammography machines. They are all part of larger capital projects already funded by the Trust and the total cost, with discounts, will be £60,600.

Improvements to Staff Rest Rooms

- Trustees heard about a proposal to spend some charitable funds on improving Staff Rest Facilities throughout the Trust. It was argued that such enhancements would support and encourage staff in their daily work; have a positive impact on long term staff retention and overall be of considerable direct and indirect benefit to patients. Trustees agreed with the proposal but were keen to manage expectations and asked that a rolling programme be created for their further consideration.

HTF Investments

- Trustees were advised that the HTF Investment Portfolio, held in the CCLA COIF Charities Ethical Investment Fund had reduced during the preceding 6 months. The Fund was valued at £1.772m on 31 March 2021 and on 20 October 2022 stood at £1.639m. The report attributed that fall to difficult market conditions and noted that the fund performance had exceeded comparator benchmarks. The income forecast for 2022 stood at £51.3k.

Confirm or Challenge of the Board Assurance Framework:
Not Applicable
Action Required by the Trust Board:
The Trust Board is asked to note the key points made and consider whether any further action is required by the Trustees at this stage. **Neil Gammon** **Independent Chair of Health Tree Foundation Trustees' Committee**

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	6 December 2022
Director Lead	Linda Jackson, Vice Chair
Contact Officer/Author	Linda Jackson, Vice Chair
Title of the Report	**Strategic Development Committee Highlights Report and Board Challenge**
Purpose of the Report and Executive Summary (to include recommendations)	The Strategic Development Committee met on 26 August where members considered : • HASR – including Maternity risk • Community Diagnostic Centres • External Demands PLACE • 5 Year capital Plan • Out of Hospital support **The Trust board is asked to consider** : • The potential risk to maternity services with the move to May/June commencement of the HASR consultation • The increasing demands on NLAG capacity of PLACE Quality Boards **The Trust Board is asked to note :** • Progress now being made on the CDC project • The involvement of the HASR PMO in five Out of Hospital specialties • Position regarding the Capital 5 year plan and next steps
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ✓ Collaborative and System Working ✓ Strategic Service Development and Improvement ☐ Finance ✓ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable

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: Click here to enter text.

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Highlight Report to the Trust Board

Report for Trust Board Meeting on:	6th December 2022
Report From:	Strategic Development Committee – 26th October 2022

Highlight Report:

Maternity

The Committee received an update on the potential options that may be carried forward to consultation for the Humber Acute Services Review. The evaluation undertaken to date has highlighted two potential options which are an Acute Hospital and a Local Emergency Hospital on the South Bank. The consultation will test people's views on the options and potential locations of those options. As part of the option appraisal there is the potential to implement either one or two obstetric units within the potential service model.

The Committee were advised that following discussions with the Integrated Care Board that the Humber Acute Services consultation timeline had moved from commencing in November 2022 till June 2023. The Committee were advised that this means that there is a potential risk of the need for a temporary service change being implemented to maternity services during the winter. This change would be made on the grounds of risk to quality and patient safety.

It will be important, should such a change be required, to evidence why and to ensure that any subsequent consultation is not prejudiced as a result of a temporary change.

Community Diagnostic Centres

The Committee received an update on the current status of the Community Diagnostic Centres programme. The Committee were advised of a number of emerging risks, including:

- Availability of Capital Funding to cover the potential cost of two full Community Diagnostic Centres on the South Bank
- The need for a comprehensive analysis of the proposed clinical pathways and associated system wide capacity/demand
- The need to ensure that a comprehensive workforce plan is put in place to support implementation
- Consideration of the future revenue funding model for the CDC and associated activity

The Committee welcomed the proposed changes to Programme Governance and the initial plans that have been put in place to implement a number of work programmes which address the risks highlighted.

External demands – PLACE

The committee highlighted last month the increasing pressures on the Executive team to meet the volume of external meetings (board development time now been allocated to this issue)

The committee were informed in the October meeting of the creation of 3 Quality Boards being set up for each of our PLACE's (NEL, NL, ER). There has been discussion with each place on the impact servicing 3 committees, with 3 different agenda's, needs and concerns.

The committee wished to flag this concern to the board and the capacity implications associated to servicing this arrangement but will continue to try and influence this arrangement

5 Year Capital Plan
The committee received a comprehensive report on the 5-year capital plan and associated risks. Once the outcome of the New Hospitals Programme is received (expected October 2022) further work will be undertaken to update options prior to the board development session in March 2023 on what the options are moving forward. The committee agreed that digital investment should also form part of the review

Out of Hospital
The HASR consultation period has now moved to May/June 2023. During the next 6 months it has been agreed that the Programme Management Office will support 5 key out of hospital work streams being:

- Frailty
- Enhanced Health in Care Homes
- Falls Prevention
- Community Diagnostic Centre's
- Humber Community Ill Child (hospital at home initiative)

It was noted that all of these workstreams will either help the acute Trust with early discharge or reduction of inpatient activity

Confirm or Challenge of the Board Assurance Framework:

N/A

Action Required by the Trust Board:

The Trust Board is asked to note the key points made

Linda Jackson
Vice Chair / Chair of Strategic Development Committee

NLG(22)227

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	6 December 2022	
Director Lead	Sean Lyons, Chair	
Contact Officer/Author	Sean Lyons, Chair	
Title of the Report	**Humber Acute Services Development Committee Highlight Report (Committees in Common)**	
Purpose of the Report and Executive Summary (to include recommendations)	The report represents the highlights from the meeting held on 11 October 2022.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
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: Click here to enter text.

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Report to the Board in Public
Humber Acute Services Development Committee held on 11 October 2022

Item: Director Overview Report P2/P3 Update	Level of assurance gained: Reasonable
Work was ongoing regarding the programme and changes to clinical models and the economic and social impact of moving services was being reviewed. Finance and out of hospital services were key to the programme. The consultation period would now take place in June 2022 Key risks: Loss of staff engagement and momentum due to delays and the need to sustain safe services during the next year	
Item: Integrated Care Programme Update	Level of assurance gained: Reasonable
Service strategies had been received for Haematology, Oncology , Neurology, ENT and Dermatology and were on trajectory. The Humber Neurology Service was now operational and had been taken out of the ICP programme and would be supported by the Joint Development Group. An assessment of Pharmacy home deliveries on the North and South Bank is being undertaken. Terms of Reference and governance arrangements have been agreed for the JDB.	

NLG(22)228

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	6 December 2022
Director Lead	Simon Parkes, NED / Chair of Audit, Risk and Governance Committee
Contact Officer/Author	Simon Parkes
Title of the Report	**Audit, Risk & Governance Committee Highlight Report – November 2022**
Purpose of the Report and Executive Summary (to include recommendations)	The attached highlight report summarises the key issues presented to, and discussed by the Audit, Risk and Governance Committee at its meeting on 24 November 2022: **1.** **HFMA Financial Governance Checklist**: The Committee received and accepted both the completed HFMA self-assessment checklist and the Internal Audit report on the review of the organisations self-assessment checklist. **For Board to Note.** **2.** **Patients Valuables –** Concerns expressed with items relating to lost jewellery. Internal Audit review of patients properties and monies (PPM) scheduled in the 2022/23 internal audit plan. **For Board to Note.** **3.** **Mortuary and Body Store Assurance** – Latest update received. Ongoing issues at Goole with achieving compliance. Further update to the February 2023 Committee. **For Board to Note.** **4.** **Document Control** – Generally improving position and documents now risk stratified. However, 1 high risk and 12 moderate risk documents overdue. Details being sent to the relevant Directors with a view to focusing on bringing these specific documents back into compliance. **For Board to Note.** **5.** **Training –** Work remains ongoing to achieve 95% compliance with IG training. However, the Committee expressed concern with the theme of training generally. **For Board to Note.**
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk & Governance Committee Agenda Papers – 24 November 2022
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ☐ Other: Click here to enter text.

Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
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: Click here to enter text.

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Highlight Report to the Trust Board

Report for Trust Board Meeting on:	6 December 2022
Report From:	Audit, Risk & Governance Committee – 24 November 2022
Highlight Report:	

1. **HFMA Financial Governance Checklist** - The Committee received the Internal Audit report on the outcome of the review of the recent self-assessment exercise involving the HFMA publication '*Improving NHS financial sustainability: Are you getting the basics right?*' The IA review concluded that appropriate evidence was provided by the organisation in relation to the checklist questions and only three recommendations were made. The Committee felt that the exercise had been conducted properly, carefully and honestly by the Trust. The Committee also received a paper outlining the approach taken by the Trust to complete the checklist, and provided the completed and audited checklist including details of actions required with lead officers / timescales, the local ICS results the a benchmarking report of 103 NHS organisations collated by The Internal Audit Network (TIAN) of which Audit Yorkshire is a member. The Trust was placed mid-range of the 103 organisations involved. The Committee advised that it would support the Chief Financial Officer as necessary with the financial management culture recognising the balance that must be struck between the multiple priorities the organisation is managing.

2. **Patients Valuables –** The Committee noted the latest Losses and Compensations report contained three items of lost jewellery totalling circa £5.7k. An Internal Audit review of patients properties and monies (PPM) is scheduled in the 2022/23 internal audit plan which will examine procedures for safeguarding PPM, including whether messages reinforcing that patients planning to come into hospital do not bring such items with them are sufficient.

3. **Mortuary and Body Store Assurance –** The Committee heard the latest update from the Director of Pathology and there remain on-going issues at Goole in relation to card access audit reviews and also the closure of the body store facility, which means that the standards of required compliance are not yet being fully met. A further update will be brought back to the Committee at its February 2023 meeting.

4. **Document Control –** Although there is a generally improving position and documents are now risk stratified, there remains 1 'high' risk and 12 'moderate' risk overdue documents. The Committee expressed concern with these specifically and requested that a list of these be sent to the relevant Directors by the Director of Corporate Governance after the meeting with a view to focusing on bringing these documents back into compliance.

5. **Training –** The Committee heard that work remains ongoing to achieve 95% compliance with Information Governance training, and all opportunities for doing so are being explored. However, the Committee expressed concern with the theme of training generally and asked what more could be done to achieve the necessary targets, etc.

Confirm or Challenge of the Board Assurance Framework:
The Committee received and considered the BAF report for Q2 of 2022/23, and were pleased to see that the High Level Risk Register items were now contained within the report, taking the information to the next level. It was commented that the BAF was creating the conversations that it should at Board sub-committees. There were no specific items that the Committee felt required escalation to the Trust Board.
Action Required by the Trust Board:
The Trust Board is asked to note the key points raised by the Committee, and consider any further action needed. **Simon Parkes** **Non-Executive Director / Chair of Audit, Risk & Governance Committee**

Name of the Meeting	**Trust Board - Public**
Date of the Meeting	6 December 2022
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Board Assurance Framework (BAF) 2022-23, Quarter Two Report**
Purpose of the Report and Executive Summary (to include recommendations)	To present the BAF to the Trust Board for assurance. The Trust Board is asked to: a) receive the BAF executive report detailed below b) receive the BAF and strategic risk register in detail (Appendix 2) c) note the risk scoring, as at 30 November 2022 for each of the strategic risks: SO1-1.1 = 15 SO1-1.2 = 20 SO1-1.3 = 12 SO1-1.4 = 20 SO1-1.5 = 9 SO1-1.6 = 16 SO2 = 20 SO3-3.1 = 20 SO3-3.2 = 20 SO4 = 8 SO5 = 8 d) receive the High-Level Risk Register (Appendix 1) e) seek assurance on the current risk rating and target risk rating of each of the strategic risks, from the Chairs of each of the Trust Board Committees and the Executive Owners f) note work has commenced to action the recommendations from the internal audit on the BAF g) note an assurance mapping exercise has been undertaken to consider the effectiveness of the controls and verify that assurances were being received for all the identified controls.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Trust Board Committees

Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
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: Click here to enter text.

***Board Assurance Framework (BAF) Descriptions:**

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Board Assurance Framework – Quarter Two 2022-23

1. Purpose of the Report

1.1. To present the BAF to the Trust Board for assurance and for the Board to review current scoring of the strategic risks and to note the referenced high-level risks.

1.2. The Trust Board is to receive the BAF (Appendix 2) and the High-Level Risk Register (Appendix 1), to gain assurance that it is operating as part of the Trust's overarching governance / control systems.

1.3. All strategic risks have been reviewed by the Executive Owners and the Trust Board Committees during quarter two.

The exception to this, is the Strategic Development Committee will review strategic risks SO1.3, SO3-3.2 and SO4 at its meeting on 15 December 2022. The Executive Director has reviewed each of these risks.

2. Strategic Objective Risk Ratings: 2022-23 Quarter Two

2.1. The table below illustrates the current risk rating of each Strategic Objective against the target risk rating by the end of March 2023:

Strategic Objective	2022-23			Risk Appetite Score
	Risk Rating Quarter 1	Risk Rating Quarter 2	Target Risk by 31/03/2023	
SO1-1.1	15	15	15	4-6
SO1-1.2	20	20	15	4-6
SO1-1.3	12	12	8	4-6
SO1-1.4	20	20	20	4-6
SO1-1.5	9	9	6	4-6
SO1-1.6	16	16	8	4-6
SO2	20	20	12	4-6
SO3-3.1	15	20	20	8-12
SO3-3.2	12	20	20	8-12
SO4	12	8	8	8-12
SO5	12	8	8	8-12

2.2 The Board is to note that several strategic risks remain at a high level of 15 and above as detailed in the above table.

2.3 SO3-3.1 and SO3-3.2 risk ratings have increased since the quarter one BAF report and have a number of significant gaps in controls..

SO3-3.1 – Gaps in Controls:
- Systems plans may not address individual organisational sustainability
- Challenges with HASR, CIP Delivery
- Uncertainty on application of long term financial framework.
- Clinical strategy required to inform Finance Strategy

● As we progress, the emerging uncertainty around the financial implications of decisions from the HAS process
● Month on month adverse variants against operational budgets

SO3-3.2 – Gaps in Controls:
● Comprehensive programme of Control and Assurance - potential inherent risk on ability of Trust to afford internal capital for major spend
● Control environment whilst comprehensive may not have ability to influence availability of Strategic Capital - investment funding/affordability
● Control environment may not be able to eliminate or reduce risk of estates condition in the short term

3. High-Level Risk Register (HLRR)

3.1. The HLRR is presented to the Board to provide oversight of the high-level risks linked to each strategic risk, which could have an impact on the achievement of the strategic risks and objectives. The high-level risks are monitored within Divisions and at the Risk Management Group. Trust Board Committees have received the HLRR as part of the quarterly review.

3.2. There are two high level risks scored at 25: No 2421 Nurse Staffing, and No 2976 Registered Nursing Vacancies.

3.3. There are 12 high level risks scored at 20:

- No 1620 Medical Gas Pipeline System,
- No 2038 Fire Compliance,
- No 2088 Building Management Systems Controller,
- No 2145 Quality of Care and Patient Safety (due to nurse staffing position),
- No 2530 Poor Registered Nursing Skill Mix on Wards,
- No 2562 Failure to meet Constitutional Targets in Emergency Care Centre,
- No 2623 Failure of Windows,
- No 2655 SGH Replacement of primary heat source and associated infrastructure and equipment,
- No 2719 Water Safety Compliance,
- No 2949 Oncology Service,
- No 2951 Electrical age and resilience of low voltage electrical infrastructure,
- No 3015 Insufficient estate resources to manage the workload demand.

4. Internal Audit Report - BAF

4.1. Following the internal audit report on the BAF, work continues to action the recommendations in quarter two/three 2022-23. Progress to date includes, assurance against planned actions and an assurance mapping exercise has been completed which considered the effectiveness of the controls and verified that assurances were being received for all the identified controls.

5. Recommendations

The Trust Board is asked to:

a) receive the BAF executive report detailed above

b) receive the BAF and strategic risk register in detail (Appendix 2)

c) note the risk scoring, as at 30 November 2022 for each of the strategic risks

d) receive the High-Level Risk Register (Appendix 1) and note the high-level risks detailed in section 3.2 and 3.3 of the report that could have an impact on the achievement of the strategic risks and objectives

e) seek assurance on the current risk rating and target risk rating of each of the strategic risks, from the Chairs of each of the Trust Board Committees and the Executive Owners

f) note work has commenced to action the recommendations from the internal audit on the BAF

g) note an assurance mapping exercise has been undertaken to consider the effectiveness of the controls and verify that assurances were being received for all the identified controls.

Appendix 1

HIGH LEVEL RISK REGISTER (AS AT 07-11-2022)

No	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Division	Specialty	Risk Rating	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
1620	08/01/2013	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Med Gas: Medical Gas Pipeline System outlet and plant - Trustwide	There is a risk of losing bed head medical gases due to medical gas wall point terminals (Oxygen, Vacuum Medical Air, Nitrous Oxide) being obsolete with limited spare parts. The loss of medical gas system could negatively impact the Trust's ability to treat inpatients and also prevents the capability to treat patients that have been transferred to the Trust.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Med Gas	1 High (Red)	20	26/11/2022	Ongoing monitoring of alarms. National supplier support for business continuity. Replacement in line with ward upgrades. Flow rate meters VIE telemetry	Inability to determine flow rates around the systems, other than design flow rates.	Significant/robust contingencies in place which have been tested in the recent critical incident (W87371).
1774	05/06/2014	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Poor condition of Fuel Oil Storage Tanks - SGH	If the Trust lost gas supplies to the SGH site the boilers would have to be fuelled by oil. The material state of the oil storage tanks has resulted in the oil being contaminated and if called upon, could damage the boilers. The strategic risk are the boilers failing to provide heat and hot water due to main hospital site.	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - HVAC & Pressure Syst	1 High (Red)	16	26/11/2022	Emergency generator fitted with own fuel supply.	No replacement plan for SGH.	External condition report.
1851	28/04/2015	30/09/2022	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Shortfall in Capacity within the Ophthalmology Service	The current risk, is the capacity does not meet the demand and the service is unable to meet this. Therefore, this impacts on ability to see patients within the clinical time scales.	Jennifer Orton	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery & Critical Care	Ophthalmology	1 High (Red)	15	23/11/2022	Work with the ICB to secure additional capacity in the independent sector.	Recent investment will not mitigate the shortfall in capacity	
2035	22/08/2016	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Equality Act 2010 compliance - Trustwide	The Trust has received numerous claims for slips, trips and falls from the state of the Trust's roads, pathways and corridors. These both damage the Trust's reputation and lead to financial loss. A number of facilities (lifts, toilets) are non-compliant with current regulations which may result in patients and staff being unable to move through the hospital sites safely and with dignity and respect.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Health & Safety	1 High (Red)	16	26/11/2022	Estates continually monitor the condition of the roads and pathways, repairing potholes as required. Larger resurfacing scheme are limited to BLM or other capital works funding when available.	Currently none, funding is required to provide adequate assurances. Staff to be made aware of the hazards of parking and moving around this area, as the site is not designated a car park.	The current control measures are not effective, it would need the "car park" to be closed to prevent further incidents.
2036	22/08/2016	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Ventilation and Air Conditioning - HVAC - Trustwide	Failure of the heating and ventilation system. This would result in a negative impact on the effective delivery of patient care.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - HVAC & Pressure Syst	1 High (Red)	15	26/11/2022	Planned preventative maintenance (PPM) in place for inspection and maintenance of all ventilation plants.	Limited BLM funding resulting in no long term replacement plan. Capital plan 22-25 capture theatre upgrades	Validation and flow checks carried out by 3rd party accredited contractor.
2038	23/08/2016	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Health & Safety	Fire Compliance	There is a risk failure of the fire alarm resulting in failure to detect fire/smoke leading to fire taking hold and hence possible serious harm and/or loss of life of patients and staff.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Fire Safety	1 High (Red)	20	26/11/2022	Panels are being replaced. DPoW ward replacement programme includes updated detection loops.	Fire detection - Mixture of analogue and digital which increases the risk of failure. Closed protocol system at SGH. Drawings - Establishment and confirmation of existing fire compartments.	Automatic fire detection - current panels to be replaced. A review of existing drawings is near completion.
2088	04/11/2016	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Buildings, Land and Plant	Building Management Systems (BMS) Controller failure/upgrade	There is the risk of failure of elements of the Building Management Systems (BMS). The BMS controls the sites heating and hot water services, therefore, temperature control of both the hospital environment and water systems could become significantly compromised.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Building Management	1 High (Red)	20	26/11/2022	Continued monitoring of the system for operation (by Estates Staff).	Reactive to ongoing BMS failures. Current BMS runs on outdated windows support system.	There are limited assurances on controls highlighted by continued BMS failures.
2145	15/02/2017	31/12/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Staffing Levels & HR	Quality of Care and Patient Safety - (due to nurse staffing position)	The Registered Nursing vacancy position in Medicine, against current, agreed establishment creates significant issues with producing a robust nursing roster. The Nurse vacancy position within Medicine has a direct impact on quality of care and patient safety. There is also a cost associated with the use of Agency Nurses in order to fill the gaps in the rosters. SNCT establishment review undertaken with Chief Nurse and implemented from 4th November roster period. This increased the Nursing establishment on most wards and both Emergency Departments by increasing the number Nurses within Medicine, which has resulted in an increase in our Nurse vacancies despite mitigation. Medicine are also staffing Escalation areas which adds further risk. In addition, Nursing staff rosters are significantly impacted due to the COVID pandemic due to staff sickness and shielding. Patient harm, increased sickness, staff leaving are possible outcomes as a result.	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	General Medicine	1 High (Red)	20	30/11/2022	1.International recruitment of staff 2.Roster approval checks in line with Rostering Policy and Procedure. 3. Shifts identified to be sent to Bank and Agencies within specified timeframes. 4.Block booking in place. 5.Twice daily staffing meetings. Redeployment of staff between wards on a daily basis. Workforce meetings Safe staff meetings PRIMS KPI meeting Check challenge meeting with deputy nurse meeting Care Navigator Roles Clinical Sister Band 6 now in place	Inability to cover all shifts via Agency / Bank. Financial implication of using premium rate agencies.	6 monthly Establishment reviews capturing information related to SNCT and Safecare. Successful Overseas Nurse resruitment - Oct 2020 - date 46 staff recruited. Update - 21.07.21. 49 Pre-registration nurses appointed to Medicine NQN's due to start in September/Oct 21 On-going recruitment drives with the support of Recruitment Team and Talent Acquisition Long term workforce planning as part of P2 of HASR/AAU

No	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Division	Specialty	Risk Rating	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
2244	20/06/2017	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	Failure to treat patients within tWT (62 days) will result in poor patient experience and may have the potential for clinical harm in some specialties. The Trust consistently achieves the 14 day and 31 day standards. The likelihood of continuing to not achieve the 62 day standards is high due to some elements of the diagnostic or staging pathway being outside of the control of NLAG and sitting with the tertiary provider. Risk register also relates to Risk ID 2008.	Abolfazl Abdi	Trustwide - All Sites (DPoW, S	Chief Operating Officer	Chief Operating Officer	Cancer Services	1 High (Red)	16	06/10/2021	(1) Weekly Cancer RTT waiting time meeting to challenge and review all cancer PTLs (62 day 1st, screening, consultant upgrade, 31 day 1st, subsequent surgery, subsequent drugs) (2) Automated RAG rated PTL (updated twice daily to reflect current position and available to all Divisional Managers). (3) 62 day Cancer Improvement Plan has translated into the Cancer Transformation Programme (2 year programme commencing 2021) (4) Cancer performance/ backlog is reported weekly to Operational Management Group (5) Improved visibility on all aspects of cancer pathways through the Cancer Power BI Performance report (which is updated daily and available to all Divisional Managers/clinicians. (6) Cancer Trackers attend Divisional Huddles in some specialties (Colorectal/Gynae) as a point of escalation. (7) A trust-wide clinical harm review process is in progress	Failure to treat patients within Cancer Waiting / Performance Target 62 day may result in poor patient experience and potential harm	62 day backlog and 104+ days waits monitored weekly at Operational Management Group
2245	20/06/2017	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Overall Performance : Non compliance with RTT incomplete target	Given our current operating models, there is a risk that there is insufficient capacity to meet demand in a number of specialities which risks the RTT position and potential for adverse patient impact. Potential for 52 week breaches and potential to not meet current 40 week maximum RTT target This could result in clinical harm	Mathew Thomas	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery & Critical Care	Surgery (All)	1 High (Red)	16	27/11/2022	(1) Capacity & demand plans have been developed for all specialties as part of the business planning 22/23 which highlight our risk specialties and gap between capacity and demand, use of the IST tool working with NHSI and strategy and planning.	Data quality and validation of clock stops.	Currently covering all clinics and wards with the use of agency and locums to mitigate the risk of rota gaps. North East Lincs and N Lincs council of members routinely review the data published.
2272	25/09/2017	31/12/2022	To offer care in estate and with equipment which meets the highest modern standards	Environmental	EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide	There is a risk that the EHO could instruct that the ward based kitchen is unfit for food preparation and issue a prohibition notice which would prevent food/drink being prepared on ward areas. This would result in a delay to patients receiving food and drink.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Catering	1 High (Red)	16	26/11/2022	1) Food preparation boards, minimal ward based food preparation of low risk food. Hazard Analysis of Critical Control Points HACCP. 2) Ward refurbishment programme 3) Quality Matron Environmental Audits 4) Flo-audits	Funding for major ward refurbishments.	Funding for major ward refurbishments. EHO currently assess each site and awards cleanliness standard up to and including 5*, these outcomes are for public communication and awareness.
2300	07/12/2017	31/12/2022	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Information Governance	Insufficient processes in place to ensure records management /quality against national guidance	The Trust has insufficient processes in place to ensure records management / quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards.	Christopher Evans	Trustwide - All Sites (DPoW, S	Digital Services	Digital Services	Information Governance	1 High (Red)	16	12/10/2022	Oversight by Trust's IG Steering Group and is managed via the Group's Action Log which is reviewed monthly.	None	The IG Steering Group monitor the progress of this actions
2388	09/07/2018	06/06/2022	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Clinical	There is a risk of deteriorating patients not being escalated appropriately.	There is a risk that patients observations and NEWS scores are not being consistently monitored and overseen which could lead to patient harm through deterioration.	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	General Medicine	1 High (Red)	15	30/11/2022	* Trust Policy and escalation process being updated and approved by Trust Management Board, * Roll-out of hand-held devices to ensure better monitoring of observations and escalation of any deteriorating patients in line with the newly updated Trust Policy. * Increased resource being applied for via business case for increased critical care outreach support and hospital at night teams. * Roll-out of ward based dashboards to support ward areas understand their performance against these quality metrics. * Continued roll-out of sepsis 6 bundle. RISK LINKED TO SEPSIS MANAGEMENT RISK NO 1513 Update - 21.01.20 - Snapshot Audit undertaken which will assist with monitoring compliance and inform actions for wards to take. Performance monitored through ward performance reviews which are later reported to PRM. Target for NEWS (on time) is 90%. * Divisional progress against targets is monitored via the Deteriorating Patient & Sepsis Group. * NEWS monitored as part of Quality updates provided to Medicine Board and Governance Meetings. * Monitored at divisional PRM Meeting. * News compliance discussed at Divisional Ward Review Meetings. * Compliance monitored at Deteriorating Patient & Sepsis Group.	Agency staff may be unaware of systems on commencement.	Maintaining NEWS compliance above 85% individual areas below this have plan and discussed at DP & Sepsis Group NEWS scoring reviewed as part of Ward Performance r/v with HoN/DHoN NEWS compliance reported through PRIM's During January 2020 an audit demonstrated - 83.68 % of NEWS scores completed within 30 minutes grace period. 74.75 % were completed without grace period. Update: NEWS trend (June '21 30 mins) 90.2% (May 89.3%) Maintaining NEWS compliance above 85% individual areas below this have plan and discussed at DP & Sepsis Group

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2421	29/12/2016	31/12/2022	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce	Staffing Levels & HR	Nurse Staffing	The risk to the Trust is that we are unable to deliver safe and effective care to our patients and provide the required level of service due to staffing shortages and reliance on temporary staff.	Eleanor Monkhouse	Trustwide - All Sites (DPoW, S	Chief Nurse	Chief Nurse	Nursing (All Specialties)	1 High (Red)	25	29/09/2022	Monthly nurse staffing assurance report that goes to the Quality & Safety Committee and reports to Board which includes nursing fill rates and CHPPD. This is triangulated with nursing sensitive indicators and discussed at a monthly nursing metrics meeting. Daily escalation process in place and Safe Care Live implemented April 2020 with supporting SOP. Head of Nursing challenge and oversight to daily staff deployment and facilitates escalation and authorisation of agency including sign off for all off framework requests. Nursing Workforce Group in place to oversee various strands of work (recruitment, retention, workforce plan and new roles). A number of task and finish groups are in place: Safe Staffing, Effective rostering, Recruitment and Retention and CNS Job Planning. Recruitment and retention strategy in place. New governance structure in place which includes effective rostering and a prospective and retrospective review of roster with Check, Challenge and Coach meetings. KPIs developed and being monitored including sickness, annual leave, training and nursing spend and bank and agency usage.	(1) High number of nurse vacancies leading to shortage of nursing staff available to cover required shifts and reliance on temporary staff. (2) Re-establishment of a Nursing & AHP Workforce Group to inform the Workforce Committee. (3) 100% compliance with Safe Care Live census by all wards to inform deployment of staff both in and out of hours and to identify temporary staffing needs. (4) Visibility and use of data from Eroster to inform decision making and target areas for improvement, use of patient acuity data from Safe Care Live.	(1) Level 1: Nurse staffing dashboard accessible and contains KPIs re. Vacancy position, agency usage etc. [Mixed assurance]. (1) Level 2: Monthly reporting to QSC and Trust Board [Mixed assurance]. (1) Level 1: Reduction in nursing turnover rates [Positive assurance] (2) Level 1: Anecdotal evidence from ward visits is that staff are transferred to different wards to support safe levels of staffing which leads to skill mix and morale challenges [Negative assurance] (2) Level 2: Daily staffing meetings with Matrons to review Safecare Live introduced Sept 2020 (risks and mitigating actions reviewed) [Mixed assurance]
2530	08/07/2019	31/10/2022	To provide care which is as safe, effective, accessible and timely as possible	Staffing Levels & HR	Poor Registered Nursing Skill Mix on Wards	Through the formal establishment reviews undertaken in March and April 2019 it has been identified that the registered nursing skill mix is low in some adult inpatient wards. The SNCT data collection over 20 days has shown some wards with their patient acuity have a need for additional registered nurses. Skill mix at times is less than 50%.	Eleanor Monkhouse	Trustwide - All Sites (DPoW, S	Chief Nurse	Chief Nurse	Nursing (All Specialties)	1 High (Red)	20	29/09/2022	Formalised establishment reviews now in place to occur every 6 months with the Chief Nurse and all ward managers. SNCT licence in place to support the collection of data. Papers went to Trust Board in 2019 to recommend an increase in registered nurses, particularly out of hours as a twilight shift. Funding agreed in 2 phases to support recommendations and recruitment underway. Further CN safe staffing establishment review unertaken in 2021 and additional funding secured for priority recommendations for 2022/23. Staffing red flag incidents are being monitored by the Chief Nurse, Deputy Chief Nurses and Heads of Nursing. The Nursing Metrics Panel is meeting monthly to monitor fill rates, including substantive fill rates, incidents (including red flags) and key nursing quality indicators and outcomes. SafeCare Live implemented April 2020 to support deployment of staff. Participating in the HEE Global Learners Programme to support recruitment of overseas nurses. Direct recruitment of overseas nurses also being pursued by the Recruitment Team. Block booking of agency continues and continue to work to increase availability of bank staff. Recruitment and retention strategy in place and Task & Finish Group meeting monthly: Work includes review of	National shortage of registered nurses. Not yet achieving 100% compliance with completion of Safe Care Live census although improving monthly and being sustained. Covid pandemic impacting on speed at which overseas nurses can commence in post.	Reduced RN turnover rate being sustained. Daily staffing meeting with Deputy Chief Nurse and Head of Nurse Staffing introduced Sept 2020 to review Safe Care Live data. 160 overseas nurses appointed between Oct 2020 and March 2022. A furhter 120 to be appointed by Dec 2022. Monthly reporting to Quality and Safety Committee/ Trust Board. Open days continue (virtually) to attract newly qualified nurses.
2562	01/09/2019	28/02/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Failure to meet constitutional targets in ECC	Due to a high level of demand at the front door and challenges with patient flow through the hospital, ED waits are a challenge which has an adverse effect on patient safety. Risk that the Trust's 4 hour A&E performance target may not be achieved and that 12 hour trolley breaches may occur. Due to a high level of demand at the front door and challenges in patient flow through the hospital, ED waits are an ongoing challenge, which has an adverse effect on patient safety.	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Emergency Care	1 High (Red)	20	21/10/2022	- Daily Operations Centre Meetings - Establishment for medical staffing in ECC increased to 14 Consultants, 12 Middle Grades, 10 Juniors - Additional consultant coverage up to midnight on shop floor 7 days a week to ensure compliance with RCEM guidance - Additional 3rd middle grade shift overnight 7 days a week to support operational pressures - Daily analysis of challenges and performance Update: 18.06.21 * ECIST support provided and action plan produced * Implemented NHS 111 First Initiative * EMAS direct streaming to SDEC now providing an alternative to going through ED and improving the patient experience * EMAS patient self-handover protocol now in place allowing ambulance crews to leave appropriate patients at ED reception to end the handover and avoid delays * Frailty service at DPOWH went live on 12th May to reduce frail patients within ED and provide an improved pathway for the patients Update: 20.07.2021 * Senior Medicine Management oversight tiers implented to improve support to ED and timely escalation Update: 09.11.2021 * New Urgent Care Service (UCS) model implemented at SGH from 18th October 2021 - phased approach to implementation due to need to build workforce numbers and clinical skills * Newly revised and relaunched iAAU/SDEC SOP to reduce barriers for patient pathway from ED and reduce patient wait times	- Exit block from ED for admission due to lack of patient flow causing long delays for patients in ED - Medical staffing vacancies, sickness, and isolation resulting in over reliance on locum/agency doctors and junior skillmix - Nurse staffing vacancies, sickness and isolation resulting in unfilled nursing shifts and over reliance on agency nurses with less ED experience - Inappropriate attendances to ED due to lack of access to alternative, more appropriate services - Update = 02.03.2021 = COVID 19 has had and is continuing to have a significant impact on the Trust's ability to maintain its constitutional A&E targets, primarily due to maintaining the flow of patients requiring isolation beds, additional PPE and social distancing requirements and delays in diagnostics - Lack of physical capacity within the ED to see patients when exit block occurs resulting in long patient waits in ED and ambulance handover delays	- Emergency Care Quality and Safety Meeting oversight - Medicine Governance Meeting oversight - Agenda item on PRIM - Recruitment plans to recruit to medical staffing vacancies through new ED specific recruitment strategy - Additional medical staff booked by Trust to support covid implications and delayed patient stays within the ED - Additional HCA staff booked by Trust to support covid implications and delayed patient stays within the ED - Implementation of phase 1 of AAU in Nov 2019, followed by phase 2 of integrated AAU in Oct 2020 has improved SDEC provision and patient flow * D2A - audits. Update: 10.01.2022 * 12hr DTA Breach Validation to identify root cause of breach and to check whether patient harm occurred Update: 08.02.2022 * UCS pilots at each site are showing improvements in patient care, exeperience and performance against the 4 hour target

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2576	13/09/2019	30/04/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Paediatric Medical Support Pathway for ECC - 'Fastrack'	There is a risk that children and young people are not triaged and assessed within the 15 minute standard as a result of acuity and activity within the Emergency Depratments which may lead to prolonged wait times for nursing and medical assessment within the Emergency Departments which may lead to a sick child not being recognised thus causing a level of harm	Preeti Gandhi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Paediatrics	1 High (Red)	16	16/10/2022	>Fast track pathway in place across both ED's	Limited paediatric medical workforce on duty out of hours and overnight which could limit ability to respond and pose a risk to care delivery across the paediatric and neonatal areas.	Incidents monitored via Ulysses and RCA's conducted where appropriate.
2592	17/09/2019	31/10/2021	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	Failure to treat patients within the cancer waiting times may result in poor patient experience and potential clinical harm. Risk register also relates to Risk ID 2244.	Jennifer Orton	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery & Critical Care	Cancer Services	1 High (Red)	16	27/11/2022	Weekly Cancer RTT waiting time meeting to challenge and review the PTL.	Failure to treat patients within Cancer Waiting / Performance Target 62 day may result in poor patient experience and potential harm.	104+ waits are reducing week on week, clinical harm review being undertaken on all 104+ patients.
2623	23/10/2019	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Health & Safety	Failure of windows - Trustwide	There is the risk of failure of windows trust wide. Natural ventilation is used in most areas of the hospital, if windows are inoperable then restricted ventilation will occur, this is key to help with COVID guidelines. There is also the risk that a faulty window could fall down uncontrollably and hurt patients or staff.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Buildings	1 High (Red)	20	26/11/2022	Periodic planned maintenance	Due to the windows been in poor state it is difficult in determining when these could fail.	Labour management system Highlight reports Capital Backlog Maintenance Window cleaning contractor reports
2655	12/12/2019	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers	Risk is loss of heating and hot water on site. The steam raising boilers are 28 years old and could fail. Boiler failure would result in SGH closing down all clinical services until temporary boilers could be connected to site.	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - HVAC & Pressure Syst	1 High (Red)	20	26/11/2022	The management of the energy centre (steam boilers) is outsourced to Engie.	Engie contract has expired. Renewing annually.	Adhoc repairs are effective. No significant loss of service.
2719	07/05/2020	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety Compliance	There is the risk of Legionella from underutilised water services and insufficiently flushing regimes impacting on the wider water systems (lack of flow). This can spread to other areas of the hospital which could result in a patient/s contracting legionnaires disease whilst in hospital.	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Water	1 High (Red)	20	01/12/2022	Risk assessments undertaken at two yearly intervals by external competent specialist contractors.	Lack of funding for infrastructure upgrading. Lack of funding to upgrade BMS system to enable thorough monitoring of water systems throughout the sites.	Hydrop defect portal giving real time data on progress of defects. Risk assessments. Good circulation temperature L8Guard electronic return management system. Authorised Engineer report. Water sampling results. Water Safety Group Minutes. Finance, &Performance Committee Highlight report to Board. Installation of TMVs to be risk assessed and approved at the relevant safety group. Maintenance to TMV are carried out through the SOPs and PPM regime.

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2898	30/03/2021	17/11/2021	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Staffing Levels & HR	Medical Staff - Mandatory Training Compliance	Mandatory Training compliance for medical staff is currently below Trust requirements. February Report - Core: 57% (Target 90%) Role Specific: 49% (Target 85%). There is a risk to patient safety if medical staff do not complete their mandatory training before each element has expired. Due to the volume of doctors demonstrating low compliance across all grades, this has impacted upon the divisional CQC improvement plan.	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Medicine (All)	1 High (Red)	16	18/01/2023	* Feb Data - Core: 63% Role Specific: 52%. * Rota Coordinators providing more directed support to all level doctors across Medicine to allocate/support training time for them to complete MT * MT raised at SMT, Board Meetings, Workforce SMT and separately at AGM/Speciality/Clinical Lead/Line Manager Level * Workforce Development plans are being developed for each Speciality within Medicine which is being supported by the Medicine Quad, HRBP and AGM down to Clinical Leads. * Reviewed at Divisional Workforce Meeting Updated - 14.03.22 Identification of 2 least compliant staff members in each area each month and target set for compliance to be met HRBP meeting monthly with the rota co-ordinators to identify 10 least compliant doctors and allocate time on the roster to complete Divisional Clinical Leads to work with divisional SMT to develop recovery plans for their specialities Training incorporated at the Quality & Safety meetings Individuals with low compliance being contacted and targets for completion set on-going at ward review meetings Linking in with course leads to look at prioritisation and alternative ways of completing training e.g. targeted cohorts New rotational doctors commenced training prior to starting in post	Potential failure to meet CQC requirements. Staff not adequately trained with potential to impact on patient care and staff H&WB	* Report collated by HR Business Partner. * Improvement plan led by AMD / ACOO. * Compliance monitored at Divisional Board / Divisional Governance Meetings. * Reviewed at Divisional Workforce Meeting * Reported via Performance Review Meetings.
2905	07/04/2021	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW	There is a risk that the following areas may not be able to receive essential supply of electricity in the event of a power failure due the age of generator (1979). This will affect clinical procedures and potential persons within the lifts becoming trapped, therefore directly affecting patient safety. - Ramp Plant Room (Med Gas Compressors +) - Theatre Plant Room (All Theatres) - Lifts - I.T and I.T Server - X-RAY - Theatres - Pathology If this risk materialises, the hospital would need to close	Simon Tighe	Diana, Princess Of Wales Hospi	Estates and Facilities	Estates and Facilities	Estates - Electrical	1 High (Red)	16	26/11/2022	Monthly test to start and run Diesel Generator for a period of 90mins	Non-compliant with HTM 06-01;17.88 Maintenance programmes should include a longer test run to establish the generator Engine's mechanical performance. A test to prove the generator engine's condition up to 110% full load should be carried out annually. The period of the test should be not less than 3 hours and ideally 4 hours. The Trust is currently only able to conduct an 80% max load test. Tests can currently only be ran for a period of 90 minutes. Potential frailty of equipment was highlighted in the 2019 Load Bank Test as it damaged a Cooling Pump & Radiator on a similar set. Non-compliant with BS7671:2018;414.2.1 Live parts shall be inside enclosures or behind barriers providing at least the degree of protection IP2X	Minor and major equipment services logged in compliance folders.
2949	26/07/2021	25/07/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Oncology Service	As part of the ongoing Oncology HASR work, a joint risk register has been created to capture all potential risks and their mitigating actions. The below are jointly reviewed at the weekly NLaG & HuTH Oncology meeting: 1)HUTH's consultant base is currently running at around 75-80% of the established workforce due to absences both related and unrelated to Covid19, and consultants leaving the organisation. There has also been a reduction in middle grades, as 2 Specialty Doctors have left. 2)Increased patient numbers, with a lesser staffed service may result in consultants and CNSs being under additional pressure, resulting in them leaving, or being off on long term sick with stress. There is also pressure due to increased workload on the administrative services. 3)The Trust are currently in the midst of the third spike of Covid19, and have over 200 inpatients, including some in the QCOH wards. We are now under national lockdown, enshrined in law, similar to that in March 2020. 4)NLaG Waiting times for Oncology patients are longer than expected due to absence of Consultant Oncologists at HUTH. Concerns escalated by Surgery Division at NLaG regarding Urology Cancer waiting times and delays to treatment of patients. 5)NLaG Matron has flagged as a serious risk, that inpatient chemotherapy can no longer be delivered on Amethyst due to a	Jill Mill	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Oncology	1 High (Red)	20	02/12/2022	1)Currently looking for locum consultants to back fill some of the work, and a locum SpD has been secured, starting week commencing 30/11/2020. Interviewing for a further 5 SpDs. 2)Ongoing work around the management of clinics including clinic redesign, telephone clinic management, practitioner support, adequate time slots etc. Support offered to all staff from management. 3)Covid19 steering group in place, with CSS Health Group and SS Division input into command structure. 7no. Covid19 + beds still in place on C30 and position monitored closely to establish requirements into the future. 4)Liaison between HUTH and NLaG Senior Management Leads to ensure oversight of the waiting times and actions to mitigate avoidable delays. Plan is to develop a single joint activity / waiting times report whic will be produced monthly and reviewed at the joint Oncology meetings. 5)Very small number of patients affected, who could be admitted at HUTH to receive inpatient chemotherapy delivery. 6)Where clinically appropriate, SACT delivery from Lloyds community infusion clinic to reduce demand on SGH dat unit. Consider reducing the number of days SGH day unit opens to consolidate staffing. Continue to access external Level 6 SACT training for RN on Amethyst Unit at DPOW to increase chemo trained workforce.		* Risks reviewed weekly at the joint NLaG & HuTH Oncology meeting and updated accordingly.

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2951	04/08/2021	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide	There is the risk of failure of Electrical and/or mechanical LV components which could cause power interruptions to key areas. The impact of such failure is for clinical departments to experience reduced capacity or ability to treat and/or carry out diagnostic investigations on patients, leading to possible harm.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Electrical	1 High (Red)	20	26/11/2022	Monitoring switch gear regularly to ensure the situation is not deteriorating.	Lack of annual switching. Ensure operational areas understand the business continuity plan in the event this risk occurs. Lack of funding to replace LV infra.	Periodic inspections carried out annually. Thermal monitoring to identify hotspots carried out annually. Electrical safety group. LV audits undertaken by AE.
2952	04/08/2021	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety Compliance: Fire ring main - Trustwide	The fire ring main is legally required to serve only water services for fire fighting, the ring main has a number of building fed from it thus making it non-compliant with regulations and could lead to enforcement action by Humberside Fire and Rescue Service.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Water	1 High (Red)	16	26/11/2022	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.		Hydrop defect portal giving real time data on progress of defects. Risk assessments. Good circulation temperature L8Guard electronic return management system. Authorised Engineer report. Water sampling results. Water Safety Group Minutes. Finance, &Performance Committee Highlight report to Board. Maintenance to TMV are carried out through the SOPs and PPM regime.
2953	04/08/2021	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety Compliance: Sensor taps - Trustwide	Due to the installation of sensor taps and the inability to flush for the required time period, there is the risk of legionella which could impact on the health of the building occupants (patients/staff).	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Water	1 High (Red)	16	26/11/2022	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.		
2954	04/08/2021	31/12/2022	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Asbestos; Risk of exposure to asbestos - Trustwide	Control of Asbestos Regulations 2012: Gap Analysis demonstrates large areas of SGH Site are current not surveyed. Therefore there is a significant risk to Patients and Staff that Asbestos containing material could be disturbed, thus Asbestos fibres could be released into a patient or work environment, resulting in an immediate closure of the affected space and a RIDDOR notification to be raised to the HSE.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Asbestos	1 High (Red)	15	26/11/2022	-Currently, there are some Asbestos Management Surveys dated 2005 & 2008 respectively; there is also additional site information available within the Asbestos Management folder located on the H drive in the following location. H:\Estates and Facilities\Estates and Capital\Estates Operational Compliance\Asbestos (SH5)\SGH Log Book	-Gap Analysis carried out in June / July 2020 demonstrates SGH has having 95 areas requiring a suitable & sufficient Asbestos Management Survey to be in place and available. This is a requirement under Regulation 4 of Control of Asbestos Regulation 2012. -The gap analysis identifies SGH has 23 folders covering areas where Asbestos Management Plans have been conducted prior to the change of regulations in 2012. These type 2 surveys do not reference all areas asbestos containing material Information and therefore cannot be considered suitable or sufficient.	-Asbestos Training Records -Control of Asbestos Policy DCP 170 -Control of Contractors Policy DCP 220 -Permit to work Policy DCP 221
2955	04/08/2021	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide	There is the risk of failure of the oxygen delivery system if the demand exceeds design capacity, which could result in loss of oxygen supply to patients causing the Trust to divert patients to neighbouring hospitals.	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Med Gas	1 High (Red)	15	26/11/2022	Daily monitoring of the oxygen consumption.		Medical Gas Policy DCP026 Medical Gas AP Staff Training Medical Gas Committee Health and Safety Committee Enhanced Med Gas AP provision CAS/DINs/NeDERs Med Gas AE support NHSEI support
2959	04/08/2021	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Replacement/ Repairs of flat roof - Trustwide	There is the risk of failure of flat roofs across the sites. A number of roofs have failed across the site, one resulting in the immediate evacuation of the ITU department. Another resulted in a section of masonry coming away which had the potential to cause serious harm or even death to a member of staff, the public or a patient.	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Buildings	1 High (Red)	16	26/11/2022	Staff report any roof leaks to the facilities department when they occur.	Limited BLM funding prevents full replacement of flat roofs and only enables patch repairs.	
2960	13/08/2021	30/11/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk of inability to safely staff maternity unit with Midwives	The risk is the potential inability to safely staff the maternity unit in order to provide care and treatment to a defined establishment due to sickness, Covid isolation and vacancies. If the staffing levels are reduced, this will impact on the ability to provide safe care to women and their babies, resulting in increased incidents and potential poor outcomes.	Preeti Gandhi	Trustwide - All Sites (DPoW, S	Directorate of Operations.	Family Services	Obstetrics / Maternity	1 High (Red)	16	25/11/2022	Daily staffing meetings for oversight of issues Thrice daily Operational meetings to escalate staffing issues SafeCare Live Process to escalate short staffing - request for bank staff / agency staff 24/7 theatre access is managed by surgery division Maternity Services Escalation Policy	Challenges in acquiring midwives via agencies due to limited numbers and trust location Acuity of unit changes requires demand for additional staff and difficult to plan	Any incidents relating to staffing compromise are monitored via weekly incident review meeting and any issues relating to safety being compromised are escalated at time of event.
2976	07/10/2021	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Staffing Levels & HR	Registered Nursing Vacancies	High Registered Nursing vacancy levels - a lower number in the UK market impacting upon the delivery of patient service, travel and accommodation issues causing some difficulties for international recruits.	Nico Batinica	Trustwide - All Sites (DPoW, S	People and Organisational Effe	People & Organisational Effect	Recruitment	1 High (Red)	25	/ /	Funding accessed through NHSi to facilitate international recruitment providing additional pipelines.		

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2992	09/11/2021	31/03/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Equipment	Changing Places facility at Scunthorpe General Hospital	There is a risk of emotional harm and distress to patients and families who visit the trust and unable to use appropriate toilet facilities. This is due to no adapted Changing Places facility at Scunthorpe General Hospital. This could result in reputational damage from complaints, safeguarding section 42 Care Act enquiries and patient harm due to psychological distress and deterioration in skin integrity,; breaches in the Human Rights Act could lead to reputational and cost implications.	Victoria Thersby	Scunthorpe General Hospital (S	Chief Nurse	Chief Nurse	Safeguarding Adults	1 High (Red)	16	07/12/2022	There are disabled toilet facilities within the Trust	Complaints by members of the public and patients attending the outpatient department	
2997	21/12/2021	31/12/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	SCC follow up out patient PTL without risk stratification	There is a risk that patients who are overdue and booked but cancel their appointments multiple times with out a risk stratification could be at risk. There is also a risk that those patient who do not have a due date and are not waiting for surgery could potentially be at risk as they do not have a risk stratification. As part of prioritising the out-patient waiting lists in accordance with Royal College guidance and the Trust's risk stratification SOP, all overdue unbooked patient were and continue to be clinically risk stratified. All patients reviewed in the out patient clinic, are risk stratified and is part of the OP outcome form However, overdue, booked patients and those patients without due dates have currently not been commissioned to be risk stratified.	Mathew Thomas	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery & Critical Care	Surgery (All)	1 High (Red)	16	27/11/2022	The majority of Out patient clinics are only booked 4 weeks in advance.		
3015	01/02/2022	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Staffing Levels & HR	Insufficient estate resources to manage the workload demand	Due to an underestimation of the impact of current major capital projects on the estates team, there is a high risk that the Estates team will fail to deliver service level compliance, statutory requirements, and provide an environment that is fit for purpose. Compounding the risk is the limited (11 personnel) number of staff holding the duties of an Authorised Person (AP) for specialist engineering fields. This is intensified by the inability of the internal project team to recruit to technical roles to support the clinical schemes, Additionally, there has been an increase in claims being lodged in relation to areas where slips, trips and falls and statutory compliance is not being met. The impact to the Trust if not actioned: Inability to meet statutory compliance, leading to potential prosecution for statutory non-compliance Lack of Engineer resource to complete mandatory work and project works Ineffective management of Pre-Planned Maintenance Ineffective management of water systems due to shortage of water APs (SGH) Inability to complete emergency testing across main estates disciplines (electrical system emergency testing, ventilation multi-disciplinary emergency testing) Ineffective management of the estates leading to reactive maintenance (firefighting) Inability to implement proactive management systems (MICAD helpdesk) Impact to patient safety Loss of workforce due to on-going work pressure and employee market shortage (supply/demand) Reduced staff morale Inability to support wider project delivery Further degradation and serious incidents within the estates Loss of financial resources due to settlement of claims (majority of claims are under the excess levels so Trust would pay full cost) Increase in overall BLM value (6 facet survey) due to limited resourcing levels in FY 2/22 & 22/23	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Health & Safety	1 High (Red)	20	26/11/2022	Resources prioritized in a reactive manner	Minimal controls in place, competing priorities for both capital and operational compliance work, resulting in poor ability to manage both within either a safe or responsive realm . Patient safety issues are delivered at cost pressure or delayed - dependant on the identified risk Until the volume of capital projects has abated, this risk will remain prevalent. This risk is expected to remain extant until completion of the ED/AAU schemes, at present this is mid 2023.	Internal policies and procedures in place
3031	02/03/2022	31/08/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Children's Diabetic Team DPoW	There is a risk that the diabetes service in DPOW will not be able to operate fully as a result of long term sickness and performance issues which may lead to parents having a lack of confidence of the service, not meeting best practice tariff, not addressing the educational needs of the ward staff (nursing and medical) and developing the service going forward eg transition to adults.	Deborah Bray	Diana, Princess Of Wales Hospi	Directorate of Operations	Family Services	Paediatrics	1 High (Red)	16	01/10/2022	Supporting staff to return to work with HR support	Staff member not currently at work, work related stress due to escalation of performance concerns. Working through LTS reviews, with HR and unions	
3036	17/03/2022	30/06/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS	There is a risk to patient safety, quality of care and patient experience due to delayed admission to ward beds due to challenges with patient flow throughout the Trust.	Anwer Qureshi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Emergency Care	1 High (Red)	16	30/11/2022	LLoS is monitored on an ongoing basis through the following meetings; Medicine Divisional Board Medicine Governance Daily Operation meetings Deprtmental Board rounds and Huddles ED 95% standard compliance		
3045	11/04/2022	30/08/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Medical Workforce Vacancies in Gastroenterology	Following departure of 2 consultants in Gastroenterology there is insufficient workforce to deliver the range of services. Resulting in: - Failure to meet constitutional targets (RTT &Cancer) - Delays in patients being seen both as inpatient & outpatients - Increased waiting times - Increase LOS - Failure to fulfil emergency GI Bleed Rota - Lack of training and supervision	Simone Woods	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Gastroenterology	1 High (Red)	16	25/11/2022	Staff on the GI bleed rota will travel to the opposite site where needed to attend a patient with a GI bleed or patient will be transferred to the alternate site for treatment if feasible.		

No	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Division	Specialty	Risk Rating	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
3048	13/04/2022	30/11/2022	To provide care which is as safe, effective, accessible and timely as possible	Operational	Challenges to recruitment of acute care physician vacancies in Acute	This risk is to highlight the difficulties in workforce recruitment and the increased pressures on staff, which has been exacerbated by the Covid-19 We have vacancies for acute care physicians (ACP) Trust-wide and it is proving very challenging to fill these posts. The cause has been due to a national shortage of ACPs and lack of applicants for the posts when we have advertised them. The impact would result in failure to recruit the required ACPs and this will delay the planned expansion of acute medicine service with extended hours with senior clinician presence on the shop floor and could result in failure to launch phase 3 of the IAAU development plan for 2023. There is a risk that due to the pressures created by having less workforce and increased demands placed on services as a result of not having a balanced workforce, this may result in the current ACPs becoming exhausted, leading to gaps in rotas and therefore not sufficient senior medical staff to ensure quality and safety of patients. In addition, this may also result in doctors withdrawing from our hospitals, exacerbating staffing issues.	Anwer Qureshi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	General Medicine	1 High (Red)	16	09/11/2022	Actively trying to recruit more clinicians through networks		
3063	27/05/2022	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Operational	Doctors Vacancies within Medicine Division	1.lack of substantive practitioners as a result of difficulties recruiting may lead to patient safety issues (lack of continuation of care due to the number of locums who may choose the leave at any time). 2. an increased financial burden for the Trust due to higher costs for locums (circa double the cost of Consultants on Trust contract). 3. There are fluctuating but significant number of vacancy posts required in Medicine.	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Medicine (All)	1 High (Red)	16	18/01/2023	weekly workforce panel workforce SMT specialty business meetings review and oversight if data	development of specialty workforce plans	workforce panel workforce SMT Div Board workforce improvement plan
3073	07/06/2022	31/03/2023	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Clinical	Lack of Speech and Language Therapy provision to Critical Care	There is a risk that patients in ICU/ ITU/ HDU at DPOW and SGH will receive suboptimal care related to the management of their swallowing, tracheostomy and communication needs as a result of the Trust being non- compliant with GPICS 2019 standards for SLT provision by not providing dedicated SLT staffing resource for patients in Critical Care and relying on a limited service provided by the general ward SLT. This may lead to patients requiring Critical Care being unable to access the appropriate level of SLT input and expertise; poorer outcomes and patient experience for patients requiring Critical Care; undiagnosed or mismanaged dysphagia potentially resulting in patient harm; long term dependence on enteral feeding; increased length of stay; inability for the MDT to benefit from the clinical advice of an expert SLT; reduced capacity in the SLT provision to the general wards also resulting in poorer patient outcomes and experience; increased length of stay; reduced flow.	Anthony Rosevear	Trustwide - All Sites (DPoW, S	Directorate of Operations	Community & Therapy Services	Speech & Language - Adults	1 High (Red)	15	02/12/2022	Able to consult with SLT colleagues in HUTH for ICU expertise	Remote consultation only; for specific patients No dedicated support or ability to implement new practice/ policy	

No	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Owner	Site	Directorate	Division	Specialty	Risk Rating	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
3074	07/06/2022	31/12/2022	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value	Financial	Financial Risk - Medicine CIP 2022/23	Non delivery of divisional financial objectives for financial year 2022/2023.	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Finance	1 High (Red)	16	05/10/2022	General budgetary Financial Management - Includes reporting, variance analysis and actions / recommendations.		
3095	14/07/2022	15/07/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Information Technology	Data Safety Risk - Delay to Patient Testing (DartOCM)	There is a risk that DART OCM (sample requesting and reporting software) will fail due to the age of the hardware which is now over 15 years old. Additionally, the Windows Server 2008 operating system is no longer supported and poses a data safety risk as no security updates are available making the system more prone to hacking and cyber-attacks. The server is already showing signs of obsolescence with frequent crashes and system errors increasing reliance on manual processes. These processes are described in the business continuity plans however they have not been tested for prolonged outages as posed by the current set up and have inherent risk such as transcription errors increasing patient safety risks. Should the server fail the electronic requesting of pathology test for GP surgeries across all Lincolnshire and Northern Lincolnshire CCGs would be unavailable. Radiology and Pathology acute result communication back to all GP surgeries using Dart would also fail. Given the equipment service provider has reduced the level of support cover to best endeavours and can no longer guarantee support or repair, any failure poses a risk of significantly delay to patient diagnostics and treatment.	Ian Storr	Trustwide - All Sites (DPoW, S	Directorate of Operations	Path Links	Information Systems	1 High (Red)	16	06/10/2022	A meeting has been convened Chaired by the Path Links' Director to support interim measures and risk management to monitor effectiveness of actions.	Provider has recently been subject to buyout resulting in loss of skills to support the aging system. As such the system is becoming more reliant on in house solutions from NLG and Path Links IT teams, such as SQL database maintenance. Whilst the team follow the trusts change control policy the supplier change control processes may not be applied.	Path Links risks are reviewed monthly at PLMB / OMG and included on the QMS KPI monitoring report for oversight.
3105	05/08/2022	30/11/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Wax Shortage - Significant Delay to Diagnostic Histopathology	Likely significant delays in processing routine surgical samples in Diagnostic Histopathology due to a national shortage in wax supply resulting in a capacity shortfall >50% . There is a global shortage of paraffin wax, which is an essential consumable used for the delivery of diagnostic Histopathology. This has been compounded by a European supply chain failure. In order to preserve valuable stock, the decision has been taken with immediate effect to stop processing non-cancer pathway samples to ensure continuity for high priority pathways. A low percentage of the non urgent samples may have unsuspected malignancy affecting treatment times and possible outcomes. The national pathology team are forecasting acute shortage of wax in the next month and ongoing supply shortage for a further two months	Michael Chomyn	Trustwide - All Sites (DPoW, S	Directorate of Operations	Path Links	Histopathology	1 High (Red)	16	11/11/2022	The decision has been made to reserve current wax supply to prioritise and maintain throughput of Cancer pathway samples.	Uncertainty in Cellular Pathology's ability to control clinical demand and avoiding unnecessary sample prioritisation.	Path Links business continuity plans are in place: Cellular Pathology Service Continuity Plan- INT-SOP-98

NHS
Northern Lincolnshire and Goole
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Board Assurance Framework - 2022 / 23

Strategic Objective	Strategic Objective Description
1. To give great care	● To provide care which is as safe, effective, accessible and timely as possible ● To focus always on what matters to our patients ● To engage actively with patients and patient groups in shaping services and service strategies ● To learn and change practice so we are continuously improving in line with best practice and local health population needs ● To ensure the services and care we provide are sustainable for the future and meet the needs of our local community ● To offer care in estate and with equipment which meets the highest modern standards ● To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.
2. To be a good employer	● To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: - inclusive values and behaviours - health and wellbeing - training, development, continuous learning and improvement - attractive career opportunities - engagement, listening to concerns and speaking up - attractive remuneration and rewards - compassionate and effective leadership - excellent employee relations.
3. To live within our means	● To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse ● To keep expenditure within the budget associated with that income and also ensuring value for money ● To achieve these within the context of also achieving the same for the Humber Coast and Vale Health Care Partnership ● To secure adequate capital investment for the needs of the Trust and its patients.
4. To work more collaboratively	● To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan ● To make best use of the combined resources available for health care ● To work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally ● To work with partners to secure major capital and other investment in health and care locally ● To have strong relationships with the public and stakeholders ● To work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: - make best use of the human capabilities and capacities locally; - offer excellent local career development opportunities; - contribute to reduction in inequalities; - contribute to local economic and social development.
5. To provide good leadership	● To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk Appetite Statement - 2022 / 23

The Trust's risk appetite is:

• For risks threatening the safety of the quality of care provided – low (4 to 6)

• For risks where there is the potential for positive gains in the standards of service provided – moderate (8 to 12)

• For risks where building collaborative partnerships can create new ways of offering services to patients – moderate (8 to 12)

Context

Healthcare organisations like NLaG are by their very nature risk averse, the intention of this risk appetite statement is to make the Trust more aware of the risks and how they are managed. The purpose of this statement is to give guidance to staff on what the Trust Board considers to be an acceptable level of risk for them to take to ensure the Trust meets its strategic objectives. The risk appetite statement should also be used to drive action in areas where the risk assessment in a particular area is greater than the risk appetite stated below.

NLAG is committed to working to secure the best quality healthcare possible for the population it serves. A fundamental part of this objective is the responsibility to manage risk as effectively as possible in the context of a highly complex and changing operational environment. This environment presents a number of constraints to the scope of NLAG's risk management which the Board, senior management and staff cannot always fully influence or control; these include:

• how many patients need to access our services at any time and the fact our services need to be available 24/7 for them whether we have the capacity available or not
• the number of skilled, qualified and experienced staff we have and can retain, or which we can attract, given the extensive national shortages in many job roles.
• numerous national regulations and statutory requirements we must try to work within and targets we must try to achieve
• the state of our buildings, IT and other equipment
• the amount of money we have and are able to spend
• working in an unpredictable and political environment.

The above constraints can be exacerbated by a number of contingencies that can also limit management action; NLAG operates in a complex national and local system where the decisions and actions of other organisations in the health and care sector can have an impact on the Trust's ability to meet its strategic objectives including its management of risk.

Operating in this context on a daily basis Trust staff make numerous organisational and clinical decisions which impact on the health and care of patients. In fulfilling their functions staff will always seek to balance the risks and benefits of taking any action but the Trust acknowledges some risks can never be eliminated fully and has, therefore, put in place a framework to aide controlled decision taking, which sets clear parameters around the level of risk that staff are empowered to take and risks that must be escalated to senior management, executives and the Board.

Risk Management

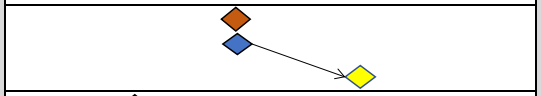
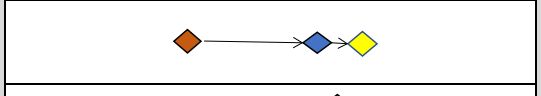
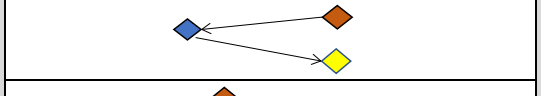
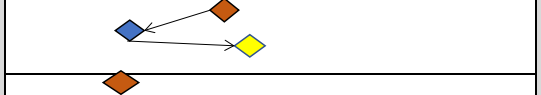
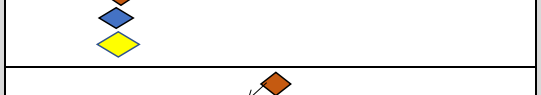
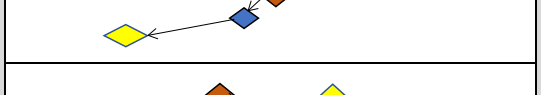
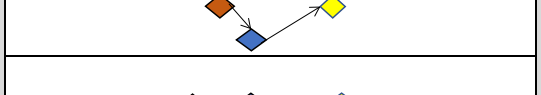
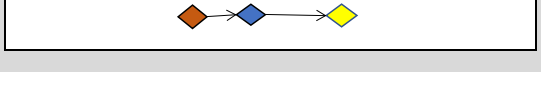
The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using the feedback as an opportunity for learning and improving the quality of our services. The Trust recognises it has a responsibility to manage risks effectively in order to:

• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

Risk Appetite Assessment

Risk Assessment Grading Matrix					
Likelihood of recurrence	Severity / Impact / Consequence				
	None / Near Miss (1)	Low (2)	Moderate (3)	Severe (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Certain (5)	5	10	15	20	25
RISK	Green Risk Score 1 - 3 (Very Low)	Yellow - Risk Score 4 - 6 (Low)	Orange - Risk Score 8 - 12 (Medium)	Red - Risk Score 15 - 25 (High)	

Strategic Risk Ratings

Strategic Risk	High Level Risk Description	Risk Consequence / Likelihood Assessment	Risk Appetite	Risk Rating 2021-22	Target Risk	Risk Rating 2022-23				Target Risk	Owner	Assurance Committee
				Q4	31.03.22	Q1	Q2	Q3	Q4	31.03.23		
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard		Low	15	15	15	15			15	Medical Director and Chief Nurse	Q&SC
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets		Low	20	20	20	20			15	Chief Operating Officer	F&PC
SO1 - 1.3	The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy		Low	12	8	12	12			6	Director of Strategic Development	SDC
SO1 - 1.4	The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate		Low	20	20	20	20			20	Director of Estates and Facilities	F&PC
SO1 - 1.5	The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care		Low	9	9	12	9			6	Chief Information Officer	ARG
SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope		Low	16	16	16	16			8	Chief Operating Officer	F&PC
SO2	The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients.		Low	20	8	20	20			12	Director of People	WC
SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities		Moderate	5	20	20	20			20	Chief Financial Officer	F&PC
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital		Moderate	12	15	15	15			20	Director of Strategic Development	SDC
SO4	The risk that the Trust is not a good partner and collaborator		Moderate	12	8	15	12			8	Director of Strategic Development	SDC
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives		Moderate	12	8	12	12			8	Chief Executive	WC

KEY	
◆	**Inherent risk score**
◆	**Current risk score**
◆	**Target risk score**

KEY TO COMMITTEE NAMES

Quality and Safety Committee - Q&SC	Workforce Committee - WC
Finance and Performance Committee - F&PC	Strategic Development Committee - SDC
Audit Risk and Governance - ARGC	

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.1: To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards nationally.

Risk to Strategic Objective 1 - 1.1: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	3	3	3	3	2
Risk Rating Score	15	15	15	15	10

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 10 October 2022, July 2022, 11 April 2022, 11 January 2022

Lead Committee: Quality and Safety Committee

Risk Owners: Medical Director and Chief Nurse

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy, Risk Management Strategy, Nursing, Midwifery & Allied Health Care Professionals Strategy, Clinical Strategy, Medical Engagement Strategy

Risk Appetite Score: Low (4 to 6)

Current Controls

- Quality and Safety Committee (Q&SC)
- Operational Plan (approved Trust Board 1/6/2021)
- Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems
- Risk Management Group
- Trust Management Board
- Quality Board, NHSE
- Quality Review Meetings with CCGs
- SI Collaborative Meeting with CCGs
- Health Scrutiny Committees (Local Authority)
- Chief Medical Information Officer (CMIO)
- Council of Governors
- SafeCare
- Daily staffing meetings
- Serious Incident Panel and Serious Incident Review Group, Patient Safety Specialist and Patient Safety Champions Group

Assurance (internal & external)

Internal:
- Minutes of Committees and Groups
- Integrated Performance Report
- 15 Steps Accreditation Tool
- Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board
- Nursing and Midwifery dashboards
- Ward Assurance Tool
- Nursing Metric Panels
- IPC - Board Assurance Framework and IPCC
- Inpatient surveys
- Friends and Family Test (FFT) platform
- Board Development Sessions - Monitoring CQC Progress
- Risk Stratification Report to Q&SC
- PPE Audits and IPC Dashboard
- Health Scrutiny Committees (Local Authority)
- Insights survey
- Stop and Check Safety Huddle
- Intentional rounding
- Nursing and Midwifery Red Flags
- Falls Huddles
- OPEL Nurse staffing levels and short term staffing SOP
- Nursing assurance safe staffing framework NHSI
- Audit Outlier Report to Quality Governance Group
- Annual nursing audit programme

External (positive):
- Internal Audit - Serious Incident Management, N2019/16, Significant Assurance
- Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance

Planned Actions

Action	Quarter / Year	Assurance
• Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays)	Q2 2023/24	Green
• Implement supportive observation	Q2 2022/23	Blue
• Continued roll out of stop and check safety huddle	Q2 2022/23	Blue
• Birthrate plus review	Q2 2022/23	Amber
• Continue to develop metrics as data quality allows	Q2 2022/23	
• Delivery of deteriorating patient improvement plan	Q4 2022/23	Green
• Implementation of End of Life Strategy (system-wide strategy)	Q4 2022/23	Amber
• Annual establishment reviews across nursing, midwifery and	Q4 2025/26	Amber
• Update IPC BAF as national changes and requirements	Q4 2022/23	Green
• Continued management of COVID19 outbreaks	Q4 2022/23	Green
• Workforce Committee undertaking Workforce Planning linked to	Q4 2022/23	Green
• Review policy and embed supportive observation		
• Audit of stop and check safety huddle compliance	Q4 2022/23	Amber
• Review of Ward Assurance Tool and Web V pilot	Q3 2022/23	Green
• Pilot of 15 Steps Star Accreditation Programme	Q4 2022/23	Green
• Management of Influenza outbreaks	Q4 2022/23	Green
• Preparation for trust requirements in DoLS and the new LPS by 31	Q4 2022/23	Amber
• Business case completed for Transition post	Q4 2022/23	Amber
	Q3 2022/23	Amber

Future Risks

- COVID-19 and Influenza surges and other infections which impact on patient experience
- National policy changes to access and targets
- Reputation as a consequence of recovery
- Additional patients with longer waiting times and additional 52 week breaches, due to COVID-19
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility
- Impact of IPC plans on NLaG clinical and non clinical strategies
- Changes to Liberty Protection Safeguards
- Skill mix of staff
- Student and International placements and capacity to facilitate/supervise/train

Strategic Threats

Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints

Adverse impact of external events (ie. Britain's exit from the European Union; Pandemic) on business continuity and the delivery of core service

Workforce impact on HASR

Gaps in Controls

- Estate and compliance with IPC requirements - see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Attracting sufficiently qualified staff - see BAF SO2
- Funded full time Transition post across the Trust

Gaps in Assurance

- Mandatory training
- Delays with results acknowledgement (system live, process not yet embedded)
- Progress with the End of Life Strategy
- Ophthalmology Waiting List remains sizeable
- Safety and delays on cancer pathways

Links to High Level Risks Register

Divisional / Departmental Risks Scoring >15:
- No 2421 Nurse Staffing = 25
- No 2145 Quality of Care and Patient Safety - (due to nurse staffing position) = 20
- No 2245 Risk to overall performance, Surgery = 20
- No 2562 Failure to meet constitutional targets in ECC, Medicine = 20
- No 2949 Joint Oncology Risk for HASR, Medicine = 20
- No 2244 Risk to overall cancer performance, Clinical Support Services = 16
- No 2898 Mandatory training compliance for medical staff, Medicine = 16
- No 3036 Risk of Harm in ED due to length of stay in department, Medicine = 16
- No 2992 Lack of Changing Places facility at SGH = 16
- No 2347 Deteriorating patient risk, Surgery = 15
- No 2388 Deteriorating patient risks, Medicine = 15
- No 3018 Delays in Children being seen at DPoWH by Paediatric Endocrine Service, Family Services = 15

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- International recruitment
- Shared clinical development opportunities
- Development of Integrated Care Provider with Local Authority

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.2: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.2: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	4	4	4	3	2
Risk Rating Score	20	20	20	15	10

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 13 October 2022, July 2022, 11 April 2022, 24 January 2022

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy,Quality Improvement Strategy, Risk Management Strategy, Learning Strategy, Nursing and Midwifery Strategy, Clinical Strategy

Current Controls

- Operational Plan 2021-22 (Trust Board approved 1/6/2021)
- Operational Management Group (OMG)
- Performance Review Improvement Meetings (PRIMs)
- Trust Management Board (TMB)
- Waiting List Assurance Meetings
- Cancer Board Meeting
- Winter Planning Group
- Strategic Planning Group
- A&E Delivery Board
- Policies, procedures, guidelines, pathways supporting documentation & IT systems
- Cancer Improvement Plan
- MDT Business Meetings
- Risk stratification
- Capacity and Demand Plans
- Emergency Care Quality & Safety Group
- Planned Care Board
- Primary and Secondary Care Collaborative Outpatient Transformation Programme
- Divisional Executive Review Meetings
- System-wide Ambulance Handover Improvement Group
- Patient Flow Improvement Group (PFIG)
- Planned Care Improvement and Productivity (PCIP)

Assurance (internal & external)

Internal:
- Minutes of Finance and Performance Committee, OMG, PRIMS, TMB, Waiting List Assurance Meetings, Cancer Board Meeting, Winter Planning Group, Strategic Planning Group, A&E Delivery Board, MDT Business Meetings, Planned Care Board, System-wide Ambulance Handover Improvement Group, PCIP, PFIG
- Integrated Performance Report to Trust Board and Committees.
- 7 Day Services Assurance Framework, action plan.
- Executive and Non Executive Director Report (bi-monthly) to Trust Board.

Positive:
- Audit Yorkshire internal audit: A&E 4 Hour Wait (Breach to Non-Breach): Significant Assurance, Q2 2019.
- Benchmarked diagnostic recovery report outlining demand on services and position compared to peers presented at PRIM, October 2020. No significant differences identified, Trust compares to benchmarked peers.
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022
- Audit Yorkshire internal audit: Waiting List Management (including Clinical Harm): Significant Assurance, Q1 2022

External:
- NHSI Intensive Support Team
- Audit Yorkshire internal audit: A&E 4 Hour Wait (Breach to Non-Breach): Significant Assurance, Q2 2019.
- Humber Cancer Board
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022
- Audit Yorkshire internal audit: Waiting List Management (including Clinical Harm): Significant Assurance, Q1 2022

Planned Actions

Action	Quarter / Year Assurance
Workforce and resources to Humber Cancer Board	Q4 2021/22
Public Health England guidance (cancer diagnosis) reviewed and implemented	Q4 2021/22
Further development of the ICP with HUTH	Q4 2021/22
Review of clinical pathways linked to HASR programme 1 ICP, 7 specialties	Q4 2021/22
Consultant led ward rounds, further development and implementation (ECIST)	Q4 2021/22
Development of Phase 2 three year HASR Plan by 2022	Q1 2022/23
Revision and Development of QSIS plans	Q1 2022/23
Progress P1 of HASR Plan - Haematology, Oncology, Dermatology	Q2 2022/23
Implementation phase 3 of AAU business case	Q2 2022/23
Validation of all RTT Clock Stops back to 75%	Q2 2022/23
Job plans complete for 22/23	Q2 2022/23
Opening of new ED build at DPoW	Q3 2022/23
Implementation of the UCS Model (funding based on Business Case agreement) On	Q2 2022/23
Outcome of the Urgent Care Services Review for South Bank of ICS agreed	Q2 2022/23
Validation of all RTT Clock Stops back to 75%	Q2 2022/23
Progress P1 of HASR Plan - Haematology, Oncology, Dermatology	Q2 2022/23
Implementation phase 3 of AAU business case	Q2 2022/23
Winter Planning for 2022/23 - ongoing	Q2 2022/23
Review and relaunch of the Daily Operations Meetings - ongoing	Q2 2022/23
Develop divisional dashboards	Q2 2022/23
Establishment of pathway for YAS to access the North Lincolnshire SPA in the same	Q2 2022/23
Development of ward 25 at SGH to provide addition single rooms	Q3 2022/23
Validation of all RTT Clock Stops back to 100%	Q4 2022/23
Introduction of Pathway to enable referrals into SPA from technology enabled care	Q3 2022/23
Diagnostic and cancer pathways reviewed and implemented	Q4 2022/23
Opening of new ED build at SGH	Q4 2022/23

Future Risks

- Further COVID-19 surges and impact on patient experience and bed planning due to IPC guidance (including norovirus).
- National policy changes to emergency access and waiting time targets.
- Funding and fines changes.
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times over 18 weeks, 52 weeks, 62 days and 104 days breaches, due to COVID-19.
- Additional patients with longer waiting times across the modalities of the 6 week diagnostic target, due to COVID-19.
- Generational workforce analysis shows significant risk of retirement in workforce.
- Many services single staff / small teams that lack capacity and agility.
- Staff taking statutory leave unallocated due to COVID-19 risk.
- Risk of independent sector providers not providing required capacity due to workforce issues (as they use NHS Consultants).
- Risk to Dermatology Service if HASR doesn't progress (retirement of 1 of the 2 wte consultants in March 2022)
- Future requirement of Type 5 SDEC activity to be submitted as part ECDS from April 23
- Inability to staff UCS due to lack of support from Primary Care
- Impact of Mutual Aid work and increase in waiting times
- Risk of no contracting for independent sector work
- Risk to gastroenterology service due to 2 WTE consultant vacancies
- Risk that funding will not be approved for further use of Independent Sector
- Funding will not be approved to uplift weekend working for elective activity and support insourcing of theatre staff to backfill vacancy position.
- Mutual Aid

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.

Adverse impact of external events (ie. Continued Pandemic) on business continuity and the delivery of core service.

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 52 week waits and Diagnostics Constitutional Standards.
- Capacity to Reduce 52 week, 104 day and over 18 week waits to meet the trusts standard of 0 waits over 40 week in 2022.
- Limited single isolation facilities.
- Review of effective discharge planning.
- Diagnostic capacity and capital funding to be confirmed.
- Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations.
- Validation of RTT Clock Stops is being undertaken in high risk areas specialties only due to ongoing capacity pressure as a result of COVID
- Reduced bed capacity due to IPC compliance requirements and high levels of norovirus (DPOW) and Covid within the Trust
- High levels of staff sickness
- Ensuring the trust is utilising its current capacity

Gaps in Assurance

- QSIS Standards improvement plans.
- Demand and Capacity planning for Diagnostics.
- Meeting national standards
- Increase in Serious Incidents due to not meeting waiting times.
- Patient safety risks increased due to longer waiting times.

Links to High Level Risks Register

No 1851, Shortfall in capacity with Ophthalmology service = 15
No 2244, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2245, Risk to Overall Performance : Non compliance with RTT incomplete target = 16
No 2562, Failure to meet constitutional targets in ECC = 20
No 2347, Risk to Overall Performance : Overdue Follow-ups = 15
No 2576, Paediatric Medical Support Pathway for ECC - 'Fastrack' = 16
No 2592, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2949, Oncology Service = 20
No 2997, SCC Follow Up Outpatient PTL without Risk Stratification = 16

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- Collaboration with PCNs in NL / NEL to support full implementation of the UCS model

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.3: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

Risk to Strategic Objective 1 - 1.3: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	4	4
Likelihood	3	3	2	2	2
Risk Rating	12	12	8	8	8

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Lead Committee: Strategic Development Committee

Enabling Strategy / Plan: NHS Long Term Plan, Trust Strategy and Strategic Plan, Clinical Strategy, Integrated Care System

Last Reviewed: 14/10/22, 23/6/22, 13 April 2022, 12 January 2022

Risk Owner: Director of Strategic Development

Current Controls

- NLaG Clinical Strategy 2021/25.
- Trust Priorities 2022/23
- Humber and North Yorkshire Health Care Partnership (HNY HCP).
- Integrated Care System (ICS) Leadership Group.
- Quality and Safety Committee.
- Acute and Community Care Collaboratives (ACC).
- Humber Cancer Board.
- Humber Acute Services - Executive Oversight Group (HAS.
- Health Overview and Scrutiny Committees (OSC).
- Trust Membership
- Council of Governors.
- Primary Care Networks (PCNs).
- Place Boards
- Clinical and Professional Leaders Board.
- Hospital Consultants Committee (HCC) / MAC
- Joint Development Board*(JDB)*
- Committees in Common (CIC)
- Strategic Development Committee (SDC)

Assurance (internal & external)

Positive:
- NHSE/I Assurance and Gateway Reviews.
- OSC Engagement.
- Clinical Senate formal review

Internal:
- Minutes from Committees and Executive Oversight Group for HAS, JDB, CiC, SDC
- Humber and North Yorkshire Health Care Partnership.
- ICS Leadership Group.
- OSC Feedback.
- Outcome of public, patient and staff engagement exercises.
- Executive Director Report to Trust Board.
- Non-Executive Director Committee Chair Highlight Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE/I (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel (Humber).

Planned Actions

Action	Quarter / Year	Assurance
To formulate a vision narrative (PCBC) for Humber Acute Services review that is understood by partners, staff and patients by (draft complete)	Q3 2022/23	Green
To undertake continuous process of stocktake and assurance reviews NHSE/I and Clinical Senate review	Q1 2023/24	Green
Joint OSC - reviews	Q1 2023/24	Green
CIC / SDC / NED / Governor reviews	Q4 2022/23	Green
Citizens Panel reviews	Q4 2022/23	Green
To undertake continuous engagement process with public and staff	Q1 2023/24	Green
Evaluation of the models and options with stakeholders	Q4 2022/23	Green
Draft report from Clinical Senate review 2 (due end July 22)	Q1 2022/23	Green
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Green
NHSEI Gateway review	Q4 2023/24	Green
ICB Executive Assurance Board / ICBoard Approval	Q4 2023/24	Green
Public Consultation	Q2/Q3 2023/24	Green

Future Risks

- Change in national policy
- Delays in legilsation.
- Operational pressures and demand affecting opportunity to engage.
- Uncertainty / apathy from staff.
- Lack of staff engagement if not the option they are in favour of.
- Out of Hospital enablers and interdependencies
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- Government legislative and regulatory changes.
- Change in local leadership meaning priority changes.
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.
- Creation of Placed based partnerships
- Strategic Capital allocation

Gaps in Controls

- A shared vision for the HAS programme is not understood across all staff/patients and partners
- Link to SO3 - 3.2 re: Capital Investment

Gaps in Assurance

- Feedback from public, patients and staff to be wide spread and specific in cases, that is benchmarked against other programmes.
- Partners to demonstrate full involvement and commitment, communications to be consistent and at the same time.
- Alignment of strategic capital
- Alignment to a System wide Out Of Hospital Strategy and ICS Strategic workforce planning

Links to High Level Risks Register

Future Opportunities

- Clinical pathways to support patient care, driven by digital solutions.
- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.
- HAS Programme
- Joint workforce solutions inc. training and development Humber wide

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.4: To offer care in estate and with engineering equipment which meets the highest modern standards.

Risk to Strategic Objective 1 - 1.4: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	4	4	4	4	4
Risk Rating	20	20	20	20	20

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Lead Committee: Finance and Performance Committee

Last Reviewed: October 2022, July 2022, 12 April 2022, 11 January 2022

Risk Owner: Director of Estates and Facilities

Enabling Strategy / Plan: Estates and Facilities Strategy, Clinical Strategy, Digital Strategy

Current Controls

- Audit Risk & Governance Committee
- Finance and Performance Committee
- Capital Investment Board
- Six Facet Survey - 5 years
- Annual AE Audits
- Annual Insurance and External Verification Testing
- Estates and Facilities Governance Group
- Trust Management Board (TMB)
- Project Boards for Decarbonisation Funds
- BLM Capital Group Meeting
- PAM (Premises Assurance Model)
- Specialist Technical Groups

Assurance (internal & external)

Positive:
- External Audits on Estates Infrastructure, Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- PAM

Internal:
- Minutes of Finance and Performance Committee, Audit Risk & Governance Committee, Capital Investment Board, Estates and Facilities Governance Group, TMB, Project Board - Decarbonisation
- PAM
- Non Executive Director Committee Chair Highlight Report (bi-monthly) to Trust Board
- Executive Director Report (6 monthly) to Trust Board
- Specialist Technical Groups

External:
- External Audits on Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- ERIC (Estates Return Information Collection)

Planned Actions

Action	Quarter / Year	Assurance
Continue to explore funding bids to upgrade infrastructure and engineering equipment - Action date; ongoing	Ongoing Actions	Green
Secure sufficient Core Capital Funding to ensure the infrastructure, engineering and equipment needs identified in the 6 facet survey can be managed appropriately.	Ongoing Actions	Red
Start Backloo Maintenance proorramme	Q1 2022/23	Green
Continue Ward 25 refurbishment	Q1 2022/23	Green
Start Core Capital Programme	Q1 2022/23	Green
Start refurbishment of old DPOW ED	Q1 2022/23	Green
Continue Backlog Maintenance programme	Q2 2022/23	Green
Continue Ward 25 refurbishment	Q2 2022/23	Green
Continue Core Capital Programme	Q2 2022/23	Green
Continue refurbishment of old DPOW ED	Q2 2022/23	Green
Continue Backlog Maintenance programme	Q3 2022/23	Green
Complete Ward 25 refurbishment	Q3 2022/23	Green
Continue Core Capital Programme	Q3 2022/23	Green
Continue refurbishment of old DPOW ED	Q3 2022/23	Green
Continue to produce and revise our 1 year business plans on an annual basis in line with Clinical & Estates & Facilities Strategy. Prioritisation is reviewed and updated as part of the business planning cycle - Action date; December 22	Q3 2022/23	Green
Continue Backlog Maintenance programme	Q4 2022/23	Green
Complete Core Capital Programme	Q4 2022/23	Green
Complete refurbishment of old DPOW ED	Q4 2022/23	Green

Future Risks

- COVID-19 future surge and impact on the infrastructure
- National policy changes (HTM / HBN / BS); Ventilation, Building Regulation & Fire Safety Order
- Regulatory action and adverse effect on reputation
- Long term sustainability of the Trust's sites
- Clinical Plan
- Adverse publicity; local/national
- Workforce - sufficient number & adequately trained staff
- Without significant investment future BLM will increase (BLM figures for 2019/20 = £97M circa, and BLM figures for 2020/21 increased to circa £107M)

Strategic Threats

- Integrated Care System (ICS) Future Funding
- Failure to develop aligned system wide clinical strategies and plans which support long term sustainability and improved patient outcomes. This could prevent changes from being made
- The above prevents changes being made which are aligned to organisational and system priorities
- Government legislative and regulatory changes
- Within the next three years a significant (60%) proportion of the trust wide estate will fall into 'major repair or replacement' 6 facet survey categorisation
- A further breakdown of strategic risk detailed in the 2019/20 6 Facet Survey Report:
22% of SGH total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'
- 19% DPoW total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'
- 29% GDH total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR
- Insufficient Capital funding

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities (development in progress)

Links to High Level Risks Register

No 1620, Medical Gas Pipeline System = 20
No 2038, Fire Compliance = 20
No 2623, Failure of windows - Trustwide = 20
No 2088, Building Management Systems (BMS) Controller failure/upgrade = 20
No 2719, Water Safety Compliance: Coronation block = 20
No 2720, Water Safety Compliance: Cold water and hot water storage (GDH) = 20
No 2951, Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide = 20
No 2655, SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers = 20
No 3015 Insufficient estate resources to manage the workload demand - Trustwide = 20
No 1774, Poor condition of Fuel Oil Storage Tanks - SGH = 16
No 2035, Equality Act 2010 compliance - Trustwide = 16
No 2272, EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide = 16
No 2905, Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW = 16
No 2952, Water Safety Compliance: Fire ring main - Trustwide = 16
No 2953, Water Safety Compliance: Sensor taps - Trustwide = 16
No 2959, Replacement/Repairs of flat roof - Trustwide = 16
No 2036, Ventilation and Air Conditioning - HVAC - Trustwide = 15
No 2954, Asbestos; Risk of exposure to asbestos - Trustwide = 15
No 2955, Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide = 15

Future Opportunities

- Closer ICS working.
- Humber Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.
- Expression of Interest submitted for New Hospital Programme (NHP) - possible updated in July 2022

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.5: To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.

Risk to Strategic Objective 1 - 1.5: The risk that the Trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the Trust vulnerable to data losses or data security breaches.

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	3	3	3
Likelihood	4	3	3	2	2
Risk Rating	16	9	9	6	6

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: October 2022, July 2022, 11 April 2022, 11 January 2022

Lead Committee: Audit, Risk and Governance Committee

Risk Owner: Chief Information Officer

Enabling Strategy / Plan: Digital Strategy

Current Controls

- Strategy and Development Committee
- Finance and Performance Committee
- Upto date Digital / IT policies, procedures and guidelines
- Digital Strategy Board
- Digital Solutions Delivery Group
- Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.
- Audit Risk & Governance Committee (including external Audior reports)
- Annual Penetration Tests
- Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication
- Trust Management Board (TMB)

Assurance (internal & external)

Internal:

- A Digital Strategy Board reviews progress of the plans to achieve the strategy
- Highlight reports to Trust Board, Audit Risk and Governance Committee, Strategic Development Committee, Finance and Performance Committee and TMB
- Digital / IT Policies all current
- CIO/Executive Director Report (6 monthly) to Trust Board

External:

- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Limited Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Limited Assurance, Q3 2019

Positive Assurance:

The Integrated Performance Report (IPR) has been revised and updated. This was done with NHSE/I who have stated it is now among the leading models for reportin

Planned Actions

Action	Quarter / Year	Assurance
• Development of a comprehensive IT BC / DR Programme including monitoring of adherence to the programme. Results of BC / DR tests recorded and formally reported by 31 December 2021. External Project Manager appointed to undertake further work on the IT BC/ DR Programme to be completed by 30,Sept. 2022 (extended from 30 April 2022) DSPT Ref: IA-20724	Q3 2022/23	Green
•Digital Reporting schedule/Work plan for Board Committees completed as of the 4th Qtr 21/22 Report to ARG July 27 / 6 Month updates provided to Board	Q3 2021/22	Blue
• The Data Warehouse options appraisal was approved through governance structures by February 2022	Q4 2021/22	Blue
• Implementation of the Data Warehouse commenced in April 2022	Q4 2021/22	Blue
• Year 2 Digital Aspirant Funds available to support funding Digital Programs (20/21 & 21/22)	Q4 2021/22	Blue
• IPR - further review of current IPR for adding Digital, Finance and Estates KPI. Review in April 2023	Q1 2023/24	Green
• Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Plus Accreditation (2nd Qtr 22/23 -July 2022)	Q4 2022/23	Amber
• Secure resources to deliver Digital Strategy and annual priorities (PAS; EPR; Data Warehouse; RPA; Document management; Infrastructure upgrades). Digital Aspirant Funds £5 M secured with additional internal Capital to deliver projects 21/22 & 22/23. Depending on when NHSX releases funds for the Unified Tech Fund, we work with the ICS to bid for funds to continue our "levelling strategy" across the ICS	Other	Amber
• £250k NHS/X/D Cyber Security Capital Funding Bid Approved - Improving Cyber Security and Management over Medical Devices and other unmanaged IT devices on the Trust network	Other	Blue
The Data Warehouse with core data sets will be completed and running on the new platform by March 2023.	Q4 2022/23	Green

Future Risks

- COVID-19 surge and impact on adoption of digital transformation
- National policy changes in some cases in short notice, requiring revisions to work plan
- Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards
- IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG specific agenda
- Ongoing financial pressures across the organisation

Strategic Threats

- Capital funding to deliver IT solutions and establish a 3 yr plan
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve

Gaps in Controls

- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.
- Develop policy and procedure to address the gaps noted in the IT Business Continuity audit in April 2020.
- Achieve DSP Toolkit and mandatory training compliance - in progress

Gaps in Assurance

- Integrated Performance Report - the Digital and Estates
- Data Warehouse solution to support outcomes from BI review

Links to High Level Risks Register

- No 2300, Insufficient processes in place to ensure records management /quality against national guidance = 16

Future Opportunities

- Humber Coast and Vale ICS, system wide collaborative working
- Clinical pathways to support patient care, driven by digital solutions
- Collaborative working with HASR and Acute Care Collaborative

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.6: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).

	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	4	4
Likelihood	2	4	4	2	1
Risk Rating	8	16	16	8	4

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Lead Committee: Finance and Performance Committee

Last Reviewed: 13 October 2022, July 2022, 11 April 2022, 24 January 2022

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan: NLAG Winter Planning and Potential COVID-19 Third Wave, Business Continuity Policy

Current Controls

- Winter Planning Group.
- Strategic Planning Group.
- A&E Delivery Board.
- Director of People - Senior Responsible Owner for Vaccinations.
- Ethics Committee.
- Clinical Reference Group
- Influenza vaccination programme.
- Public communications re: norovirus and infectious diseases.
- Chief Operating Officer is the Senior Responsible Officer for Executive Incident Control Group.
- Ward visiting arrangements changed and implemented, Red and Green Zones, expansion of critical care faciliites.
- COVID-19 Executive Incident Control (Gold Command).
- Patient Flow Improvement Group (PFIG)
- Discharge System Improvement Group
- Planned Care Improvement and Productivity (PCIP)

Assurance (internal & external)

Internal:
- Regional EPRR scenarios and planning exercises in preparation for 'Brexit' have been undertaken alongside partners, including scenarios involving transportation, freight and traffic around local docks with resulting action plan.
- Business continuity management system and business continuity plans
- Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, Executive Incident Control Group, A&E Delivery Board, Clinical Reference Group, PFIG, Discharge System Improvement Group, PCIP

Positive:
- Half yearly tests of the Major incident response cascades
- Annual review of business continutiy plans.
- Internal audit of emergency planning compliance 2018/19 (due 2021/22).

External:
- Emergency Planning self-assessment tool and peer review against the NHSE EPRR Core Standards
- NHSE review of emergency planning self-assessment 2019/20.
- Internal audit of emergency planning compliance 2018/19 (due 2021/22).

Planned Actions

Action	Quarter / Year	Assurance
Lateral flow testing staff is ongoing	Ongoing	
Business Intelligence monitoring re: pandemic	Ongoing	
Rolling Schedule of annual business continuity plans	Ongoing	
Review of EPRR work programme and exercise programme	Q2 2022/23	
Implementation of new national EPRR Strategic Health Commander training	Q2 2022/23	Amber
LRF Flood Exercise	Q2 2022/23	
Winter Planning for 2022/23	Q2 2022/23	
CBRN training aligned to New DPOWH ED transition plan	Q3 2022/23	
Relaunch of loggist training and provision	Q4 2022/23	
Major incident table top training	Q4 2022/23	

Future Risks

- COVID-19 third surge.
- Availability of dressing, equipment and some medications post Brexit.
- Costs and timeliness of deliveries due to EU Exit.
- Additional patients with longer waiting times RTT, Cancer and Diagnostics due to COVID-19.
- Risk to Oncology Waiting Times due to HUTH operational pressures.
- Risk to Dermatology Service if HASR doesnt progress (retirement of 1 of the 2 wte consultants in March 2022)
- Longer waiting times for pateints due to HUTH Mutual Aid work
- Risk to gastroenterology service due to 2 WTE consultant vacancies

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints.

Gaps in Controls

- Capacity to meet demand (workforce).
- Bed Capacity challenges in Northern Lincolnshire, East Riding and Lincolnshire due to ASC workforce challenges being seen and likely to continue into 2022/23

Gaps in Assurance

Links to High Level Risks Register

Future Opportunities

- Closer Integrated Care System working.
- Provider collaboration.

Strategic Objective 2 - To be a good employer

Description of Strategic Objective 2: To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations.

Risk to Strategic Objective 2: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	4	4	4
Likelihood	3	4	2	3	1
Risk Rating	15	20	8	12	4

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 14 November 2022, September 2022, July 2022, 6 April 2022, March 2022

Lead Committee: Workforce Committee

Risk Owner: Director of People

Enabling Strategy / Plan: People Strategy, NHS People Plan, Leadership Development Strategy

Current Controls

Locally
- Workforce Committee
- Audit Risk & Governance Committee
- Trust Management Board (TMB)
- PRIMS
- Nursing,midwifery & AHP recruitment and retention group
- Nursing Apprenticeship task and finish group
- International recruitment programme Task & Finish group
- Remuneration and Terms of Service Committee (RATS)
- Culture Transformation Board (CTB) & Culture Transformation Working Group (CTWG)
- Workforce Systems Group (Finance, HR and Operations)
- NLAG People Strategy approved by the Board June 2020
- People Directorate - People Strategy Annual Delivery Implementation Plan 2022-23 (Workforce Committee approved July 2022 and TMB September 2022)
- Annual NHS staff survey and quarterly People Pulse

Regional and ICB
- Humber and North Yorkshire (HNY) – ICB Strategic Workforce Group
- Humber Workforce Group
- ICB People Strategy
- HNY ICB HRD Group
- Yorkshire and North East – HRD Group

National
- National HRD Forum
- NHS People Plan and People Promise
- NHS Employers Forum

Assurance (internal & external)

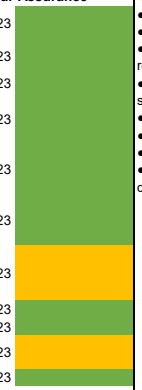
Internal:
- Minutes of Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, PRIMS, Recruitment and Retention Group, Nursing Apprenticeship Group, Internal Recruitment Programme Group, Culture Transformation Board, Workforce Systems Group, Remuneration and Terms of Service Committee.
- NHS People Plan, NLAG People Strategy and Implementation Plan reported to Workforce Committee.
- Recruitment Plans signed off divisionally
- Workforce Integrated Performance Report
- Annual staff survey and people pulse results
- Medical engagement survey 2019
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board

Positive:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance

External:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance
- Minutes of Regional and ICB workforce groups
- Minutes of National HRD Forum and NHS Employers Forum

Planned Actions

Action	Quarter / Year
Developing Recruitment plans for 22/23 to recruit to non registered an	Q1 2022/23
Review of Recruitment Processess to ensure that they are streamlined, inclusive, responsive and timely	Q1 2022/23
Health and Wellbeing plan communicated to staff	Q1 2022/23
Just and Learning Culture Framework to be introduced/piloted as part of the roll out of the new disciplinary policy -- subject to approval of disciplinary policy	Q1 2022/23
Setting up a working group to oversee payment processes to ensure streamlined processes between People/Operations and Finance Directorate	Q1 2022/23
Set up Culture Transformation Board to develop plans to address issues identified through staff survey, FTSU and other data on staff morale and culture	Q2 2022/23
Review of Statutory and Mandatory training is underway to clarify what staff need to undertake in line with national benchmarks	Q2 2022/23
Development of Recrutiment Dashboard to support recrutiment	Q2 2022/23
Culture Transformation Launch event - 4th August	Q2 2022/23
Development and Sign off of Performance Metrics to support roll out of Leadership Strategy and Culture Transformation	Q2 2022/23
Implementation and roll out of Clever Together - Big conversation - Be	Q2 2022/23
Continued delivery against NHS People Plan	Q3 2022/23
Continue collaboration between NLAG and HUTH and the HCV wider network	Q3 2022/23
Analysis of results from Big Conversation - Be the Change (clever	Q3 2022/23
Continued review of the Health and Wellbeing offer to staff	Q3 2022/23
Review of the Educational /Leadership Development offer and future	Q3 2022/23
Staff Survey 22/23 roll out	Q3 2022/23
Continued implementation of People Strategy by 31 March 2024	Q4 2022/23



Future Risks

- Staff morale and turnover
- COVID-19 third surge and impact on staff health and wellbeing.
- National policy changes.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Provide safe services to the local population.
- Succession planning and future talent identification.
- Visa changes / EU Exit.
- Staff retention and ability to recruit and retain HR/OD staff to deliver people agenda

Strategic Threats

- ICS Future Workforce
- Integrating Care: Next Steps
- Future staffing needs / talent management

Gaps in Controls

- Slower international recruitment of clinical staff due to visa backlogs

Gaps in Assurance

- Increase in nurse staff vacancies and conversion of the 50 overseas nursing recruits

Other Significant Risks & Links to High Level Risks Register

No 1851, Shortfall in Capacity within the Ophthalmology Service - 15
No 2421, Nurse Staffing, Risk Rating = 25
No 2530, Poor Registered Nursing Skill Mix on Wards = 20
No 2898, Medical Staff - Mandatory Training Compliance = 16
No 2960, Risk of inability to safely staff maternity unit with Midwives = 16
No 2997, SCC follow up out patient PTL without risk stratification = 16
No 3015, Insufficient estate resources to manage the workload demand = 20
No 3045, Medical Workforce Vacancies in Gastroenterology = 16
No 3048, Challenges to recruitment of acute care physician vacancies in Acute = 16
No 3063, Doctors Vacancies within Medicine Division = 16

Future Opportunities

- Closer ICS working
- Provider collaboration
- International recruitment

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.1: To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP.

Risk to Strategic Objective 3 - 3.1: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	4	4	1	4	4
Risk Rating	20	20	5	20	20

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: November 2022, 19 July 2022, 18 May 2022, 31 January 2022

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Financial Officer

Enabing Strategy / Plan: Trust Strategy, Clinical Strategy, ICS

Current Controls

- Capital Investment Board, Trust Management Board (TMB), PRIMs, Model Hospital.
- National benchmarking and productivity data constantly reviewed to identify CIP schemes.
- Engagement with Integrated Care System on system wide planning
- Monthly ICS Finance Meetings
- Operational and Finance Plan 2022/23
- Counter Fraud and Internal Audit Plans
- Trustwide Budgetary Control System

Assurance (internal & external)

Internal:
- Minutes of Audit Risk & Governance Committee, Trust Management Board, Finance and Performance Committee, Capital Investment Board, PRIMs, Monthly ICS Finance Meetings
- Non-Executive Director Highlight Report (bi-monthly) to Trust Board

Positive:
- Letter from NHSE related to financial special measures and achievement of action plan. On track to deliver the requirements set out by NHSE
- Internal Audit Reports - Internal Control - significant assurance

External:
- Financial Special Measures Meeting - Letter from NHSE related to financial special measures and achievement of action plan
- Approval received at ICS Level for 2022-23 capital plan
- Internal Audit Reports - Internal Control - significant assurance
- Agreed Financial Plan at ICS Level for 2022/23

Planned Actions

Action	Quarter / Year	Assurance
Undertake financial planning as part of HNY HCP exercise and agree a balanced financial plan for 2022/23 - this is still work in progress with a plan deficit of £6m currently. Included within this are two key actions: productivity improvement plans to return the Trust to 19/20 activity levels as a minimum, and a robust and recurrent cost improvement plan which is capable of being delivered in year	Q4 2022/23	Green
Work with system partners, specifically community and local authorities to ensure that our local systems are working in unison to tackle the issues of system flow	2022/23	Green
Agree financial recovery plan to meet 2022/23 year-end target	Q4 2022/23	Green
Agee finance implications of P2 specialities to inform PCBC	Q4 2022/23	Green
Undertake financial planning for 2023/24	Q4 2022/23	Green

Future Risks

- COVID-19 further surges and impact on finance and CIP achievement
- National policy changes
- Impact of HAS plans on NLaG clinical and non clinical strategies
- Savings Programme not sufficient and deteriorating underlying run rate which is execerbated by the elective recovery programme
- Impact of external factors such as problems with residential and domicilary care, causing hospitals to operate at less than optimum efficiency and cause financial problems

Strategic Threats

- ICS Future Funding
- Integrating Care: Next Steps
- System wide control total

Gaps in Controls

- Systems plans may not address individual organisational sustainability
- Challenges with HASR, CIP Delivery
- Uncertainty on application of long term financial framework.
- Clinical strategy required to inform Finance Strategy
- As we progress, the emerging uncertainty around the financial implications of decisions from the HAS process
- Month on month adverse variants against operational budgets

Gaps in Assurance

- Trustwide Budgetary Control System
- Recurrent delivery of Cost Improvement Programme Plan
- Management of financial risks arising from the lack of flow
- Individual organisational sustainability plans may not deliver system wide control total

Links to High Level Risks Register

- No 3074, Financial Risk - Medicine CIP 2022/23 = 16

Future Opportunities

- Closer ICS working
- Provider collaboration
- System wide collaboration to meet control total

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.2: To secure adequate capital investment for the needs of the Trust and its patients.

Risk to Strategic Objective 3 - 3.2: The risk that the Trust fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades.

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5
Likelihood	3	3	3	3	3
Risk Rating	15	15	15	15	15

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 14/10/22, 23/6/22, 13 April 2022 (DoSD), 14 February 2022

Lead Committee: Strategic Development Committee

Risk Owners: Chief Financial Officer and Director of Strategic Development

Enabling Strategy / Plan: Trust Strategy, Clinical Strategy, Humber Acute Services Programme/ Capital Investment EOI and potential SOC for NHP

Current Controls

- Capital Investment Board (Internal Capital)
- Trust (Internally) Agreed Capital programme and allocated budget - annual/three yearly
- Trust Strategic Development Committee
- Trust Board
- Trust Committee(s) in Common
- ICS Strategic Capital Advisory Group
- NHSE/I - HAS Assurance Reviews
- NHSE/I Financial Speciall Measures Assurance Reviews

Assurance (internal & external)

Internal:
- Minutes of Internal Trust Meetings

External:
- Financial Special Measure Meeting with NHSE/I
- NHSE/I attendance at AAU / ED Programme Board
- NHSE/I Assurance Review Feedback
- CiC Minutes

Planned Actions

Action	Quarter / Year	Assurance
Agree forecast spend for current year as part of wider ICS capital planning exercise	Q4 2022/23	Green
Find a solution to address BEIXS/Salix funding issues with regards to year end cut off	Q2 2022/23	Green
Develop strategic capital plan as part of comprehensive service planning exercise - to be completed by end March 2023	Q4 2022/23	Green
Secure approval for Acute Assessment Unit, Full Business Case	Q4 2021/22	Green
Develop Capital Investment Strategic Outline Case for development of SGH/DPoW	Q3 2022/23	Green
Develop TiF submission through acute collaboratives for additional theatre capacity	Q3 2022/23	Green
Develop integrated bid across N and NE Lincs for implementation of CDH aligned to ICS Core Programme	Q4 2022023	Green

Future Risks

- National policy changes - implications of three year capital planning
- Lack of investment in infrastructure through Targeted Investment Fund (TIF)
- Inability of Trust to fund capital through internal resource - potential lack of external funding sources
- Inability of Trust to gain Capital Departmental Resource Limit (CDEL) cover for strategic capital investment if not on New Hospital Programme (NHP)
- Not gaining a place on the NHP
- Challenges with existing estate continue and significant issues remain with Backlog Maintenance (BLM), Critical Infrastructure Risk (CIR)

Strategic Threats

- ICS Capital Funding Allocations
- Inability to gain national strategic capital through NHP
- Inability to offset CDEL if non NHS funding sources used for capital investment

Gaps in Controls

- Comprehensive programme of Control and Assurance - potential inherent risk on ability of Trust to afford internal capital for major spend
- Control environment whilst comprehensive may not have ability to influence availability of Strategic Capital - investment funding/affordability
- Control environment may not be able to eliminate or reduce risk of estates condition in the short term

Gaps in Assurance

- Assurance review process does not create a direct link to sources of strategic capital investment
- ICS CDEL may not be sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providers

Links to High Level Risks Register

Future Opportunities

- Provider collaboration and use of Place based funding
- Use of TiF, CDH and Towns Centre funds to support capital spend
- System wide collaboration to major capital development needs.
- Announcement of multi year, multi billion pound capital budgets for NHS
- Gaining a place on the NHP

Strategic Objective 4 - To work more collaboratively

Description of Strategic Objective 4: To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale (HCV) Health Care Partnership (HCP) (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan (LTP): to make best use of the combined resources available for health care, to work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally, to work with partners to secure major capital and other investment in health and care locally, to have strong relationships with the public and stakeholders, to work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: make best use of the human capabilities and capacities locally; offer excellent local career development opportunities; contribute to reduction in inequalities; contribute to local economic and social development.

Risk to Strategic Objective 4: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	4	4	4	4
Likelihood	3	3	2	2	2
Risk Rating	15	12	8	8	8

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: October 2022, 23/6/22, 13 April 2022, 12 January 2022

Lead Committee: Strategic Development Committee

Risk Owner: Director of Strategic Development

Enabing Strategy / Plan: NHS Long Term Plan, Trust Strategy, Clinical Strategy, Humber Acute Services Programme, Communications & Engagement Strategy

Current Controls

- Audit Risk & Governance Committee (ARGC).
- Trust Management Board (TMB).
- Finance and Performance Committee (F&PC).
- Strategic Development Committee (SDC).
- Capital Investment Board (CIB).
- HAS Executive Oversight Group.
- HNY HCP.
- ICS Leadership Group.
- Wave 4 ICS Capital Committee.
- Executive Director of HAS and HAS Programme Director appointed.
- NHS LTP.
- ICS LTP.
- NLaG Clinical Strategy.
- NLaG Membership of ICP Board NE Lincs.
- Committees in Common (Trust Board approved 1/6/2021)
- Acute and Comunity Collaborative Boards
- Clinical Leaders & Professional Group
- Council of Governors.
- Joint Overview & Scutiny Committees
- MP cabinet and LA senior team briefings
- Primary/Secondary Interface Group (Northbank&Southbank)

Assurance (internal & external)

Positive:
- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE/I Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Clinical Senate review approach and process

Internal:
- Minutes of HAS Executive Oversight Group, HNY HCP, ICS Leadership Group, Wave 4 ICS Capital Committee, ARGC, F&PC, TMB, SDC, CIB, CoG
- Non Executive Director Committee chair Highlight Report to Trust Board
- Executive Director Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE/I (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE/I Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Councillors / MPs / Local Authority CEOs and senior teams

Planned Actions

Action	Quarter / Year	Assurance
Recruit to Strategic Development - Associate Medical Director to support the ICS collaboration - Dec 21 (complete and in post)	Q3 2021/22	Green
HAS two year programme (current to March 2023) - 12 month rolling	Q4 2023/24	Green
Options appraisal for HAS Capital Investment to be approved	Q4 2022/23	Green
To undertake continuous process of stocktake and assurance reviews NHSE/I and Clinical Senate review	Q1 2023/24	Green
Joint OSC - reviews	Q1 2023/24	Green
CIC / SDC / NED / Governor reviews	Q4 2022/23	Green
Citizens Panel reviews	Q4 2022/23	Green
Clinical Senate reviews	Q4 2022/23	Green
To undertake continuous engagement process with public and staff	Q4 2022/23	Green
Evaluation of the models and options with stakeholders	Q4 2022/23	Green
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Green
NHSEI Gateway review	Q1 2023/24	Green
ICS Board approval	Q1 2023/24	Green
Public Consultation	Q2/Q3 2023/24	Green

Future Risks

- National policy changes
- Delays in legislation
- Long term sustainability of the Trust's sites.
- Change to Royal College Clinical Standards.
- Capital Funding.
- ICS / Integrated Care Partnership (ICP) Structural Change.
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- ICS Future Funding.
- Failure to develop aligned system wide strategies and plans which support long term sustainability and improved patient outcomes.
- Government legislative and regulatory changes.
- Integrated Care: Next Steps and Legislative Changes.
- Strategic capital.

Gaps in Controls

- Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.
- Local Authority, primary care and community service, NED and Governor engagement / feedback (during transition)
- ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Lack of integrated plan and governance structure.
- Alignment with Out of Hospital strategies and programmes

Links to High Level Risks Register

Future Opportunities

- HNY ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Strategic workforce planning system wide and collaborative training and development with Health Education England / Universities etc.
- Acute and community collaborative.

Strategic Objective 5 - To provide good leadership

Description of Strategic Objective 5: To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk to Strategic Objective 5: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

Risk Rating	Inherent Risk	Current Risk	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	4	4
Likelihood	4	3	2	2	2
Risk Rating	16	12	8	8	8

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 14 November 2022, September 2022, July 2022, 6 April 2022, March 2022

Lead Committees: Workforce Committee and Trust Board

Risk Owner: Chief Executive

Enabing Strategy / Plan: Trust Strategy, NHS People Plan, People Strategy, Leadership and Development Strategy

Current Controls

- Trust Board, Trust Management Board, Workforce Committee, PRIMS
- CQC and NHSE Support Teams
- Board development support programme with NHSE support.
- Significant investment in strengthened structures, specifically (a) Organisational structure, (b) Board structure, (c) a number of new senior leadership appointments
- Development programmes for clinical leaders, ward leaders and more programmes in development
- Communication with the Trust's senior leaders via the monthly senior leadership community event
- NHSI Well Led Framework
- PADR compliance levels via PRIM as part of the Trust's focus on Performance improvement
- Joint posts of Trust Chair and Chief Financial Officer, with HUTH
- Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, Humber and North Yorkshire Health and Care Partnership.

Assurance (internal & external)

Internal:
- Leadership Strategy signed off by Trust Board - May 2022
- Minutes of Trust Board, Trust Management Board, Workforce Committee and PRIMS
- Trust Priorities report from Chief Executive (quarterly)
- Integrated Performance Report to Trust Board and Committees.
- Letter from NHSE related to financial special measures and achievement of action plan.
- Chief Executive Briefing (bi-monthly) to Trust Board
- Board and Commiteee meeting structures
- Workforce Implementation Plan report (includes development and leadership programmes) to Workforce Committee
- Senior Leadership Community presentation
- Trust Board - Well-Led assessments at Board Development

Positive:
- Letter from NHSE related to financial special measures and achievement of action plan.

External:
- CQC Report - 2020 (rated Trust as Requires Improvement).
- Financial and Quality Special Measures.
- NHS Staff Survey.
- Minutes of Collaborative Working Relationship groups

Planned Actions

Action	Quarter / Year	Assurance
Introduction of x3 Portfolio Governance Boards including one for leadership and career development with representation from all stakeholder staff groups, leadership development programmes we design in-house, commission, or subscribe to, align with our People Strategy aims of attracting, developing and retaining leaders as a preferred employer. From April 2022.	Q1/2 2022/23	
Continued development of the Leadership Development Model for all leaders and managers towards building a culture of compassion-centred, collective leadership. This programme, modular in approach, will include Leading with Kindness, Courage and Respect, underpinned with processes and skill development in difficult conversations, embodying the Trust values, and improving what it feels like for staff to work at NLaG. From April 2022, subject to funding	Q1/2 2022/23	
Refreshing of the coaching model with the move towards a Coaching and Mentoring Bureau, offering staff at all levels, opportunities for coaching and mentoring. All participants on leadership development programmes will have a coach for the duration of their development course. We aim to introduce mentoring, both peer to peer, role and career, and reverse, during 2022 with some small scale pilot programmes including a pilot EDI-centric reverse mentoring programme to further strengthen inclusion. September 2022, subject to funding	Q2 2022/23	
Refresh of our PADR process referred to in the Training & Development submission, will include process components and skills training to enable identification of talent, development of potential, and proactive planning for succession. Refer to the Leadership and Career development draft schematic in the Appendices for concept. December 2022	Q3 2022/23	
Introducing a managerial core skills programme for newly appointed managers 2022 and beyond. December 2022	Q3 2022/23	
Continued development and implementation of Value based leadership - subject to funding and resources	Q4 2022/23	

Future Risks

- COVID-19 third surge and impact on finance and CIP achievement.
- National policy changes.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Current vacancy for the Head of Education which is currently being covered by temporary resource

Strategic Threats

- Non-delivery of the Tr+L21ust's strategic objectives
- Continued quality/financial special measures status
- CQC well-led domain of 'inadequate'
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives
- Failure to obtain support for key changes needed to ensure improvement or sustainability
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users

Gaps in Controls

- No investment specifically for staff training / courses to support leaders work within a different context and to be effective in their roles as leaders within wider systems

Gaps in Assurance

- Financial Special Measures
- Quality Special Measures

Links to High Level Risks Register

None

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration
- System wide collaboration to meet control total
- HASR

Key to Assurance	
Red	Action rated red means the action is off track, with no mitigation and pose a significant risk to the delivery of the strategic objective
Amber	Action rated amber mean it is in progress, but off track with, no mitigation and could pose a risk to the strategic objective being delivered
Yellow	Action rated amber mean it is in progress, off track, with mitigation, and could pose a risk to the strategic objective being delivered
Green	Actions rated green mean they are on track to deliver.
Blue	Closed action which supports the progress towards the delivery of the strategic objective

Name of the Meeting	**Trust Board (public)**
Date of the Meeting	6 December 2022
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**NHS England Consultation on the NHS Provider Licence**
Purpose of the Report and Executive Summary (to include recommendations)	The Trust Board is asked to note: a) NHS England are consulting with all providers on the proposed changes to the NHS Provider Licence. Appendix A details each of the amendments and the questions being asked by NHSE. **b)** the Collaborative Acute Providers Board agreed to the proposed responses to the consultation on the NHS Provider Licence at its meeting on 28 November 2022, and for the Director of Corporate Governance to submit the responses to the consultation on behalf of the CAP Board. **c)** the consultation ends on 9 December 2022.
Background Information and/or Supporting Document(s) (if applicable)	NHS Providers Next Day Briefing: 2022-10-28-next-day-briefing-provider-licence-etc.pdf (nhsproviders.org) NHS England, Provider Licence consultation notice, Part A, B, C: b1654-provider-licence-consultation-notice-part-a-october-22-1.pdf (england.nhs.uk) b1653-provider-licence-consultation-notice-part-b-nhs-provider-licence-october-22.pdf (england.nhs.uk)
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Executive Team, Collaborative of Acute Providers Board
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable

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: Click here to enter text.

***Board Assurance Framework (BAF) Descriptions:**

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

NHS England, NHS Provider Licence Consultation

1. Purpose of the Report

1.1. To inform the Board on the consultation by NHS England on the proposed changes to the NHS Provider Licence. Appendix A details each of the amendments and the questions being asked by NHSE.

1.2. To advise the Board that responses will be sent on behalf of the Collaborative Acute Providers Board to the proposed amendments to the NHS Provider Licence. The Director of Corporate Governance will be submitting the responses to the consultation on behalf of the CAP Board.

2. Introduction

2.1. The NHS provider licence was first introduced in 2013 and is held by all NHS foundation trusts. It forms part of the oversight arrangements for NHS providers. The provider licence serves as the legal mechanism for any formal regulatory intervention and underpins mandated support for the most challenged providers.

2.2. Existing arrangements will be maintained until the new modified licence takes effect.

2.3. This report links to the report presented to Trust Board on the consultation on Enforcement Guidance, which sets out the processes NHSE will apply when using its licence enforcement powers.

2.4. This NHS Provider Licence proposal does not change the overall approach to NHS provider oversight as set out in the NHS Oversight Framework 2022/23.

3. Proposed Changes to the Provider Licence

3.1. The need to change the licence has arisen from changes to the statutory and operating environment, as well as economic regulation, competition to system working and collaboration. The changes proposed reflect the new legislation that came into force on 1 July 2022: Health and Care Act 2022.

3.2. The consultation proposes four types of changes:

- Supporting effective system working
- Enhancing the oversight of key services provided by the independent sector
- Addressing climate change
- Technical amendments

3.3. NHSE would like to hear from Trusts with an interest in the provisions.

3.4. The consultation ends on 9 December 2022.

4. Consultation

4.1. The CAP Board, at its meeting on 28 November 2022, agreed with the proposed responses and requested the Director of Corporate Governance to submit these on behalf of the CAP Board.

4.2. Each of the consultation questions, condition, and response is provided in Appendix A for noting by the Board.

4.3. The proposed amendments to the provider licence are those set out in legislation and national policy and is based on system working and collaboration between providers. It is considered that the proposed amendments by NHSE are required on this basis.

5. References

NHS England, Code of Governance, 27 October 2022
NHS England, Guidance on good governance and collaboration, 27 October 2022
NHS England, NHS Oversight Framework 2022/23
NHS England, Consultation-on-the-revised-nhs-enforcement-guidance-october-2022

6. Recommendations

The Trust Board is asked to note:

a) NHS England are consulting with all providers on the proposed changes to the NHS Provider Licence. Appendix A details each of the amendments and the questions being asked by NHSE.

b) the Collaborative Acute Providers Board agreed to the proposed responses to the consultation on the NHS Provider Licence at its meeting on 28 November 2022, and for the Director of Corporate Governance to submit the responses to the consultation on behalf of the CAP Board.

c) the consultation ends on 9 December 2022.

Appendix A – Consultation Proposals, Questions and Responses

Condition	Proposal	Questions	Response
Supporting System Working (New Condition). Full proposed text in draft licence section 2: NHS trusts and foundation trusts working in systems WS1: Co-operation condition. Reference: Sections 72 and 82 NHS Act 2006, collaboration set out in the Long Term Plan and Guidance on Good Governance and Collaboration.	To introduce a new condition on co-operation that reflects existing expectations on NHS trusts and foundation trusts to consistently co-operate with other NHS organisations / organisations that deliver NHS care, ICBs and Local Authorities for the purposes of: • Developing and delivering system plans • Delivering NHS services • Improving NHS services To reflect requirements on NHS trusts and foundation trusts to consistently co-operate with other NHS organisations / organisations that deliver NHS care and the ICBs they are partners of for the purposes of delivering system financial plans. To reflect expectations on NHS trusts and foundation trusts to consistently co-operate in the delivery of agreed system workforce plans.	i) To what extent do you agree/disagree with the proposed new co-operation licence condition found in in the purposes of developing and delivering system plans, delivering NHS services and improving NHS services? Please explain your answer including any feedback on the wording of this condition. ii) To what extent do you agree/disagree with the inclusion in this proposed licence condition of the requirement to consistently co-operate for the purpose of delivering system financial plans?	Fully agree with the proposed new condition. It is imperative that NHS FTs work with all organisations in the development of system plans. Such actions support us in fulfilling our Anchor Organisation role but will ensure that through collaboration we focus on improving patient experience, patient outcomes, reducing health inequalities, improving health and well-being, streamlining patient pathways integrate services and drive efficiencies. Ultimately ensuring care is provided at the right time and in the right place. There does need to be reciprocal contractual discussions with colleagues outside the NHS eg local authorities to consistently cooperate in the delivery of system plans. Fully agree with the proposed new condition. If we are to respond to the challenges we currently face we need to

		Please explain your answer including any feedback on the wording of this condition.	ensure that we develop integrated financial plans to allow for improved resource allocation and the realisation of productivity and efficiency savings. In responding to this criteria we must ensure that we allow for the difference in financial reporting and regulation across different organisational types. Our plans must go beyond joined-up back office functions and joint procurement opportunities and look at wider system delivery budgets. There will be challenges that need to be addressed in this area in particular regarding capital funding.
		iii) To what extent do you agree/disagree with the inclusion in this proposed licence condition of the requirement to consistently co-operate for the purpose of delivering system workforce plans? Please explain your answer including any feedback on the wording of this condition.	Fully agree with the proposed new condition. Workforce will be critical to our success and we can only deliver where we have more joint recruitment, look to local as well as wider and do not compete for scarce resources. The challenges in enacting will be based upon different training

			and development approaches and different levels of pay and benefits within different sectors. These factors will need to be considered in the planning. There does need to be reciprocal contractual discussions with colleagues outside the NHS eg local authorities to consistently cooperate in the delivery of system plans.
		iv) Are there elements of this proposed co-operation condition that should be extended to independent sector providers? Please explain your answer.	No, not at this stage. This may be worth pursuing in the longer term as they will be impacted by different funding, contracting, resourcing arrangements. It will be important to embed across multiple public and voluntary bodies first. The complexities of new ways of working needs to be embedded.
Reflecting the Triple Aim duty and having regard to health inequalities (New Condition) Full proposed text in draft licence section 2: NHS trusts and	To introduce a new condition in NHS trusts, FTs and NHS Controlled Providers to have regard to the Triple Aim and comply with their duty to consider the likely effects of their decisions on: a) the health and wellbeing of the people of England (including inequalities in that health and wellbeing)	i) To what extent do you agree/disagree with the proposed inclusion of the Triple Aim, as set out in the 2022 Act, in a new licence condition for NHS trusts and foundation trusts and NHS controlled providers? Please explain your answer including any feedback on the wording of this condition.	Fully agree. It is essential to embed a genuine focus on health and well-being and inequalities. this will ultimately improve patient experience, patient outcomes, streamline patient pathways integrate services and drive efficiencies. It will be essential to ensure that this reflects the variations within

foundation trusts working in systems WS2: Triple Aim condition. Reference: Health inequalities as defined by the NHSE Core20PLUS5 approach.	b) the quality of services provided or arranged by both themselves and other relevant bodies (including reducing inequalities in benefits from those services) c) the sustainable and efficient use of resources by both themselves and other relevant bodies. For the licensee to have regard to guidance concerning the Triple Aim.	ii) Are there elements of this proposed Triple Aim condition that should be extended to independent sector providers? Please explain your answer.	urban, rural and coastal health economies as well as for those individuals who have protected characteristics. Fully agree. The Independent Sector currently provide a significant amount of elective activity on behalf of the NHS. It will be essential that they are contractually bound to ensuring that they deliver services in a way that maximises access for all.
Reflecting digital obligations to enable system working and promote digital maturity (New Condition). New condition on digital: section 2: NHS trusts and foundation trusts working in systems WS3: Digital condition. Additional governance requirements:	To introduce a new condition on NHS trusts and foundation trusts to comply with information standards published under s250 of the Health and Social Care Act 2012 as they pertain to co-operation and the Triple Aim and to comply with required levels of digital maturity as set out in guidance published by NHS England. To add additional requirements for the Licensee to have appropriate systems and processes in place to meet guidance on digital maturity.	i) To what extent do you agree / disagree with a proposed new licence condition reflecting compliance with relevant digital information standards and digital maturity for the purposes of co-operation and meeting the Triple Aim? Please explain your answer including any feedback on the wording of this condition.	Partially agree. Digital systems and information governance ultimately underpin all that we do. But currently levels for system and organisational digital maturity vary. Systems often do not link together and are not interoperable. The delivery of the criteria will require all systems to have a similar level of maturity which will ultimately require significant capital investment. The cost of complying with digital obligations could be challenging unless capital funding is available.

- section 4: NHS provider conditions NHS2: Governance arrangements Paragraph 3(b) (for NHS trusts / foundation trusts) - section 5: NHS Controlled Providers Conditions CP1 Paragraph 3(b) (for NHS controlled providers).		ii) To what extent do you agree / disagree with the proposed amendment to the NHS governance condition NHS2 and the NHS Controlled provider condition reflecting the need for systems and processes to meet digital maturity expectations? Please explain your answer including any feedback on the wording of this additional requirement. iii) Are there elements of these proposed digital conditions that should be extended to independent sector providers? Please explain your answer.	Additionally the skills to design and implement mature systems are in scarce supply and impact upon overall deliverability. The Trust should not be penalised for failing to implement these standards if they cannot afford to implement the core digital systems required. The ability of providers to comply with these requirements will be impacted by capital funding, workforce availability and the delay in the planned digital maturity assessments for this autumn Fully agree. Based on the interoperability point above. The independent sector is an integral part of our delivery framework. it is essential that information governance and digital interoperability is streamlined to protect patient access and care.
Reframing the integrated care condition as a positive obligation to integrate service provision and	To reframe the Integrated Care Condition as a positive obligation – the licensee shall act in the interests of the people who use health care services by ensuring that its provision of NHS services is integrated and enable co-	i) To what extent do you agree/disagree with the reframing of the Integrated Care condition as a positive obligation, on all licence holders? Please explain your answer, including any feedback on the wording of this condition.	Fully agree with the proposed new condition. Will improve patient experience, patient outcomes, reduce health inequalities, improve health and well-being, streamline patient pathways integrate services and drive

reduce health inequalities Full proposed text in draft licence section 1: Integrated Care 1C1: Provision of integrated care.	operation with other providers of health care services with a view to: a) Improving the quality of health care services provided or the efficiency of their provision b) Reducing inequalities of access c) Reducing inequalities with respect to the outcomes achieved for them by the provision of those services		efficiencies. This is part of the Long-Term Plan, Health and Care Act 2022 and collaborative / system working. IS should sign up to the principles of addressing health inequalities by working in partnership with NHS Services to ensure there is no widening of health inequalities.
Reflecting personalised care in patient choice Full proposed text in draft licence section 1: Integrated Care 1C2: Personalised Care and Patient Choice	To expand the patient choice condition into IC2: Personalised Care and Patient Choice through the addition of requirements for providers to support the implementation and delivery of personalised care by: - Having due regard to the guidance on personalised care and comply with legislation - Ensuring that people who use services are offered control to manage their own health and wellbeing to best meet their circumstances, needs and preferences, working in partnership with other services where required. - Retaining patient choice.	i) To what extent do you agree/disagree with the expansion of the patient choice condition to include requirements around personalised care? Please explain your answer, including any feedback on the wording of this condition.	Fully agree with the proposed new condition. Will improve patient experience, patient outcomes, reduce health inequalities, improve health and well-being.
Removing the competition condition	To remove Choice and Competition Condition 2:	i) To what extent do you agree/disagree that the choice and competition condition 2: competition	Fully agree. The Health and Care Act 2022 requires system working and

	Competition Oversight which states that the Licensee shall not: a) enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS, or b) engage in any other conduct which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS.	oversight should be removed from the provider licence? Please explain your answer.	collaboration. Joint procurement and service provision will see efficiencies and value for money through sharing resources.
Enhancing the oversight of key services provided by the independent sector: Broadening the range of providers where Continuity of Services conditions will apply. Full proposed text in draft licence section 3: General conditions G8:	To amend General Condition 9 in the current licence to remove now redundant clauses related to creation of Commissioner Requested Services (CRS) for foundation trusts on 1 April 2013. To add a process for NHS England to determine Hard to Replace Providers and as such apply the Continuity of Service Conditions of the Licence to those providers. To amend Cos6 (Co-operation in the event of financial stress) and CoS7 (Availability of resources) to reference Hard to Replace	i) To what extent do you agree/disagree with the application of continuity of services conditions to Hard to Replace Providers and the modifications to licence conditions G8, CoS6 and CoS7. Please explain your answer, including any feedback on the specific amendments to the related conditions. ii) Do you agree that NHS England should have the ability to determine who is a Hard to Replace Provider? Please explain your answer.	Fully agree. Provides continuity of service for patients and service users who rely on these vital services. Fully agree.

Application of section 5 (Continuity of service) and section 6: Continuity of services CoS6: Co-operation in the event of financial or quality stress and CoS7: availability of resources.	Providers as well as providers of CRS.		
Enhancing the oversight of key services provided by the independent sector: Expanding the scope of Continuity of Services conditions to include quality governance standards. Full proposed text in draft licence section 6: Continuity of services CoS3 Standards of corporate	To introduce a requirement within CoS 3 for standards of Quality Governance which would reasonably be regarded as: - Suitable for a provider of Commissioner Requested Services - Suitable for a Hard to Replace Provider - Providing reasonable safeguards against the licensee being unable to deliver services due to 'quality stress'. Within CoS6 introduce the concept of 'quality stress' as a quality equivalent to financial going concern risk, that creates a risk to the ongoing provision of services. Quality Stress may apply to specific services or all services'	i) To what extent do you agree/disagree with the proposed new requirements for quality governance for independent sector providers that are subject to the continuity of services conditions as drafted in licence condition 6: Continuity of Services CoS3 and CoS6? Please explain your answer, including any feedback on the specific amendments to CoS 3 and CoS 6 condition.	Fully agree. Fundamental standards of care, quality, patient experience and outcomes should be the same whatever the provider.

governance, financial management and quality governance and CoS6: Co-operation in the event of financial or quality stress.			
Addressing climate change: Tackling climate change and delivering net zero Full proposed text in draft licence: - section 4: NHS provider conditions NHS2: Governance arrangements Paragraph 3(b) (for NHS trusts and foundation trusts) - section 5: NHS Controlled Provider condition CP1: Governance arrangements (for NHS-	To add additional requirements to the trust governance condition (formerly FT4; CP1 for Controlled Providers) to ensure NHS trusts, foundation trusts and NHS Controlled Providers have regard to guidance on tackling climate change and delivering net zero emissions, and take all reasonable steps to minimise the adverse impact of climate change on health as outlined in the 2022 Act.	i) To what extent do you agree/disagree with this proposed addition of having regard to guidance on delivering net zero as a requirement of the governance condition 2 (previously FT4) and the NHS Controlled Provider condition 1? Please explain your answer including any feedback on the wording of this condition. ii) Are there elements of this proposed condition that should be extended to independent sector providers? Please explain your answer.	Fully agree. It is essential that Trust look at how they deliver on net zero. To date funding for schemes have been piecemeal levels of grant funding. Trusts are also limited on internal capital funding availability and CDEL limits set through the whole of government accounts. The delivery of schemes is often capital intensive and will require significant capital funding. Fully agree. The Independent sector is a major provider of NHS services and should be required to implement the same standards of environmental care as those required within NHS Trusts.

controlled providers).			
Technical amendments: Shifting the focus of the costing conditions to support integration and improvement. Full proposed text in Section 7: Costing of the draft provider licence.	To update the expectations on all licence holders to record, submit and ensure completeness of costing data in line with the Approved Costing Guidance by: - Replacing pricing condition 1 with an updated costing condition which requires mandated providers (currently NHS trusts and foundation trusts in acute, mental health, ambulance, and community sectors) to record and submit costing mandated data consistent with the requirements of the Approved Costing Guidance. - Replacing pricing condition 2 with an updated costing condition which requires mandated providers to submit the mandated information outlined in Costing Condition 1 to NHS England. - Replacing pricing condition 3 with an updated costing condition which requires mandated providers to have processes in place to ensure the accuracy and completeness of costing and other relevant information collected and submitted to NHS England as	i) To what extent do you agree/disagree with the wording changes required to reposition pricing conditions 1 and 2 as the new costing conditions 1 and 2. Please explain your answer including any feedback on the wording of this condition. ii) To what extent do you agree/disagree with replacing pricing condition 3 with the new costing condition 3: assuring the accuracy of pricing and costing information. Please explain your answer, including any feedback on the wording of this condition.	Fully agree. This reflects national policy, the NHS Long Term Plan and system working – streamlines processes.

	per the Approved Costing Guidance.		
Technical amendments: Amending the pricing conditions to reflect changes to national policy. Full proposed text in section 8: Pricing of the draft provider licence.	To update the wording in the existing Pricing Condition 4 so that the licensee shall comply with the rules and apply the methods concerning charging for the provision of NHS services set out in the NHS Payment Scheme and renaming Pricing Condition 1. To remove existing Pricing Condition 5 that requires constructive engagement with CCGs prior to appealing to Monitor for a local tariff modification.	i) To what extent do you agree/disagree with the proposed wording change to Pricing Condition 4? Please explain your answer including any feedback on the wording of this condition. ii) To what extent do you agree/disagree with the proposed removal of Pricing Condition 5 from the provider licence? Please explain your answer.	Fully agree. This reflects national policy, the NHS Long Term Plan and system working – streamlines processes. Fully agree. This reflects national policy, the NHS Long Term Plan and system working – streamlines processes.
Technical amendments: Streamlining reporting requirements.	To remove paragraphs 3 and 4 from the existing General Condition 6: Systems for compliance with licence conditions and related obligations. To remove paragraph 8 from Foundation Trust Condition 4: Requirements to submit a Corporate Governance Statement and paragraph 8 from Controlled Provider Condition 1.	i) To what extent do you agree/disagree with the removal of paragraphs 3 and 4 from General Condition 6 of the existing licence? Please explain your answer- including any risks or benefits you see related to the removal of these requirements. ii) To what extent do you agree with the proposed removal of Paragraph 8: requirements to submit a Corporate Governance Statement within FT4 for NHS trusts and foundation trusts (renamed NHS2 in proposed draft licence) and CP1 for NHS Controlled Providers? Please explain your answer- including any risks or benefits you see related to the removal of these requirements.	Fully agree. This proposal removes the requirement around self-certification for NHS trusts and foundation trusts due to duplication with annual reporting requirements and reduces regulatory burdens.
Technical amendments: Applying conditions to NHS trusts and updating language to reflect the	To apply relevant existing conditions which apply to all licensees to NHS trusts, including the general conditions, integrated care conditions, costing and pricing conditions and continuity of service conditions (if applicable).	i) To what extent do you agree/disagree to apply all core conditions to NHS trusts (including the general conditions, integrated care conditions, costing and pricing conditions and continuity of service conditions, if applicable) and to extend the foundation trust conditions to NHS trusts? Please explain your answer.	Fully agree. Aligns processes with system working.

current statutory framework.	To extend the foundation trust conditions to NHS trusts excluding specific legislative requirements which relate only to foundation trusts. We propose to rename this section NHS governance conditions. (which we propose to rename as NHS governance conditions). To remove all references to Monitor or NHS Commissioning Board and replace them with 'NHS England'. To amend references to commissioning to reflect the new role of Integrated Care Boards and of bodies which may hold delegated commissioning functions.	ii) To what extent do you agree/disagree with these proposed wording changes to ensure the provider licence accurately reflects the names of the statutory NHS organisations? Please explain your answer.	Fully agree. Aligns processes with system working.
Technical amendments: Removing obsolete conditions.	To remove conditions that have never been used and/or where we have no intention to use them in the future: - General Condition 3 that requires licence holders to pay annual fees to Monitor. - Foundation Trust Condition that obliges a FT licence holder to pay a fee to Monitor in respect of registration and related costs. - Foundation Trust Condition 3 to provide information to a governors advisory panel as defined in the 2006 Act.	i) To what extent do you agree/disagree with the proposal to remove General Condition 3 from the provider licence? Please explain your answer. ii) To what extent do you agree/disagree with the proposal to remove Foundation Trust Condition 2 from the provider licence? Please explain your answer. iii) To what extent do you agree/disagree with the proposal to remove Foundation Trust Condition 3 from the provider licence? Please explain your answer.	Fully agree as they have never been used.

Technical amendments: Amending the Fit and Proper Persons condition.	To accept the changes to licence condition G4 as per the consultation run by Monitor in 2021 to align the condition with regulation 5 of the Fit and Proper Persons Regulations which set out a Fit and Proper Persons test.	For licensees who received their provider licence after March 2021: Do you agree/disagree with the previously consulted upon technical amendment to modify condition G4 to align it with Regulation 5 of the Fit and Proper Persons Regulations? Please explain your answer.	*Not applicable.*

NLG(22)231

Name of the Meeting	**Trust Board - Public**
Date of the Meeting	6 December 2022
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**NHS England Consultation on the Enforcement Guidance**
Purpose of the Report and Executive Summary (to include recommendations)	To advise the Trust Board on consultation being undertaken by NHS England (NHSE) on the NHS Enforcement Guidance. The Trust Board is asked to approve the responses to the consultation questions on the Enforcement Guidance. The consultation asks to what extent respondents agree with proposed changes to: i) introduce a two-tier approach to ICB enforcement that includes an undertakings process. *Response: Agree, as this will align enforcement provisions with the existing provider undertaking process.* ii) align the enforcement guidance with current policy and operational best practice, including reducing the emphasis on investigations and removing the prioritisation framework. *Response: The Trust would agree with this approach.* iii) Any additional comments on how the guidance could be improved. *Response: The Trust has no other comments on the guidance.*
Background Information and/or Supporting Document(s) (if applicable)	NHS Providers Next Day Briefing: 2022-10-28-next-day-briefing-provider-licence-etc.pdf (nhsproviders.org) NHS England, Consultation-on-the-revised-nhs-enforcement-guidance-october-2022
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Executive Team
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:**

	☐ 1 - 1.6 **To be a good employer:** ☐ 2	✓ 5 ☐ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

NHS England, Consultation on the revised NHS Enforcement Guidance

1. Purpose of the Report

1.1. To advise the Trust Board on consultation being undertaken by NHS England (NHSE) on the NHS Enforcement Guidance (see Appendix A for the full consultation document).

2. Introduction

2.1. The current enforcement guidance was issued by Monitor (NHS Improvement) and relates primarily to providers.

2.2. NHSE intends to issue revised and expanded enforcement guidance to ensure alignment with new legislation and its new responsibilities arising from the 2022 Health and Care Act.

2.3. The 2022 Act inserts a new section 14Z61 of the NHS Act 2006 to give NHSE powers to direct ICBs, transfers NHS Improvement's provider enforcement powers to NHS England, and introduces licensing for NHS trusts.

3. Proposed Changes

3.1. The proposed revisions main focus is on alignment with the new legislation and NHSE's responsibilities under the amended Health and Care Act 2022, alignment with current policy, the NHS Oversight Framework and operational best practice.

3.2. The basic processes that NHSE would follow when taking provider enforcement action have not changed in the revised enforcement guidance.

3.3. The revised guidance sets out that NHSE will exercise its enforcement powers in line with the principles set out in the NHS Oversight Framework, working with and through Integrated Care Boards (ICBs) wherever possible and with an emphasis on systems working together to resolve problems.

3.4. Providers may be subject to:

- discretionary requirements
- undertakings
- additional governance licence conditions (foundation trusts only)
- monetary penalties (up to a maximum of 10% of turnover determined by NHSE)
- revocation of licence (this is likely to be rare and only applied in extreme circumstances)
- directions for NHS trusts (s27B NHS Act 2006).

3.5. ICB Enforcement

3.5.1. It is proposed to introduce a two-tier approach to enforcement that reflects legislation in relation to patient choice, meaning an ICB may be subject to directions and undertakings.

3.5.2. The enforcement will ensure parity with NHS provider organisations in terms of NHS England's approach to enforcement

3.6. Gathering, Handling and Evaluating Information

3.6.1. NHSE will monitor and gather information about performance for each of the themes (quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities) of the NHS Oversight Framework, using quantitative and qualitative information and consider if a provider has breached their licence.

3.7. Deciding on Appropriate Enforcement Outcomes

3.7.1. NHSE's regional teams will take the lead in progressing enforcement matters.

3.7.2. The national team leads in enforcement matters for patient choice.

3.7.3. NHSE's regional or national committees make the decision on whether to take enforcement action.

3.8. Right to Appeal

3.8.1. An appeal may be made to the first-tier tribunal in the event of a discretionary requirement, a non-compliance penalty, or to refuse to issue a compliance certificate undertaking or a patient choice undertaking being imposed by NHSE.

4. Issues

4.1. There is a potential risk of inconsistency when approaching regulatory oversight applied by NHSE whenever it discharges its operational, assessment, enforcement and support duties.

4.2. There is no clear guidance on how a breach of a licence condition would be determined by NHSE.

4.3. There is a lack of clarity around decision-making responsibilities where a provider spans multiple ICBs.

5. Consultation Questions and Responses

5.1. The consultation asks to what extent respondents agree with proposed changes to:

i) introduce a two-tier approach to ICB enforcement that includes an undertakings process

Response: Agree, as this will align enforcement provisions with the existing provider undertaking process.

ii) align the enforcement guidance with current policy and operational best practice, including reducing the emphasis on investigations and removing the prioritisation framework

Response: The Trust would agree with this approach.

iii) Any additional comments on how the guidance could be improved.

Response: The Trust has no other comments on the guidance.

5. References

NHS England, Code of Governance, 27 October 2022
NHS England, NHS Oversight Framework 2022/23
NHS England, Consultation-on-the-revised-nhs-enforcement-guidance-october-2022
NHS Providers, Provider-licence-briefing

6. Recommendations

The Trust Board is asked to:

a) note the consultation being undertaken by NHS England (NHSE) on the NHS Enforcement Guidance.

b) approve the responses to the consultation questions on the Enforcement Guidance, relevant to NLAG Foundation Trust, as follows:

The consultation asks to what extent respondents agree with proposed changes to:

i) introduce a two-tier approach to ICB enforcement that includes an undertakings process

Response: Agree, as this will align enforcement provisions with the existing provider undertaking process.

ii) align the enforcement guidance with current policy and operational best practice, including reducing the emphasis on investigations and removing the prioritisation framework

Response: The Trust would agree with this approach.

iii) Any additional comments on how the guidance could be improved.

Response: The Trust has no other comments on the guidance.

Classification: Official

Publication reference: PR1421

Consultation on the revised NHS enforcement guidance

27 October 2022

Contents

1. Introduction

1. Under the new Health and Care Act 2022 (the 2022 Act), NHS England has statutory accountability for oversight of both integrated care boards (ICBs) and NHS providers. NHS Improvement (Monitor and the NHS Trust Development Authority) has been abolished and NHS England has assumed responsibility for carrying out NHS Improvement's statutory functions, including the regulation of NHS providers, the exercise of provider enforcement powers, enforcement powers over ICBs in relation to compliance with patient choice provisions, and publishing and revising the guidance on the use of those powers.

2. The current enforcement guidance was issued by Monitor (NHS Improvement) and relates primarily to providers. Monitor (NHS Improvement) also issued enforcement guidance relating to its oversight role and enforcement powers over clinical commissioning groups and NHS England in relation to compliance with

patient choice provisions. NHS England intends to issue revised and expanded enforcement guidance to ensure alignment with new legislation and its new responsibilities arising from the 2022 Act:

i. The 2022 Act inserts a new section 14Z61 of the NHS Act 2006 to give NHS England powers to direct ICBs, transfers NHS Improvement's provider enforcement powers to NHS England, and introduces licensing for NHS trusts.

ii. The NHS Act 2006, as amended by the 2022 Act, also gives NHS England powers to oversee and take enforcement action in relation to ICBs' compliance with patient choice provisions.

iii. Reflecting those responsibilities, and unlike the existing Monitor/NHS Improvement enforcement guidance, this revised guidance would not be focussed primarily on enforcement in relation to providers.

3. The revised enforcement guidance would describe NHS England's intended approach to using its enforcement powers, including by setting out the use of powers to direct an ICB and the licence enforcement mechanisms that apply to foundation trusts, NHS trusts, licensed independent providers of NHS services, and licensed NHS controlled providers. It explains the regulatory and statutory processes in the event of enforcement action and subsequent rights of appeal, including:

   i. when NHS England may decide to take action, and what action it can take;

   ii. how NHS England is likely to decide what kind of sanctions to impose using its powers under the 2022 Act; and

   iii. the processes NHS England intends to follow when taking enforcement action.

4. NHS England's revised enforcement guidance would be published pursuant to:

   i. NHS England's duty under section 108 of the Health and Social Care Act 2012 to publish guidance about the use of its provider enforcement powers under the Act;

   ii. NHS England's duty under section 14Z51 of the NHS Act 2006 to publish guidance about the exercise of ICB functions.

   iii. NHS England's duties, on commencement of the relevant provisions in the 2022 Act, under section 6G of the NHS Act 2006 to publish guidance about

the use of its enforcement powers relating to patient choice; and a procedure for entering into patient choice undertakings, under paragraph 2 of Schedule 1Z1 to the NHS Act 2006.

5. This document consults on the revised enforcement guidance.

2. The proposed changes

Summary of the proposed changes

6. The proposed revisions to the enforcement guidance focus on:

    i. The changes required due to the abolition of Monitor and the NHS Trust Development Authority (known as NHS Improvement) and the transfer of functions to NHS England.

    ii. Alignment with new legislation and NHS England's new responsibilities under the NHS 2006 and the Health and Social Care Act 2012, as amended by the 2022 Act as set out above. Updates to the guidance include:

        a. the process for ICB enforcement

        b. removal of references to enforcement action for breach of competition rules – competition functions have been removed by the 2022 Act

        c. revisions to the language to reflect the change from Monitor to NHS England as the regulatory body for NHS foundation trusts, and the extension of the provider licence to NHS trusts.

        d. NHS England's enforcement powers in relation to patient choice provisions.

    iii. Alignment with current policy including the NHS Oversight Framework and operational best practice, including:

        a. reducing the emphasis on investigations in the event of suspected provider licence breach, in line with established practice

        b. removing the 'prioritisation framework' that Monitor used to inform its decisions on whether or not to begin or continue ongoing cases (the framework has since fallen out of use).

Provider enforcement

7. The basic processes that NHS England would follow when taking provider enforcement action have not changed in the revised enforcement guidance. The

revised guidance, however, sets out that NHS England will exercise its enforcement powers in line with the principles set out in the NHS Oversight Framework, working with and through ICBs wherever possible and with an emphasis on systems working together to resolve problems.

ICB enforcement

8. NHS England is proposing to introduce a two-tier approach to enforcement that reflects:

    i. ICB legislation in relation to patient choice; and

    ii. ensures parity with NHS provider organisations in terms of NHS England's approach to enforcement.

9. NHS England's powers to direct ICBs align with the powers NHS England may apply to providers that are in breach of their licence conditions (in particular the power to impose 'discretionary requirements').

10. The revised enforcement guidance would introduce an ICB undertakings process to be applied at a lower threshold than that required for directions (e.g., reasonable grounds to suspect that the ICB has failed or is at risk of failing to discharge its functions). This is in conjunction with the enforcement provisions relating to patient choice provisions and would be aligned with the existing provider undertaking process[1].

11. These undertakings would set out the actions the ICB agrees to take to resolve the identified issues, in line with the existing provider undertakings process:

    i. ICB undertakings will be agreed by NHS England and the ICB and would set out the remedial actions that will be taken to address the specific challenges identified.

    ii. By agreeing undertakings, the ICB would be giving a commitment that it will comply and carry out the relevant actions.

3. Responding to the consultation

12. In so far as the guidance applies to providers and to patient choice provisions, the proposals to revise and extend the existing enforcement guidance are subject to

[1] These undertakings are non-statutory. For matters relating to patient choice, statutory undertakings may be required by NHS England for the ICB in the context of a formal investigation.

NHSE's statutory duties to consult[2]. Consistent with those duties, we are consulting existing and potential licence holders (including NHS trusts), ICBs, the Care Quality Commission (CQC) and its Healthwatch England Committee, and other system and sector stakeholders. Additionally, we are keen to hear from other bodies with an interest in the provision of healthcare in England. An overview of the changes made to the enforcement guidance is attached as (Appendix 1).

13. This consultation document should be read alongside the updated enforcement guidance, the 2022/23 NHS Oversight Framework, and the consultation document that sets out the proposed changes to the NHS provider licence and guidance for NHS-controlled providers.

14. We are asking those who wish to respond to this consultation to answer the two questions below and to send their answers to us using this link. The consultation ends on 09 December 2022. Following consultation, the revised NHS enforcement guidance will replace and supersede the Monitor enforcement guidance.

Consultation

1. To what extent do you agree with the proposed changes to:

    a. introduce a two-tier approach to ICB enforcement that includes an undertakings process?

    b. align the enforcement guidance with current policy and operational best practice, including reducing the emphasis on investigations and removing the prioritisation framework?

    Please explain your reasons.

2. Please provide any additional comments on how the guidance could be improved.

[2] See section 108 of, and paragraph 9 of Schedule 11 to, the 2012 Act and section 6G of, and paragraph 2 of Schedule 1ZA to, the NHS Act 2006.

Appendix 1: Proposed changes to the enforcement guidance

Theme	Overview of change
NHS England's statutory responsibilities	With the introduction of the Health and Care Act 2022, the proposed guidance reflects the abolition of NHS Improvement and NHS England's new oversight responsibilities for ICBs and providers (paragraph 1 of the revised enforcement guidance) NHS England has statutory accountability to oversee both ICBs and providers, and to intervene when necessary following principles of fairness and proportionality (paragraphs 1,2, and 3 of the revised enforcement guidance) NHS England also has new enforcement powers in relation to ICBs and their compliance with patient choice provisions (paragraph 24 and 25 of the revised enforcement guidance)
Changes to the existing enforcement guidance	Removal of references to enforcement action for breach of competition rules as Monitor's competition functions were removed by the Health and Care Act 2022 (Chapter 1 of the current enforcement guidance). NHS England's shift away from rigid application of the 'prioritisation framework' that Monitor used to inform its decisions on whether or not to begin or continue ongoing cases. The framework has since fallen out of use and the guidance has been updated to reflect current best practice and the legal framework by which NHS England oversees ICBs and providers (Chapter 2 of the current enforcement guidance). NHS England's shift away from formal investigations where possible. The revised guidance reflects the collaborative process NHS England will follow with ICBs and providers when gathering information and investigating any concerns (Chapter 4 of the current enforcement guidance).
Additions to the existing enforcement guidance	Inclusion of enforcement relating to NHS trusts, to reflect the extension of the provider licence to NHS trusts on commencement of relevant provisions under the 2022 Act (paragraph 36 of the revised enforcement guidance). Creating guidance to cover enforcement in relation to ICBs as well as providers. The proposed revised guidance would include a new approach to ICB enforcement that includes the use of undertakings entered into by ICBs as the first step of enforcement action. The guidance also sets out the options and process for using ICB directions (paragraphs 32-35 of the revised enforcement guidance). NHS England's enforcement powers relating to patient choice provisions. Monitor had an oversight role and enforcement powers

	over clinical commissioning groups and NHS England in relation to compliance with The National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 and certain provisions in the NHS Standing Rules. Under the Health and Care Act 2022, when the provisions come into force, NHS England will have a similar oversight role and enforcement powers over ICBs in relation to compliance with patient choice provisions (paragraph 31 of the revised enforcement guidance)

Name of the Meeting	**Trust Board - Public**	
Date of the Meeting	6 December 2022	
Director Lead	Helen Harris, Director of Corporate Governance	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	**Code of Governance for NHS Provider Trusts**	
Purpose of the Report and Executive Summary (to include recommendations)	To advise the Trust Board on the new Code of Governance that has been published by NHS England on 27 October as part of a suite of other governance documents. The Board is asked to note that the new code comes into force on 1 April 2023.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Executive Team
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.
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1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Code of Governance for NHS Provider Trusts

1. Purpose of the Report

1.1. To advise the Trust Board on the new Code of Governance (see Appendix A) for NHS Provider Trusts, which will come into force on 1 April 2023.

2. Introduction

2.1. The new code will replace the NHS Foundation trust code of governance, which was last updated in 2014 and will apply to all trusts.

2.2. The code sets out principles to help trusts deliver effective corporate governance, and provisions with which trusts must comply, or explain how the principles have been met in other ways. The code will apply from 1 April 2023 and has been updated to reflect:

- its application to NHS trusts and aligning with the proposed extension of the NHS Provider licence
- changes to the UK Corporate Governance Code in 2018
- the establishment of integrated care systems (ICS) under the Health and Care Act 2022
- the evolving NHS Oversight Framework, under which trusts will be treated similarly regardless of their constitution as an NHS trust or foundation trust.

2.3. The code sets out a common framework for the corporate governance of trusts. It has been developed to help providers deliver effective corporate governance, contribute to better organisational and system performance and improvement, and discharge duties in the best interests of patients, service users and the public.

2.4. The code brings best practices of the NHS and the private sector and is built on a set of principles. Each principle incorporates a set of detailed provisions, to help the trust demonstrate the effectiveness of governance practices.

3. What is Corporate Governance

3.1. Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered.

3.2. This means delivering high quality services in a caring and compassionate environment, while collaborating within ICSs to integrate care and complying with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

3.3. Robust governance structures that support collaborative leadership and relationships with system partners and other stakeholders, and strong local accountability will help trusts maintain the trust and confidence of the people and communities they service.

3.4. Boards should be committed to improving governance on a continuing basis through evaluation and review.

4. Requirements of the Code

4.1. The provisions in the code are not mandatory, although non-compliance may form part of a wider regulatory assessment on adherence to the Provider Licence; and some of the provisions are statutory requirements because they are enshrined elsewhere in legislation.

4.2. In order to meet the requirements of the code, the Trust must 'Comply' or 'Explain' against each of the provisions with the code. Reasons for non-compliance will need to be explained by illustrating how its practices are consistent with the principle.

4.3. One of the requirements within the new Code of Governance, will be how NHS Provider Trusts are collaborating with the 'system' and with 'provider collaboratives'.

4.3.1. NHSE has issued guidance under the NHS Provider Licence on good governance and collaboration. Provider Trusts will be judged against their contribution to the objectives of the Integrated Care System and three key areas of collaboration:

- engaging consistently in shared planning and decision-making,
- consistently take collective responsibility with partners for delivery of high quality and sustainable services across various footprints including system and place; and
- consistently taking responsibility for delivery of agreed system improvements and decisions.

4.4. Trusts must ensure that they are meeting the governance requirements as set out in the 2006 Act and those reflected in the NHS provider licence. This is to determine if there is a risk of a breach of the licence condition 'Foundation Trust Condition 4': Governance in the NHS foundation trust.

4.5. As part of governance arrangements, Trusts need to provide NHSE with the:

- Corporate Governance Statement (in the annual plan),
- Code of Governance disclosure (to be submitted with the annual report),
- Annual Governance Statement.

5. Current vs New Code of Governance

The main differences are as follows:

NHS Foundation Trust (FT) Code of Governance 2014	Code of Governance for NHS Provider Trusts (1 April 2023)
Specifically for FT's only	For all NHS Providers
	Single framework for overseeing systems and organisations
	Modelled on the UK Corporate Governance code 2018
Section A: Leadership Includes Division of Responsibilities	Section A: Leadership and Purpose Promoting the long-term sustainability of the Trust as part of the ICS and wider healthcare system. Ensuring alignment with the Integrated Care Partnership's integrated care strategy Decision-making complies with the Triple Aim (better health and wellbeing, better quality of health services and sustainable use of resources The Trust to contribute to the five-year joint plan and annual capital plan agreed by the Integrated Care Board. Reduce health inequalities. Relations with Stakeholders – ICS, ICB, Place-Based, key partnerships.
	Section B: Division of Responsibilities (Chair, Chief Executive, Non-Executive Directors and Council of Governors)
Section B: Effectiveness Composition, appointments to the board, commitment, development, information and support, succession, evaluation, re-appointment of directors and re-election of governors; resignation of directors)	Section C: Composition, Succession and Evaluation In addition to the FT Code, the new code includes the requirement of the Trust to carry out externally facilitated development reviews of their leadership and governance using the Well-led framework every three to five years. The Chair is responsible for ensuring that the Board and council work together effectively. Selection panel for a post should include at least one external assessor from NHS England and / or a representative from the ICB.
Section C: Accountability	Section D: Audit, Risk and Internal Control
Section D: Director Remuneration	Section E: Remuneration
Section E: Relations with Stakeholders	This section is included in the new Code in Section A.

Appendix B: The role of the Nominated Lead Governor	Appendix B: Council of Governors and role of the nominated Lead Governor The Council of Governors leadership principles have been transferred from the FT Code Section A to the new Code Appendix B. Additional requirement is for Governors to take account of the interests of the public at large, includes the population of the local system of which the trust is part. To give consideration to the FT and the needs of the system and wider NHS and emerging best practice
Appendix C: The FT Code of Governance and other Regulatory Requirements	Appendix C: The Code and Other Regulatory Requirements Addition of the Department of Health and Social Care Group accounting manual.

6. General Information: Other Publications / Consultations

6.1. In conjunction with the publication of a new Code of Governance and Guidance on Good Governance and Collaboration; NHSE has issued a consultation on the NHS Provider Licence and the Enforcement Guidance. A separate report has been prepared in relation to these consultations for the Board to consider.

7. References

NHS England, Code of Governance, 27 October 2022
NHS England, Guidance on good governance and collaboration, 27 October 2022
NHS England, Provider-licence-consultation-notice-part-a, 27 October 2022

8. Recommendations

The Trust Board is asked to note:

a) the new Code of Governance (Appendix A), which comes into force from 1 April 2023,

b) the other suite of governance documents linked to the Code of Governance: the NHS Provider Licence, Corporate Governance Statement and the Annual Governance Statement on an annual basis,

c) a Board and Committee effectiveness framework is to be developed based on the new code requirements to enable board and committee evaluations to be undertaken in quarter four 2023/24.

Classification: Official

Publication reference: PR2076

NHS England

Code of governance for NHS provider trusts

27 October 2022

Contents

Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

About this document

This code sets out a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems.

Key points

- Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered.
- In the NHS this means delivering high quality services in a caring and compassionate environment while collaborating through system and place-based partnerships and provider collaboratives to integrate care.
- Best practice is detailed in the following sections: board leadership and purpose, division of responsibilities, composition, succession and evaluation, audit, risk, internal control and remuneration.

Action required

- Trusts must comply with each of the provisions of the code or, where appropriate, explain in each case why the trust has departed from the code.

Other guidance and resources

- Integrated care systems: design framework
- Working together at scale: guidance on provider collaboratives
- The wider suite of Integrated care systems: guidance

Introduction

1. Why is there a Code of Governance?

1.1. NHS England has issued this Code of Governance (the code) to help NHS providers deliver effective corporate governance, contribute to better organisational and system performance and improvement, and ultimately discharge their duties in the best interests of patients, service users and the public.

1.2. The board of directors is a unitary board. This means that within the board of directors, the non-executive directors and executive directors make decisions as a single group and share the same responsibility and liability. All directors, executive and non-executive, have responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

1.3. In this code, we bring together the best practices of the NHS and private sector. We set out a common overarching framework for the corporate governance of trusts that complements the statutory and regulatory obligations they have (these are referenced throughout this document).

1.4. As with the UK Corporate Governance Code, each section of this code is built around a set of principles emphasising the value of good corporate governance to long-term sustainable success. Each section also incorporates a set of more detailed provisions to implement these, which can help trusts demonstrate the effectiveness of governance practices and their contribution to the long-term success of the organisation and its wider system.

2. What is new about this version of the code?

2.1 This version of the code applies from April 2023. A great deal has changed since we last updated the code in 2014. NHS England, Monitor and the NHS Trust Development Authority (TDA) started formally working together on 1 April 2019 to provide better support to delivery of the NHS Long Term Plan (January 2019), which set the direction for greater integration of care with providers collaborating with partners in health and care systems. All systems had achieved integrated care system (ICS) status by April 2021. The Health and Care Act 2022 has merged Monitor and the TDA into NHS England and removed legal barriers to

collaboration and integrated care, making it easier for providers to take on greater responsibility for service planning and putting ICSs on a statutory footing through establishing for each ICS:

- An integrated care partnership (ICP), a statutory joint committee of the integrated care board (ICB) and the upper tier local authorities in the ICS, that brings together organisations and representatives concerned with improving the care, health and wellbeing of the population. Each partnership has been established by the NHS and local government as equal partners and has a duty to develop an integrated care strategy proposing how the NHS and local government should exercise their functions to integrate health and care and address the needs of the population identified in the local joint strategic needs assessment(s).
- An ICB, which brings the NHS together locally, to improve population health and care; its unitary board allocates NHS budget and commissions services, and – having regard to the ICP's integrated care strategy – produces a five-year joint plan for health services and annual capital plan agreed with its partner NHS trusts and NHS foundation trusts.

2.2 The ICP and ICB, together with other key elements of the new arrangements including place-based partnerships and provider collaboratives, are tasked with bringing together all partners within an ICS.

2.3 At the heart of effective collaboration is the expectation that providers will work effectively on all issues, including those that may be contentious for the organisation and system partners, rather than focusing only on those issues for which there is already a clear way forward or which are perceived to benefit their organisation. The success of individual NHS trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver high quality care and effective use of resources.[1]

2.4 To support this shift, we have put in place a new single framework for overseeing NHS systems and organisations, the NHS Oversight Framework, which will evolve particularly for 2023/24. Under this new framework we intend to continue to treat

[1] Integrated Care Systems: design framework, p30

providers in comparable circumstances similarly unless there is sound reason not to.

2.5 This updated code therefore applies to both NHS foundation trusts and, for the first time, NHS trusts. NHS foundation trusts and NHS trusts are constituted differently.

- NHS foundation trusts are public benefit corporations and their boards of directors have a framework of local accountability through members and a council of governors. The NHS foundation trust council of governors is responsible for holding the non-executive directors individually and collectively to account. In turn, NHS foundation trust governors are accountable to the members who elect them and must represent their interests and the interests of the public.
- NHS trusts were established by orders of the Secretary of State for Health and Social Care. Their chairs and non-executive directors are appointed by NHS England[2] and they do not have a council of governors or members. Instead, we have a duty to hold the chair and non-executive directors of NHS trusts individually and collectively to account for the performance of the board.

2.6 Despite their different constitutions, there are overarching principles of corporate governance that apply to both NHS trusts and NHS foundation trusts. Where particular provisions of the code apply only to NHS foundation trusts or NHS trusts, we explicitly indicate this. Where we refer to 'trusts' in this code, we mean both NHS trusts and NHS foundation trusts. We use the term 'chief executive' to apply to the chief executives of NHS foundation trusts and the chief officers of NHS trusts, except in sections that are specific to NHS trusts, where we use 'chief officer'. References to 'directors' include the chair, executive and non-executive directors.

2.7 The UK Corporate Governance Code, on which the code has always been based, has also been updated a number of times since 2014. This code is modelled on the 2018 version of the UK Corporate Governance Code.

[2] Chairs and non-executive directors hold a statutory office under the National Health Service Act 2006. The appointment and tenure of office are governed by the NHS Trusts (Membership and Procedure) Regulations 1990. NHS England makes NHS trust chair and non-executive director appointments using powers delegated by the Secretary of State for Health and Social Care. Board appointments are regulated by the Commissioner for Public Appointments to provide independent assurance that they are made in accordance with government's Principles of Public Appointments and Governance Code for public bodies.

3. What is corporate governance?

3.1 A trust board needs to be able to deliver entrepreneurial and effective leadership and prudent and effective oversight of the trust's operations, to ensure it is operating in the best interests of patients, service users and the public.

3.2 Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered. In the NHS this means delivering high quality services in a caring and compassionate environment, while collaborating within ICSs to integrate care and complying with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. Robust governance structures that support collaborative leadership and relationships with system partners and other stakeholders, and strong local accountability will help trusts maintain the trust and confidence of the people and communities they service. Good corporate governance is dynamic. Boards should be committed to improving governance on a continuing basis through evaluation and review.

3.3 Robust corporate and quality governance arrangements complement and reinforce one another. Quality governance is the combination of structures and processes at and below board level to lead on trust-wide quality performance, including (i) ensuring required standards are achieved and (ii) investigating and acting on sub-standard performance. Clinicians are at the frontline of ensuring patients receive quality care. However, the board of directors takes final and definitive responsibility for improvements, successful delivery and, equally, failures in the quality of care. Effective governance therefore requires boards to pay as much attention to quality of care and quality governance as they do to the financial health of their organisation. Boards also set the tone of their organisation by demonstrating shared values and behaviours, and recognising their organisation's role in an ICS and the wider NHS, and the risks and opportunities this may present for quality of care. Further guidance can be found in the Well-led framework for leadership and governance developmental reviews.

4. What should trusts do to fulfil the code's requirements of good governance?

4.1 We seek to support good governance by offering sound guidance. We are keen that trusts have the flexibility to ensure their structures and processes work well now and in the future, while making sure they meet the code's overall requirements for good governance, which are designed with the interests of patients, service users and the public in mind.

4.2 Ultimately only directors can demonstrate and promote the board behaviour needed to guarantee good corporate governance in practice. Good governance requires continuing and determined effort and boards have opportunities within the framework of the code to decide themselves how they should act.

Comply or explain

4.3 The provisions of the code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of Condition FT4 of the NHS provider licence (also known as the governance condition; NHS England has deemed it appropriate that Condition FT4 applies to NHS trusts as well as NHS foundation trusts under it's "shadow" licence regime). However, non-compliance may form part of a wider regulatory assessment on adherence to the provider licence.

4.4 Satisfactory engagement between the board of directors, the council of governors and members of foundation trusts, and patients, service users and the public is crucial to the effectiveness of trusts' corporate governance approach. Directors and, for foundation trusts, governors both have a responsibility for ensuring that 'comply or explain' remains an effective basis for this code.

Disclosure requirements

4.5 To meet the requirements of 'comply or explain' each trust must comply with each of the provisions of the code (which in some cases will require a statement or information in the annual report, or provision of information to the public or, for foundation trusts, governors or members) or, where appropriate, explain in each case why the trust has departed from the code.

4.6 We recognise that departure from the specific provisions of the code may be justified in particular circumstances. Reasons for non-compliance with the code should be explained, with the trust illustrating how its actual practices are consistent with the principle to which the particular provision relates. It should set out the background, provide a clear rationale and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the trust should indicate when it expects to conform to the provision.

4.7 The form and content of this part of the statement are not prescribed, the intention being that trusts should have a free hand to explain their governance policies in the light of the principles, including any special circumstances applying to them which have led to a particular approach.

4.8 It is important to note that:

- Some provisions require a statement or information in the annual report. Where information would otherwise be duplicated, trusts need only provide a clear reference to the location of the information within their annual report.
- Other provisions require a trust to make information publicly available or, for foundation trusts, to provide information to their governors or members.
- The remaining provisions are those for which 'comply or explain' applies.
- Schedule A of the code sets out which provisions fall into which category.

5. How does the code fit with other NHS England requirements?

5.1 Although compliance with the provisions in this code is on a 'comply or explain' basis, we have included and clearly identified in the code any relevant statutory requirements. In the first instance, boards, directors and, for foundation trusts, governors should ensure they are meeting the specific governance requirements set out in the NHS provider licence.

5.2 The code sits alongside other NHS England reporting requirements which relate to governance but do not conflict or connect with the code. The code also includes references to other NHS England publications that focus on audit and internal control:

- NHS foundation trust annual reporting manual.[3]

5.3 For clarity, we have provided a detailed explanation of how the different requirements sit together and the purpose of each in Appendix C.

6. Further information

6.1 Trusts may also find it useful to consult other guidance and sources of best practice about governance of public bodies and the NHS. In particular, the following publications are likely to be useful when considered alongside the code:

- Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts
- Guidance on good governance and collaboration under the NHS provider licence
- Your statutory duties: A reference guide for NHS foundation trust governors
- Foundation trust councils of governors and system working and collaboration: An addendum to your statutory duties – A reference guide for NHS foundation trust governors
- Director-governor interaction in NHS foundation trusts: A best practice guide for boards of directors
- The Healthy NHS Board 2013 – Principles for good governance
- The seven principles of public life: covers the standards of behaviour in and principles of public
- Board governance essentials: a guide for chairs and boards of public bodies: developed by CIPFA (the Chartered Institute of Public Finance Accountants), this guide gives advice on the roles of chairs and board members.

[3] This is updated on a yearly basis and published on our website.

Section A: Board leadership and purpose

1. Principles

1.1 Every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust as part of the ICS and wider healthcare system in England, generating value for members in the case of foundation trusts, and for all trusts, patients, service users and the public.

1.2 The board of directors should establish the trust's vision, values and strategy, ensuring alignment with the ICP's integrated care strategy and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. The board of directors must satisfy itself that the trust's vision, values and culture are aligned. All directors must act with integrity, lead by example and promote the desired culture.

1.3 The board of directors should give particular attention to the trust's role in reducing health inequalities in access, experience and outcomes.

1.4 The board of directors should ensure that the necessary resources are in place for the trust to meet its objectives, including the trust's contribution to the objectives set out in the five-year joint plan and annual capital plan agreed by the ICB and its partners, and measure performance against them. The board of directors should also establish a framework of prudent and effective controls that enable risk to be assessed and managed. For their part, all board members – and in particular non-executives whose time may be constrained – should ensure they collectively have sufficient time and resource to carry out their functions.

1.5 For the trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the board of directors should ensure effective engagement with them, and encourage collaborative working at all levels with system partners.

1.6 The board of directors should ensure that workforce policies and practices are consistent with the trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The board is

responsible for ensuring effective workforce planning aimed at delivering high quality of care.

2. Provisions

2.1 The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.

2.2 The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.

2.3 The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.

2.4 The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners,[4] and that risk is managed effectively. The board should regularly review the trust's performance in these areas against

[4] This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system.

regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.

2.5 In line with principle 1.3 above, the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.

2.6 The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.

2.7 The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.

2.8 The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.

2.9 The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place

for the proportionate and independent investigation of such matters and for follow-up action.

2.10 The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.[5]

2.11 Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.

[5] Directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests.

Section B: Division of responsibilities

1. Principles

1.1 The chair leads the board of directors and, for foundation trusts, the council of governors, and is responsible for its overall effectiveness in leading and directing the trust. They should demonstrate objective judgement throughout their tenure and promote a culture of honesty, openness, trust and debate. In addition, the chair facilitates constructive board relations and the effective contribution of all non-executive directors, and ensures that directors and, for foundation trusts, governors receive accurate, timely and clear information.

1.2 Responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. No individual should have unfettered powers of decision.

1.3 Non-executive directors should have sufficient time to meet their board responsibilities. They should provide constructive challenge and strategic guidance, offer specialist advice and lead in holding the executive to account.

1.4 The board of directors should ensure that it has the policies, processes, information, time and resources it needs to function effectively, efficiently and economically.

1.5 The board is collectively responsible for the performance of the trust.

1.6 The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust, and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.

1.7 All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.

2. Provisions

2.1 The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.

2.2 The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.

2.3 The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.

2.4 A foundation trust chair is responsible for ensuring that the board and council work together effectively.

2.5 The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.

2.6 The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:

- has been an employee of the trust within the last two years
- has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the trust

- has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme
- has close family ties with any of the trust's advisers, directors or senior employees
- holds cross-directorships or has significant links with other directors through involvement with other companies or bodies
- has served on the trust board for more than six years from the date of their first appointment[6]
- is an appointed representative of the trust's university medical or dental school.

Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.

2.7 At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.

2.8 No individual should hold the positions of director and governor of any NHS foundation trust at the same time.

2.9 The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.

2.10 Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.

2.11 In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior

[6] But note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval.

independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.

2.12 Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.

2.13 The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.

2.14 When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

2.15 All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.

2.16 All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting

agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.

2.17 The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the board of directors.

Section C: Composition, succession and evaluation

1. Principles

1.1 Appointments to the board of directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for board and senior management. Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. Both appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths.[7] In particular, the board should have published plans for how it and senior managers will in percentage terms at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher.

1.2 The board of directors and its committees should have a diversity of skills, experience and knowledge. The board should be of sufficient size for the requirements of its duties, but should not be so large as to be unwieldy. Consideration should be given to the length of service of the board of directors as a whole and membership regularly refreshed.

1.3. Annual evaluation of the board of directors should consider its composition, diversity and how effectively members work together to achieve objectives. Individual evaluation should demonstrate whether each director continues to contribute effectively.

2. Provisions for NHS foundation trusts board appointments

2.1 The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges,

[7] For more information refer to the Equality Act 2010, The NHS' successive Equality Delivery Systems (EDS) and the NHS Workforce Race Equality Standard (WRES).

risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.

2.2 There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.

2.3 The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.

2.4 The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.

2.5 Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.

2.6 Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent

members should be in the majority on the committee and also on the interview panel.

2.7 When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.

2.8 The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.

2.9 Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.

Relevant statutory requirements

2.10 A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.

2.11 It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.

2.12 The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.

2.13 Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.

2.14 The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.

3. Provisions for NHS trust board appointments

3.1 NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.

4. Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts

4.1 Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.

4.2 The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.

4.3 Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.

4.4 Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.

4.5 There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.

4.6 The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.

4.7 All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.

4.8 Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on:

- holding the non-executive directors individually and collectively to account for the performance of the board of directors
- communicating with their member constituencies and the public and transmitting their views to the board of directors
- contributing to the development of the foundation trust's forward plans.

The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.

4.9 The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.

4.10 In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited

circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.

4.11 The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.

4.12 The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.

4.13 The annual report should describe the work of the nominations committee(s), including:

- the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline
- how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition
- the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives
- the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served
- the gender balance of senior management and their direct reports.

5. Development, information and support

5.1 All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.

5.2 The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.

5.3 To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.

5.4 The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.

5.5 The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.

5.6 A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.

5.7 The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.

5.8 The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.

5.9 The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.

5.10 The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.

5.11 The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a

timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.

5.12 The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.

5.13 Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.

5.14 Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.

5.15 Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.

5.16 Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.

Relevant statutory requirements

5.16 The board of directors must have regard to the council of governors' views on the NHS foundation trust's forward plan.

Insurance cover

5.17 NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.

Section D: Audit, risk and internal control

1. Principles

1.1 The board of directors should establish formal and transparent policies and procedures to ensure the independence and effectiveness of internal and external audit functions, and satisfy itself on the integrity of financial and narrative statements.

1.2 The board of directors should present a fair, balanced and understandable assessment of the trust's position and prospects.

1.3 The board of directors should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the trust is willing to take to achieve its long-term strategic objectives.

1.4 Organisations should also refer to Audit and assurance: a guide to governance for providers and commissioners.

2. Provisions

2.1 The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.

2.2 The main roles and responsibilities of the audit committee should include:

- monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them
- providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy

- reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself
- monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors
- reviewing and monitoring the external auditor's independence and objectivity
- reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements
- reporting to the board of directors on how it has discharged its responsibilities.

2.3 A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.

2.4 The annual report should include:

- the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed
- an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans
- an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.

2.5 Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.

2.6 The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.

2.7 The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.

2.8 The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.

2.9 In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.

Section E: Remuneration

1. Principles

1.1 Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, with the skills and experience required to lead the trust successfully, and collaborate effectively with system partners. Trusts should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements. Trusts should follow NHS England's Guidance on pay for very senior managers in NHS trusts and foundation trusts and NHS trusts should also follow Guidance on senior appointments in NHS trusts.

1.2 Any performance-related elements of executive directors' remuneration should be transparent, stretching and designed to promote the long-term sustainability of the NHS foundation trust. They should also take as a baseline for performance any required competencies specified in the job description for the post.

1.3 The remuneration committee should decide if a proportion of executive directors' remuneration should be linked to corporate and individual performance. The remuneration committee should judge where to position its NHS foundation trust relative to other NHS foundation trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration despite no corresponding improvement in performance.

1.4 The remuneration committee should also be sensitive to pay and employment conditions elsewhere in the NHS, especially when determining annual salary increases.

1.5 There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding their own remuneration.

1.6 The remuneration committee should take care to recognise and manage conflicts of interest when receiving views from executive directors or senior management, or consulting the chief executive about its proposals.[8]

1.7 The remuneration committee should also be responsible for appointing any independent consultants in respect of executive director remuneration.

1.8 Where executive directors or senior management are involved in advising or supporting the remuneration committee, care should be taken to recognise and avoid conflicts of interest.

1.9 NHS trusts should wait for notification and instruction from NHS England before implementing any cost of living increases.

2. Provisions

2.1 Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions.

- Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.
- Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate.
- Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary.
- For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors.

[8] For further information on conflicts of interest see Managing conflicts of interest in the NHS: Guidance for staff and organisations.

- The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.

2.2 Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.

2.3 Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.

2.4 The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.

2.5 Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.[9]

2.6 The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.

2.7 The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board

[9] Severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements.

should define senior management for this purpose and this should normally include the first layer of management below board level.

Relevant statutory requirements

2.8 The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.

Schedule A: Disclosure of corporate governance arrangements

Trusts are required to provide a specific set of disclosures to meet the requirement of the Code of Governance. These should be submitted as part of the annual report (as set out for foundation trusts in the NHS foundation trust annual reporting manual and for NHS trusts in DHSC group accounting manual.

The provisions listed below require a supporting explanation in a trust's annual report, even in the case that the trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

Provision	Requirement
Section A, 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.
Section A, 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.
Section A, 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based

Provision	Requirement
	partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.
Section B, 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school.

Provision	Requirement
	Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.
Section B, 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.
Section B, 2.19 (NHS foundation trusts only)	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.
Section C, 2.5 (NHS foundation trusts only)	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.
Section C, 2.8 (NHS foundation trusts only)	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.
Section C, 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.
Section C, 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the

Provision	Requirement
	annual report and a statement made about any connection it has with the trust or individual directors.
Section C, 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.
Section C, 5.15 (NHS foundation trusts only)	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.
Section D, 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed

Provision	Requirement
	• an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.
Section D, 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.
Section D, 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.
Section D, 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.
Section D, 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material

Provision	Requirement
	uncertainties regarding going concern. Trusts should refer to the *DHSC group accounting manual* and *NHS foundation trust annual reporting manual* which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.
Section E, 2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.

For the provisions listed below, **the basic 'comply or explain' requirement applies**. The disclosure in the annual report should therefore contain an explanation in each case where the trust has departed from the code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn. In providing an explanation for any variation from the code, the trust should aim to illustrate how its actual practices are consistent with the principles to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the trust expects to conform to the provision.

Provision	Requirement
Section A, 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and

Provision	Requirement
	intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.
Section A, 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.
Section A, 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.
Section A, 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.
Section A, 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their

Provision	Requirement
	areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.
Section A, 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.
Section A, 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.
Section A, 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.
Section B, 2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.
Section B, 2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.
Section B, 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive

Provision	Requirement
	directors in particular, and ensuring a constructive relationship between executive and non-executive directors.
Section B, 2.4 (NHS foundation trusts only)	A foundation trust chair is responsible for ensuring that the board and council work together effectively.
Section B, 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.
Section B, 2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.
Section B, 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.
Section B, 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.

Provision	Requirement
Section B, 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.
Section B, 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.
Section B, 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.
Section B, 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

Provision	Requirement
Section B, 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.
Section B, 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.
Section B, 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.
Section B, 2.18	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.
Section B, 2.19	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.
Section C, 2.1 (NHS foundation trusts only)	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and

Provision	Requirement
	opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.
Section C, 2.2 (NHS foundation trusts only)	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.
Section C, 2.3 (NHS foundation trusts only)	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.
Section C, 2.4 (NHS foundation trusts only)	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.
Section C, 2.5 (NHS foundation trusts only)	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors.

Provision	Requirement
Section C, 2.6 (NHS foundation trusts only)	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.
Section C, 2.7 (NHS foundation trusts only)	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.
Section C, 3.1 (NHS trusts only)	NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.
Section C, 4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for

Provision	Requirement
	ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.
Section C, 4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.
Section C, 4.4 (NHS foundation trusts only)	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.
Section C, 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.

Provision	Requirement
Section C, 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.
Section C, 4.8 (NHS foundation trusts only)	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors • communicating with their member constituencies and the public and transmitting their views to the board of directors • contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.
Section C, 4.10 (NHS foundation trusts only)	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its

Provision	Requirement
	enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.
Section C, 4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.
Section C, 4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.
Section C, 5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.
Section C, 5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training

Provision	Requirement
	including on equality diversity and inclusion, including unconscious bias.
Section C, 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.
Section C, 5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.
Section C, 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.
Section C, 5.6 (NHS foundation trusts only)	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.
Section C, 5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.
Section C, 5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive

Provision	Requirement
	directors; as well as facilitating appropriate induction and assisting with professional development as required.
Section C, 5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.
Section C, 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.
Section C, 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.

Provision	Requirement
Section C, 5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.
Section C, 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.
Section C, 5.16 (NHS foundation trusts only)	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.
Section C, 5.17	The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.
Section C, 2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board

Provision	Requirement
	of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.
Section C, 2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities.

Provision	Requirement
Section D, 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this.
Section D, 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.
Section E, 2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. • Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic

Provision	Requirement
	salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.
Section E, 2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.
Section E, 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.
Section E, 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.
Section E, 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.

The provisions listed below require information to be made **available to governors,** even in the case that the trust is compliant with the provision.

Provision	Requirement
Section C, 4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and

Provision	Requirement
(NHS foundation trusts only)	unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors.
Section C, 5.7 (NHS foundation trusts only)	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.

The provisions listed below require supporting information to be made **available to members**, even in the case that the trust is compliant with the provision.

Provision	Requirement
Section C, 2.9 (NHS foundation trusts only)	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.

The provisions listed below require information to be made **publicly available,** even in the case that the trust is compliant with the provision. This requirement can be met by making supporting information available on request

Provision	Requirement
Section B, 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.
Section C, 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.
Section E, 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.

Appendix A: Role of the trust secretary

The trust secretary has a significant role in the administration of corporate governance. In particular, the trust secretary would normally be expected to:

- ensure good information flows to the board of directors and its committees and between senior management, non-executive directors and the governors where relevant
- ensure that procedures of both the board of directors and the council of governors are complied with
- advise the board of directors and the council of governors (through the chair) on all governance matters
- be available to give advice and support to individual directors, particularly in relation to the induction of new directors and assistance with professional development.

Appendix B: Council of governors and role of the nominated lead governor

1. Principles

1.1 The powers and obligations of governors of NHS foundation trusts are set out in the 2006 Act, as amended by the 2012 Act. This appendix describes the relevant areas of the governors' role. In addition, *Your statutory duties: A reference guide for NHS foundation trust governors* (August 2013) examines how governors can deliver their duties and an addendum to this document, System working and collaboration: The role of foundation trust councils of governors (October 2022) clarifies how governors can continue to perform their duties within the context of system working.

1.2 The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.

1.3 The council of governors is responsible for representing the interests of NHS foundation trust members, the public at large, and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.

1.4 To discharge their duty to represent the public, councils of governors are required to take account of the interests of the public at large. This includes the population of the local system of which the trust is part and the whole population of England as served by the wider NHS.

1.5 Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members, the public at large, and the stakeholder organisations that either elected or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.

1.6 Governors should discuss and agree with the board of directors how they will undertake these and any additional roles, giving due consideration to the circumstances of the NHS foundation trust and the needs of the system and wider NHS and emerging best practice.

1.7 Governors should work closely with the board of directors and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The governors must be consulted on the development of forward plans for the trust and any significant changes to the delivery of the trust's business plan.

1.8 Governors should use their voting rights to hold the non-executive directors individually and collectively to account and act in the best interest of patients, members and the public at large. If the council of governors does withhold consent for a major decision, it must justify its reasons to the chair and the other non-executive directors, bearing in mind that its decision is likely to have a range of consequences for the NHS foundation trust, the system and the wider NHS. The council of governors should take care to ensure that reasons are considered, factual and within the spirit of the Nolan principles.

2. Provisions

2.1 The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should make every effort to attend these meetings. The NHS foundation trust should take appropriate steps to facilitate attendance.

2.2 The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition and procedures of the council of governors should be reviewed regularly.

2.3 The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record

should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.

2.4 The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.

2.5 The chair is responsible for leadership of both the board of directors and the council of governors but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive and other executives and non-executives, as appropriate, to their meetings. In these meetings other members of the council of governors may ask the chair or their deputy, or any other relevant director present at the meeting, questions about the affairs of the NHS foundation trust.

2.6 The council of governors should establish a policy for engagement with the board of directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners. The council of governors should input to the board's appointment of a senior independent director.

2.7 The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.

2.8 The council of governors should only exercise its power to remove the chair or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chair with the senior independent director in the first instance.

2.9 The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, eg clinical statistical data and operational data.

2.10 The chair (and the senior independent director and other directors as appropriate) should maintain regular contact with the governors to understand their issues and concerns.

2.11 Governors should seek the views of members and the public on material issues or changes being discussed by the trust. Governors should provide information and feedback to members and the public at large regarding the trust, its vision, performance and material strategic proposals made by the trust board.

2.12 It is also incumbent on the board of directors to ensure governors have the mechanisms in place to secure and report on feedback that enables them to fulfil their duty to represent the interests of members and the public at large.

2.13 The chair should ensure that the views of governors and members are communicated to the board as a whole. The chair should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested to do so by governors. The senior independent director should attend sufficient meetings with governors to hear their views and develop a balanced understanding of their issues and concerns.

2.14 The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.

2.15 The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.

3. Additional statutory requirements

3.1 The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.

3.2 The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the NHS foundation trust annual reporting manual:

(a) the annual accounts
(b) any report of the auditor on them
(c) the annual report.

3.3 The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, eg for data protection or commercial reasons. Governors should respect the confidentiality of these documents.

3.4 The council of governors may require one or more of the directors to attend a meeting to obtain information about the trust's performance of its functions or the directors' performance of their duties, and to help the council of governors decide whether to propose a vote on the trust's or directors' performance.

3.5 Governors should use their rights and voting powers from the 2012 Act to represent the interests of members and the public at large on major decisions taken by the board of directors. These voting powers require:

- More than half the members of the board of directors who vote and more than half the members of the council of governors who vote to approve a change to the constitution of the NHS foundation trust.
- More than half the governors who vote to approve a significant transaction.
- More than half the governors to approve an application by a trust for a merger, acquisition, separation or dissolution.
- More than half the governors who vote to approve any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more. For example, governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the trust's total income.
- Governors to determine together whether the trust's non-NHS work will significantly interfere with the trust's principal purpose, which is to provide

goods and services for the health service in England, or its ability to perform its other functions.

3.6 NHS foundation trusts are permitted to decide themselves what constitutes a 'significant transaction' and may choose to set out the definition(s) in the trust's constitution. Alternatively, with the agreement of the governors, trusts may choose not to give a definition, but this would need to be stated in the constitution.

3.7 In taking decisions on significant transactions, mergers, acquisitions, separations or dissolutions, governors need to be assured that the process undertaken by the board was appropriate, and that the interests of the public at large were considered. A council may disagree with the merits of a particular decision of the board on a transaction, but still give its consent because due diligence has been followed and assurance received. To withhold its consent, the council of governors would need to provide evidence that due diligence was not undertaken.

3.8 The external auditors of a foundation trust must be appointed or removed by the council of governors at a general meeting of the council.

4. Lead governor

4.1 The lead governor has a role in facilitating direct communication between NHS England and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chair or the trust secretary, if one is appointed.

4.2 It is not anticipated that there will be regular direct contact between NHS England and the council of governors in the ordinary course of business. Where this is necessary, it is important that it happens quickly and in an effective manner. To this end, a lead governor should be nominated and contact details provided to NHS England, and then updated as required. Any of the governors may be the lead governor.

4.3 The main circumstances where NHS England will contact a lead governor are where we have concerns about the board leadership provided to an NHS foundation trust, and those concerns may in time lead to our use of our formal powers to remove the chair or non-executive directors. The council of governors appoints the chair and non-executive directors, and it will usually be the case that

we will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the trust, and to rectify successfully any issues, and also for the governors to understand our concerns.

4.4 NHS England does not, however, envisage direct communication with the governors until such time as there is a real risk that an NHS foundation trust may be in breach of its licence. Once there is a risk that this may be the case, and the likely issue is one of board leadership, we will often wish to have direct contact with the NHS foundation trust's governors, but quickly and through one established point of contact, the trust's nominated lead governor. The lead governor should take steps to understand our role, the available guidance and the basis on which we may take regulatory action. The lead governor will then be able to communicate more widely with other governors. Similarly, where individual governors wish to contact us, this would be expected to be through the lead governor.

4.5 The other circumstance where NHS England may wish to contact a lead governor is where, as the regulator, we have been made aware that the process for the appointment of the chair or other members of the board, or elections for governors or other material decisions, may not have complied with the NHS foundation trust's constitution, or alternatively, while complying with the trust's constitution, may be inappropriate. In such circumstances, where the chair, other members of the board of directors or the trust secretary may have been involved in the process by which these appointments or other decisions were made, a lead governor may provide us with a point of contact.

Appendix C: The code and other regulatory requirements

Although compliance with the provisions in this guide is not necessarily mandatory, some of the provisions in this document are statutory requirements because they are enshrined elsewhere in legislation.

In the first instance, boards, directors and, for NHS foundation trusts, governors, should ensure that they are meeting the governance requirements for NHS foundation trusts as set out in the 2006 Act (as amended by the 2012 Act) and reflected in the NHS provider licence. This code sits alongside a number of other NHS England reporting requirements that relate to governance.

NHS England uses reasonable evidence, from disclosures made to us by NHS foundation trusts and NHS trusts, to determine if there is a risk of a breach of the licence condition 'Foundation Trust Condition 4: Governance in the NHS foundation trust' and to make a decision regarding intervention.

The information we receive includes: a **forward looking** disclosure on corporate governance (the corporate governance statement); a **backward looking** disclosure on corporate governance (the code of governance for NHS provider trusts); and a **backward looking statement on internal control, risk and quality governance** (the annual governance statement).

For clarity, here we have provided a brief explanation of how the different requirements sit together and the purpose of each.

- **Corporate governance statement – in the annual plan**

  To comply with the provider licence, the Annual Plan also includes a requirement for a corporate governance statement. This is a mandatory requirement. This is a forward looking statement of expectations regarding corporate governance arrangements over the next 12 months and trusts should be aware that **"issues not identified and subsequently arising can be used as evidence of self-certification failure"**. The requirement for the completion of the corporate governance statement is separate to the disclosure requirements of this code.

- **The code disclosure requirements – listed in this document and the NHS foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual**

  This document is designed to set out **standards of best practice for corporate governance.** It is not mandatory to comply with this guidance, however, the NHS foundation trust annual reporting manual and Department of Health and Social Care group accounting manual do require trusts to make some specific disclosures on a 'comply or explain' basis regarding the provisions listed in this document. (A detailed list of the disclosures required is provided in Schedule A of this.) This is a backward looking statement which should be submitted with the annual report.

- **Annual governance statement – in the NHS foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual**

  In addition to listing the code disclosure requirements, the NHS Foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual also require an annual governance statement. The annual governance statement is a backward looking statement which captures information on risk management and internal control, and includes some specific requirements on quality governance.

  Completion of the Annual governance statement is a **mandatory requirement**. The annual governance statement does not relate to this code.

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This publication can be made available in a number of alternative formats on request.

Name of the Meeting	**Trust Board – Public**
Date of the Meeting	6th December 2022
Director Lead	Christine Brereton, Director of People
Contact Officer/Author	Karl Portz, Equality and Diversity Lead
Title of the Report	**Equality Diversity and Inclusion Strategy and Equality Objectives**
Purpose of the Report and Executive Summary (to include recommendations)	The EDI Strategy and Equality Objectives are due to be refreshed on 31st December 2022. Work has already begun to support the refresh. However, given recent changes and development in this area, it is now proposed and this report provides the rationale, to extend this refresh date by six months. The EDI Strategy and Equality Objectives will continue to be reported through to the Workforce Committee. The Trust Board is recommended to approve the extension of the current EDI Strategy and Equality Objectives for six months, until 30 June 2023.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ✓ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A at this stage
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	An extension to the existing review dates to allow for a more inclusive approach to future development

Recommended action(s) Required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

***Board Assurance Framework (BAF) Descriptions:**

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

1.0 Purpose of the Report

This paper is to provide the Trust Board with an update on the Northern Lincolnshire and Goole Foundation Trust Equality, Diversity and Inclusion Strategy and Equality Objectives. It recommends that the current refresh date is extended by six months and it also provides the rationale for this change.

2.0 Background

The current Equality and Diversity Strategy which contains our Equality Objectives (appendix 1) are due to be refreshed by 31st December 2022. Both the Strategy and our Equality Objectives are still fit for purpose and meet our Public Sector Equality Duty (PSED) requirements. Our PSED general duties are to eliminate unlawful discrimination, advance equality of opportunity and to foster good relation between all protected characteristics. It is recommended that the Trust extend the deadline for this review given the rational below. The current associated strategy and supporting objectives continue to meet our legal or contractual equality reporting requirements whilst a more inclusive review takes place.

3.0 Rational

The rationale for this this change is:

- Explore a singular approach to the development of an Equality, Diversity and Inclusion Strategy between HUTH and NLaG given recent and planned changes.
- Explore the benefits of jointly addressing health inequalities across the Hull, East Riding, North Lincolnshire and North East Lincolnshire footprint.
- Explore specifically joint impacts on social deprivation and social mobility, both of which are known to impact the footprint significantly
- Allow time for the completion of the national review of EDI strategy. This will enable both organisations to adopt any emerging EDI principals.

4.0 Recommendation

To extend the current Equality, Diversity and Inclusion Strategy, and our Equality Objectives for six months until 30 June 2023.

Appendix 1

Equality Objectives (2018 – 2022)

Implement the NHS Equality Delivery System 2 (EDS) within NLaG.

A national tool designed for the NHS and supported by the NHS Chief Executive, Simon Stevens and the NHS Equality Council. This system provides an overarching approach to enable the monitoring of equality and fairness across service delivery, workforce and leadership issues for all equality groups (protected characteristics).
Collect, analyse, assess, record and act on patient data that recognises all relevant protected characteristics under the Equality Act 2010.

By ensuring that NLaG with an accurate patient baseline, we will be able to better inform the development, design and delivery of future service provision. In addition, this will enable NLaG to develop an alert and flagging system to ensure we support patients with specifics requirements more effectively.

Ensure that all staff have the skills and knowledge to treat patients, carers and colleagues with dignity and respect.

To develop and deliver a blended approach to learning covering equality, diversity, dignity and respect, for all staff across NLaG. To support this, ensure that all policies, procedures, functions and services have a robust equality impact assessment completed.

Report and deliver against the Workforce Race Equality Standard and its Action Plan for improvement.

Ensure that we develop and enhance our approach to recruitment, selection and promotion to positively attract, retain and support the progression of diverse individuals within the workforce. This will be underpinned by the effective analysis of workforce data to recognise all relevant protected characteristics defined within the Act and to compare and assess this relative to regional and sub-regional population and census data.

Report and deliver against the Workforce Disability Equality Standard and its Action Plan for improvement.

Ensure that we develop and enhance our approach to recruitment, selection and promotion to positively attract, retain and support the progression of diverse individuals within the workforce. This will be underpinned by the effective analysis of workforce data to recognise all relevant protected characteristics defined within the Act and to compare and assess this relative to regional and sub-regional population and census data.

Develop and Grow Staff Equality Support Networks.

To facilitate the establishment and self-management of staff support networks for minority groups within workforce of the Trust and to provide opportunities for people who consider they are part of one of these groups to share, learn and contribute to improving the Trust. This will particularly seek the perspectives from currently underrepresented groups within the workforce of the Trust, including but not confined to: staff that consider they have a disability or long term condition, black & minority ethnic staff (BME) and lesbian, gay, bisexual and transgender staff (LGBT).

NLG(22)215

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6th December 2022	
Director Lead	Dr Kate Wood, Medical Director	
Contact Officer/Author	Gary Burroughs	
Title of the Report	**Smoke-free pledge**	
Purpose of the Report and Executive Summary (to include recommendations)	To draw the Boards attention to the NHS Smoke-free Pledge, and our progress in the actions to enable recommending us to sign up to this as an organisation. This needs approval by the Trust Board as the signatory includes the Trust Chair.	
Background Information and/or Supporting Document(s) (if applicable)	The NHS Smoke free Pledge Specific updates on actions by the Trust to show we are fulfilling the appropriate actions	
Prior Approval Process	✓ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ✓ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ☐ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Not applicable	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Specific focus for improving health inequalities	
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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The NHS Smokefree Pledge

As local health leaders we acknowledge that:

- Smoking is the leading cause of premature death, disease, and disability in our communities
- Smoking places a significant additional burden on health and social care services and undermines the future sustainability of the NHS
- Healthcare professionals have a key role to play in motivating smokers to try to quit and offering them further support to quit successfully
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities
- Smoking is an addiction starting in childhood with two thirds of smokers starting before the age of 18
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the tens of thousands of people its products kill in England every year

We welcome:

- The Government's ambition to make England smokefree by 2030 and tackle health inequalities in smoking prevalence
- The NHS Long Term Plan's commitment for all smokers in hospital, pregnant women, and long-term users of mental health services to be offered NHS funded tobacco dependence treatment by 2023-24
- NICE public health guidance on tobacco

In support of a smokefree future, _____ commits from _____to:

- Treat tobacco dependency among patients and staff who smoke in line with commitments in the NHS Long Term Plan and Tobacco Control Plan for England
- Ensure that smokers within the NHS have access to the medication they need to quit in line with NICE guidance on smoking in secondary care
- Create environments that support quitting through implementing smokefree policies as recommended by NICE
- Deliver consistent messages about harms from smoking and the opportunities and support available to quit in line with NICE guidance
- Actively work with local authorities and other stakeholders to reduce smoking prevalence and health inequalities
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Support Government action at national level
- Publicise this commitment to reducing smoking in our communities and join the Smokefree Action Coalition (SFAC), the alliance of organisations working to reduce the harm caused by tobacco

Signed by:

Chair

Chief Executive

Medical/Clinical Director

Endorsed by:

Amanda Pritchard, Chief Executive, NHS England

Prof Dame Helen Stokes-Lampard, Chair, Academy of Medical Royal Colleges

Prof Jim McManus, President, Association of Directors of Public Health

Prof Maggie Rae, President, Faculty of Public Health

Dr David Strain, Chair, BMA Board of Science

Gill Walton, Chief Executive, Royal College of Midwives

NHS England | Academy of Medical Royal Colleges | Association of Directors of Public Health | Faculty of Public Health | BMA | Royal College of Midwives

9th March 2022

1. **Treat tobacco dependency among patients and staff who smoke in line with commitments in the NHS Long-Term Plan and Tobacco Control Plan for England.** Trust Patients - The Tobacco Dependency Treatment Service commenced in August 2022 and has just finished its pilot on 7 key wards (Stage 1). From November 2022 to January 2023 the service is being rolled out to all Trust wards/Units and will then be available to all patients. We are currently on track. The NHSE have identified Humber & North Yorkshire (H&NY) Region as one of the most progressive in England, and H&NY have recognised our Trust as the most progressive in the region.
   Trust Staff - The Enhanced Staff Offer has been operational since the start of October 2022 on the Grimsby and Goole sites, and will be rolled out in Scunthorpe from the 28th November 2022.
2. **Ensure that smokers within the NHS have access to the medication they need to quit in line with NICE guidance on smoking in secondary care.** All medicines protocols were completed and have been tested during the pilot. (Stage 1). Everything is in place for the roll out across the Trust. This includes Vapes where patients can access these also from the Tobacco Dependency Treatment Team to support patients to quit.
3. **Create environments that support quitting through implementing Smokefree Policies as recommended by NICE.** The Trust has signed up to the ICB endorsed SF policy that recognises that truly Smokefree environments are not created by forcing smokers to the boundaries of the estate, rather that they are fostered through positive engagement with care services and the offer of support. The Trust is dedicated to ensuring that people have the best opportunity to benefit from care and recover well and see the Smokefree policy as being central to that. As a Trust, we recognise that tobacco dependency is a chronic, relapsing, and treatable condition, which the NHS has the same responsibility to treat as it does other similar medical conditions. We also understand that the implementation of this Policy must be supportive of people who smoke, those people who do not smoke, and those people who wish to either reduce the amount that they are smoking or stop smoking entirely. In accordance with this position our Policy has been developed to support our workforce, patients, and visitors in achieving an entirely Smokefree estate. This is supported by the Trust's Tobacco Dependency Treatment Service offer for patients, employees and visitors, uniform and human resource and policies. The Policy has just gone through a consultation period with all relevant staff/stakeholders and will be forwarded to the Trust Management Team in November 2022 for sign off. (Pending amendments)
4. **Deliver consistent messages about harms from smoking and the opportunities and support available to quit in line with NICE guidance.** The Trust is working with Humber and North Yorkshire Health and Care Partnership to develop the Quit Together brand. Quit Together provides clear and consistent messaging about tobacco use and tobacco dependency treatment. The Trust's Tobacco Dependency Treatment Team are working with staff in the hospital to deliver evidence-based approaches to conversations around tobacco dependence, in line with best practice and NICE guidance. Together we will build a shared understanding of the importance of one message, many voices and work towards all staff delivering very brief advice to people who smoke. If you smoke, the best thing you can do for your health is to stop. The best way of doing that is with medication and support and that is available here for free. I can make that referral for you now!
5. **Actively work with Local Authorities and other stakeholders to reduce smoking prevalence and health Inequalities.** The Trust is a partner with the ICB and other Trusts in ensuring that the benefits of delivery of the Long-Term Plan for tobacco do not start with admission and stop on discharge. The Trust has fostered excellent working relationships with all local authorities and their stop smoking services to ensure that people receive ongoing care on discharge, delivered in a timely manner. We are also working to expand the reach of the programme into primary care settings, so that all people with planned admissions to hospital are aware that the Trust is Smokefree and have a plan in place to support them on admission. The Trust has engaged with NHSE and Local Authority partners in offering an enhanced stop smoking service to staff, which runs alongside the LTP offer allowing staff with the opportunity to receive support whilst at work. The Trust is a founding member of the ICB Tobacco Programme Board and is actively involved in creating and supporting opportunities to work with partners in wider elements of tobacco control, such as communication of risk and supporting outreach opportunities such as lung health checks. This will be further enhanced via the Trust Health Inequalities Steering Group.
6. **Protect tobacco control work from the commercial and vested interests of the tobacco industry.** The Trust is committed to upholding Article 5.3 of the WHO Framework Convention of Tobacco Control and does not allow the tobacco industry to influence policy within the Trust.
7. **Support Government action at national level.** The Trust's wholesale engagement with the Long-Term Plan is our commitment to supporting the Government's ambition for a Smokefree 2030. The Trust also supports the recommendations made in the Khan Review and recognises the need for a new Tobacco Control Plan for England and the benefits that this can bring to the people of Northern Lincolnshire and Goole.
8. **Publicise this commitment to reducing smoking in our communities and join the Smokefree Action Coalition (SFAC), the alliance of organisations working to reduce the harm caused by tobacco.** The Trust is a signatory to the Smokefree Pledge and the members of our tobacco dependency team are all signed up to the Smokefree Action Coalition.

Northern Lincolnshire and Goole NHS Foundation Trust

Agenda Number: NLG(22)234

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6th December 2022	
Director Lead	Gill Ponder, Non-Executive Director / Chair of F&P Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance and Performance Committee – Minutes of the meetings held on 21st September 2022 and 19th October 2022.**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Finance and Performance Committee Meeting held on 21st September 2022 and approved on 19th October 2022, Meeting held on 19th October 2022 and approved on 23rd November 2022.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Finance and Performance Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ☒ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

MINUTES

FINANCE & PERFORMANCE COMMITTEE

Meeting: Wednesday 21 September 2022, Microsoft Teams

Present:	Gill Ponder	Non Executive Director (Chair)
	Fiona Osborne	Non Executive Director
	Ian Reekie	Lead Governor
	Brian Shipley	Deputy Director of Finance
	Shaun Stacey	Chief Operating Officer
	Richard Peasgood	Executive Assistant to COO
	Jug Johal	Director of Estates & Facilities
In Attendance:	Jennifer Granger (for item 6.1)	Head of Compliance & Assurance
	Keith Fowler (for items 8.1 and 8.2)	NHS Trust Sustainability Lead
	Ab Abdi	Deputy Chief Operating Officer
	Jackie France (for items 9.3 and 9.4)	Associate Director of Patient Services
	Rosie Osborn (Minute Taker)	Directorate Secretary

ITEM

Gill Ponder welcomed everyone to the Finance and Performance Committee which was held via Microsoft Teams.

1. Apologies

Apologies for absence were received from Lee Bond and Manesh Singh.

2. Quoracy

It was noted that the Committee was quorate.

3. Declarations of Interest

There were no Declarations of Interest declared.

4. To Approve the Minutes of the Meeting held on 24 August 2022

The minutes were reviewed with the following amendments requested:

- Page 3, item 7.3 – to insert 'Fiona Osborne stated this was not her recollection of the meeting'.
- Page 1 – The word 'discharge' in Anne Marie's job title is spelt incorrectly.
- Page 7 – It should read that it is still awaiting DOH approval and not NHSE approval.
- Page 8 – Gill requested the high scoring risks relevant to that month's deep dive only.

Subject to these amendments the minutes were approved.

5. Matters Arising / Action Log

5.1 The action log was reviewed and updated as follows:

5.2 F&P Committee Workplan

The workplan was reviewed and there were no issues raised by the Committee.

5.3 Terms of Reference

The Terms of Reference were approved by the Committee.

5.4 Action Plan

The Committee reviewed progress with the Action Plan produced following the Committee's Self-Assessment earlier in the year.

The Action Plan would be updated monthly and reviewed at each meeting until all actions had been completed.

5.5 Medical Gas Pipeline System (MGPS) letter

Within this letter, there were specific actions assigned to the Finance and Peformance Committee which were discussed. Jug Johal proposed that this should be linked to the work plan item on Medical Gases in order to provide assurance. Gill Ponder queried how many times the Medical Gas audit was carried out and Jug Johal explained that it was carried out once a year. Gill queried whether this was sufficient to ensure routinely testing and validation to which Jug responded the annual audit from the AE was only carried out once a year in order to provide the information. Gill reiterated that the Committee needed to srutinise the operational plan to use the Medical gases and ensure the effectiveness of the delivery against the plan, as well as ensuring that it was routinely tested and validated.

Shaun Stacey advised this could be linked to the review of the annual Winter Plan and the bed review produced every 2 years. Shaun suggested that the Medical Gas Committee provide a report twice a year to the Finance and Performance Committee with a high level review of how Medical Gases were being utilised in the organisation, clinically and operationally.

Fiona Osborne raised that they do have a formal SI process and somehow this letter had been produced outside the SI process, but having the letter would enable these requirements to be addressed.

Gill Ponder summarised and confirmed that they would continue with the annual Medical Gas report from Estates and Facilities and the twice yearly reports from the Medical Gas Committee. It was agreed that it would be valuable for the Chief Pharmacist to attend the meeting to present those reports.

ACTION: Jug Johal is to bring the report from the SI to next month's meeting

Jug Johal reiterated that they need to be careful with what was focused on as this was not an oxygen usage issue, it was about the capacity of the system. He also reminded the Committee that the infrastructure at Scunthorpe hospital had not yet been upgraded, so there remained a risk there until that was done.

ACTION: Richard Peasgood to add the new reports from the Medical Gas Committee to the Workplan for the Finance and Performance Committee

6. Presentations for Assurance

6.1 CQC Progress Report – *Jennifer Granger joined the meeting for this item.*

Gill Ponder welcomed Jennifer Granger to the meeting. Jennifer Granger took the previously circulated CQC Progress report as read. Jennifer explained that the overall Trust position was

that 85% of the 145 actions were currently green or blue. Within the last month 5 actions were closed and sent to the CQC with 1 being relevant to this Committee. The Finance and Performance Committee now had 27 actions of which none were marked as red, 6 were amber, 3 were green and 16 were blue and closed.

Gill Ponder queried that on page 11 in section 43 there were some actions listed that did not have a Committee named against them and asked Jennifer if those actions were aligned to this Committee. and if there were any of those actions that the Committee should be aware of.

Jennifer would add a column to the report to ensure it explained which Committee those actions were aligned to. Jennifer would highlight if any were outstanding for this Committee for next month's meeting.

ACTION: Jennifer Granger to add an extra column into the report to highlight which actions were aligned to which Committee for next month's meeting.

Fiona asked about the 'must do' action on page 7 and enquired what was actually required from them to enable this to be submitted and for the action to turn blue. Jennifer explained they were looking at drafting an assurance paper in order to identify any gaps to address.

ACTION: Jennifer Granger would provide a template for next month's meeting, explaining what they required to ensure they were being consistent with their approach.

7. Review of NLaG Monthly Financial Position

7.1 Finance Report M05

Brian Shipley presented the finance report for M05 and did raise that month 5 saw a slight stablisation, however this was mainly driven through underspends in clinical supplies and insourced activity linked to low activity delivery in month. He went on to highlight key areas to note:

- The Trust had £0.15m deficit in August which was £0.05m worse than plan
- The Trust has a £2.59m year-to-date deficit which was £3.73m worse than plan
- Income was £0.01m below plan in month
- Clinical income was £0.19m below plan due to low high-cost drug spend (£0.31m)
- Pay was £0.94m overspent in month
- Medical staff was £1.11m overspent with increased non-elective and emergency activity driving overspends across Medicine acute care and ED.
- Nursing was £0.09m overspent in month.
- Other pay was £0.08m underspent in month
- Non pay was £0.83m overspent in month
- Post EBITDA items were £0.11m underspent in month
- COVID 19 expenditure was £2.77m year-to-date

Brian Shipley went on to draw the Committee's attention to the fact that the Trust was currently £3.73m behind plan at the end of month 5. If no mitigating actions were taken, initial forecast assessments project a potential £8.8m end of year deficit risk.

Brian Shipley highlighted to the Committee that there was a new table on page 8 of the report and explained that, as part of the planning guidance, agency ceilings were being re-introduced. The Trust was currently forecasting to be £3.0m adrift of the ceiling.

Regarding CIP, at the end of August, the Trust had delivered £4,293k against its core year to date plan of £4,542k, an under delivery of £249k. With a year to date over delivery of £281k against its Covid reduction targets, the Trust was over delivering by £33k against its £8,875k total programme year to date.

Fiona Osborne commented the overall forecast deficit was a multiple of the current deficit and asked if this was a coincidence or if the forecast was a run rate review analysing specific challenges. Brian Shipley stated that the forecast had not been generated via a simple straightline process but incorporated seasonal variation and included known deviations to the current run rate. Next month's report would incorporate the potential mitigating actions that needed to be taken and would go into more detail.

Fiona Osborne asked how many of the CIP plans were not allocated to a specific scheme currently and Brian Shipley agreed to provide this information within the meeting once he had retrieved it from the embedded report. He provided the information by emailing the embedded report that Fiona Osborne and Gill Ponder had been unable to open to them during the meeting.

Gill asked whether the proposed government support for increasing energy costs would reduce the level of risk built in to the forecast outcome. Brian explained that it would not change because the Trust were in contract until the end of March 2023, so would not see the increases until then. Gill also asked about productivity and the effect it was having on finances and whether there was anything more that could be done to improve productivity and to increase activity levels. Shaun Stacey explained there was a productivity improvement programme which focussed in detail on behaviour and delivery.

Gill highlighted that on page 11 of the Finance report, Medicine stood out on nursing spend and regarding medical staffing there hds been a large increase in unsocial rates that year and she queried the reason for this rise. Shaun Stacey explained that the principal of this with the medical staffing was that there were many vacancies within Medicine that they were trying to fill but the overseas process was moving slowly. Recruitment and Covid absences were driving this problem.

Gill asked from page 13 of the report what the meaning of over established and unfunded cost pressures was, to which Brian explained that it was mainly within Medicine and it was an additional resource that was required for extended SDEC opening hours and he confirmed that was still a temporary staffing cost.

Gill expressed that on page 16 it referenced a workforce group being on hold and she asked if there was a need to refer this to the Workforce Committee. Brian explained that it alluded to a slightly separate meeting which was more focused around the CIP element.

ACTION: Brian to confirm if there was anything that the Committee could do to help with this

Gill asked a question on behalf of Maneesh Singh who could not attend the meeting that day and asked if there was a way higher rates could be paid to current staff in order to utilise bank staff rather than more costly agency rates, in the hope that it would improve morale and have an overall positive effect on the departments and finances. Brian explained that had been carried out in various ways where internal bank rates had been increased, but from an overall financial perspective the increase of paying everybody more did not create a bigger supply of staff to enable reduced agency spending. It was worse overall because the Trust were paying more for labour without it leading to the expected cost reductions.

Brian confirmed that the underlying deficit had worsened to £31.85m against plan. There was a risk that the deficit would worsen if the Trust did not achieve its financial plan for the current year.

Shaun expressed concerns regarding the time taken to be able to employ overseas nurses and doctors due to the issues with receiving passports and visas for the United Kingdom.

7.2 Recovery Support Programme for finance (RSPf) – Letter for information

Brian took the Recovery Support Programme for finance (RSPf) as read. There were no questions, as the letter was self-explanatory.

7.3 Cost Efficiency

- Reference Costs Submission

The paper was an update paper to explain the cost collection for 2021/22 was submitted on time and any errors were flagged. A re-submission was made on 6th September 2022 due to resolving a validation problem.

Fiona Osborne asked, other than the content in the main report, was there anything within the annexes that had not been presented to the Committee previously. Brian explained that those reports had already been seen and reviewed previously so the information was accurate.

7.4 Business Case Assurance

- Progress Updates

There were no items for discussion under that agenda item. .

7.5 Assurance Confirmation

Gill summarised from an assurance perspective that it was the risk to the financial year outturn and the work that was taking place to try to mitigate the position that should be included in the Highlight Report to the Board.

8. Estates & Facilities (SO1.4) – *Keith Fowler joined for this item.*

8.1 Green Plan
8.2 Sustainability

The Greener NHS's 'Delivering a net zero National Health Service report highlights that left unabated, climate change would have devastating effects on human health and subsequently the NHS. The report set out the trajectories and actions required for the NHS to achieve its net zero targets. The 2021/22 NHS Standard Contract set out the requirement for Trusts to develop a Green Plan to detail their approaches to reducing their emissions. Trusts are now required to submit quarterly data returns to the Greener NHS programme who would review the sustainability performance of the Trust against a range of themes.

Keith Fowler presented the presentation to the Committee and he went on to highlight key areas to note:

Targets

- Net zero by 2040 for our direct Carbon Footprint
- Net zero by 2045 for Carbon Footprint Plus
- Reduce carbon, waste and water
- Improve air quality
- Reduce the use of avoidable single-use plastics
- Protect our services from climate change
- Encourage sustainable behaviours

Next Steps

- Allocate an annual sustainability budget
- Employ a Band 4 data support officer and build a dedicated sustainability team
- Establish annual reporting requirements against KPIs
- Progress delivery of the action plan laid out within the Green Plan

- Review Greener NHS quarterly data submission progress and target areas for improvement

Keith Fowler also went through the Green Travel Plan in detail and explained that a Green Travel Plan was a document that aimed to assess the current travel trends within an organisation and aimed to encourage a behavioural shift which would lead to the use of more sustainable modes of travel to and from the site. In 2019, transport became the largest contributor to UK domestic greenhouse gas emissions responsible for a total of 27%.
The NHS was responsible for 9.5 billion road miles each year which equated to 3.5% of all road travel in England. Travel was also responsible for 14% of the NHS' total emissions.

Keith Fowler highlighted that the Trust had a route to net zero travel that was planned for the next 20 years to take place over time. It was noted that currently we were not on track to meet our targets tied to reducing our travel and transport carbon footprint. He went on o highlight the targets and next steps of the Green Travel Plan:

Targets

- Decrease single occupancy vehicle use
- Convert fleet and pool vehicles to fully electric
- Increase percentage of active travel to site
- Encourage uptake of electric vehicles
- Increase percentage of staff car sharing to commute to site
- Encourage uptake of public transport

Next Steps

- Increase current travel budget
- Undertake annual staff/visitor travel surveys
- Undertake green fleet reviews to identify immediate areas of action
- Continue to improve active travel facilities across all sites
- Improve EV charging infrastructure at all sites
- Work with the local council and additional partners to improve active travel options (e.g. green routes between major sites)

Jug Johal thanked Keith Fowler for presenting the above information and wanted to highlight that they are one of the leaders nationally for the work that they have carried out for Sustainability which is a really positive aspect.

Fiona Osborne asked, regarding the statistics around the travel emissions if there was an anticipation for this current year and if they were pre-empting an increase for business travel given lockdown restrictions had been lifted. Keith Fowler believed it was unlikely and felt staff had adapted how they travelled to work since the pandemic, whilst other services like additional shuttle services had been put on at different times of the day.

Gill asked if either Keith Fowler or Jug Johal had faced any resistance or problems regarding the rise in electric vehicles (EVs) with regards to charging points and access and asked if there was resistance, how would they tackle that?. Keith explained that within the next year they were anticipating to see the volume of fleet leased electric/ hybrid vehicles come out of term, go through the auction process and then hit the second hand market. Keith believed that the flood of EVs and hybrid vehicles would be a huge boost to supply which should lead to a cost reductions down into the second-hand market which would make it more accessible to staff.

8.3 Assurance Confirmation

Gill Ponder expressed from an assurance perspective that the Committee were fully assured in this area and could confidently report that to the Board.

Jug Johal summarised by re-iterating that the documents had been brought to the Committee for approval and he has requested that a recommendation to the Trust Board was made to approve the documents. The Committe agreed that they could recommend Board approval.

9. Review of NLAG Monthly Performance and Activity Delivery (IPR) (SO1.2/ SO1.6)

9.1 Unplanned Care

- Urgent Care Performance
- Ambulance Handovers
- Patient Flow in Discharge to Assess Performance

Shaun Stacey took the circulated report as read and stated that he would provide an update on Unplanned Care and then will provide a brief introduction on Planned Care but Ab Abdi and Jackie France would provide a further update in detail. Shaun Stacey went on to highlight the following key issues from the report:

- ED continues to be challenged
- There is continued poor flow out of department resulting in poor ambulance handover and 12 hour DTAs
- Inability to operate UCS and SDEC 24/7 is having an impact
- UCS and SDEC still performing well
- Continue to have good average LOS for elective and non-elective
- Patient flow was a large focus and further review was happening on why there were flow problems
- Continued vacancy level in nursing in Medicine
- 60 unfunded beds
- Bed occupancy at c90% creating flow issues

Highlights

- Percentage of patients discharged same day as admission (excluding daycase)
- Inpatient Elective average length of stay
- Inpatient Non-Elective average length of stay

Lowlights

- Diagnostic Procedures Waiting Times – 6 week breach rate (DM01)
- Outpatient Overdue Follow Up (Non RTT)
- Ambulance Handover Delays 60+ Minutes

Fiona Osborne asked what kind of impact was Shaun Stacey expecting the new Emergency Departments (EDs) to have and when he was hoping to see an improvement. Shaun Stacey explained that you can not relate improvement in performance to the opening of a department; the flow problem would not change however it would increase cubicle capacity.

Gill Ponder raised the number of patients discharged by noon and asked if any research or analysis had been carried out into what it would take to improve those numbers. Shaun Stacey reiterated that making decisions the night before and earlier would help contribute to meeting this target of discharging patients before noon.

Fiona Osborne asked Shaun Stacey what the estimated the level of escalation beds would be coming up to the seasons where Covid, the flu and other seasonal illnesses could occur more in patients. Shaun Staey explained there was a community approach already in place with our community providers. The Trust would have circa 22 beds for escalation during winter if the home 1st approach began to struggle.

9.2 Planned Care

- H2 Recovery Position Update
- RTT 52 Weeks and above, overdue follow ups
- Cancer waiting times
- Levelling up of waiting lists with ICS

Shaun Stacey raised that in terms of the IPR report they continued to sustain improvements in planned care although there was limited assurance.

9.3 Productivity and Efficiency Programme – *Ab Abdi and Jackie France joined for this item*

Ab Abdi presented the first part of the presentation attached focusing on Planned Care Improvement and Productivity (PCIP) and Jackie France followed by presenting the information on the Outpatient Transformation Programme. Ab Abdi went on to highlight the following key issues from the presentation:

- 3.39 cases average per session, with 2.36 cases following OTD cancellations
- Session utilisation at 84.12% due to the loss of 2 theatres at DPOW and intermittent loss of 1 or more theatres at SGH (TIF funding secured for theatre upgrades)
- Work on programme with milestone and targets – highlight report monthly to PCIP
- KPIs created to measure success
- Theatre Board accountable and responsible to PCIP
- Supported our neighbouring providers by accepting a total of 771 mutual aid patients; 435 of these patients had now received their treatment, including 11 x 104+ waits.
- GIRFT work was ongoing.
- RTT Performance slightly deteriorated in July - some effect from mutual aid pathways.
- Clinicians maintained risk stratification at 100% of all inpatients.
- TIF 2 short form business cases for refurbishing 3 NLAG Theatres (7 & 8 in DPoW and A in SGH) had been submitted to the region, to provide additional 15 Theatres sessions in NLAG. Approval had still not been received - if approved, work was expected to complete in May 2023.
- Independent Sector usage continued to support with elective recovery - reducing in line with plans to improve core capacity efficiency and productivity.
- Additional anaesthetic Health Record Review and Anaesthetic Assessment clinics held in August and to be continued.
- There were continued challenges within incomplete RTT waits 18w+ such as Anaesthetic assessment (currently 35ww), theatre capacity, mutual aid and there were issues at the Ophthalmology hub at Goole Hospital.
- Cancer an area of challenge - July showed an increase but performance had dropped again in August - still under validation.
- Cancer 62 day backlog was increasing.
- The Trust was trying to appoint a Cancer Lead.
- Working on Lung Health Check pathways.
- GIRFT Theatre principles being embedded.

Ab Abdi explained that the pressures on performance continued especially in areas such as equipment and workforce and he explained the mitigations that were included in the presentation.

9.4 Patient Administration Transformation Delivery

Jackie France took the presentation as read. Jackie highlighted to the group that their priority nationally had been on long waiting patients which had had an impact on their follow up backlog. Jackie France explained that the number of follow up appointments due had dramatically increased by 4,000. The focus over the next 6 months was to change clinical practice in order to reduce the overdue follow up figures. Jackie explained that factors such as Patient initiated follow up (PIFU) and Connected Health Network (CHN) would help towards reducing this backlog as a lot of work was being carried out on both methods. A proposal was being drawn

up to be put to the Clinical Leads regarding PIFU and how they could channel this within their activity. They were looking at some specialties to make PIFU the default option and had confirmed it needed to be discharge or PIFU without specific reason. Jackie explained that all changes had been implemented to record risk stratification and operational teams had now got access to their data via PowerBI.

Fiona Osborne asked Ab Abdi about Diagnostics and whether more focus or Deep Dive was required within this Committee. Ab Abdi explained that PCIP had been formed within the last few months and those meetings were continuing but he did express that he felt a deep dive would be beneficial.

ACTION: Ab Abdi to provide a report to enable a deep dive to be carried out on Diagnostic performance.

9.5 Assurance Confirmation

Gill Ponder summarised the discussion and confirmed that the Committee could not be assured that the Trust would achieve constitutional standards of performance in Unplanned or Planned Care, but were assured by the actions being taken to drive an improvement in performance.

10. Finance & Performance Committee Governance Documents

10.1 SO1-1.6 BAF Review

The Committee had reviewed SO1-1.6 and agreed that the BAF updates provided a good level of assurance that controls were in place and that any gaps in controls were being mitigated. No questionss were raised.

11. Items for Information

11.1 Performance Letters to Divisions

Received and noted.

12. Any Other Urgent Business

None raised.

13. Matters to Highlight to other Trust Board Assurance Committees

None raised.

Review of Meeting

A couple of items on the agenda had overrun their allotted time slot, so the meeting finished a bit later than scheduled, which was disappointing.

It was suggested that future presentations were taken as read, as Committee members had read the slides in advance, so did not need the presenters to go through them at the meeting.

DATE & TIME OF NEXT MEETING: Wednesday 19 October 2022 – 1.30pm Face to Face

MINUTES

FINANCE & PERFORMANCE COMMITTEE

Meeting: Wednesday 19 October 2022, Executive Boardroom, DPOW

Present:	Gillian Ponder	Non Executive Director (Chair)
	Fiona Osborne	Non Executive Director
	Jug Johal	Director of Estates & Facilities
	Lee Bond	Chief Financial Officer
	Brian Shipley	Deputy Director of Finance
	Shaun Stacey	Chief Operating Officer
	Richard Peasgood	Executive Assistant to COO
In Attendance:	Simon Tighe	Deputy Director of Estates & Facilities (Item 7)
	Abdi Abolfazl	Deputy COO (Item 8.3/8.4)
	Jennifer Grainger	Head of Compliance & Assurance (Item 6.1)
	Shiv Nand	Governor (Observer)
	Lynn Arefi (Minute Taker)	Executive Assistant

ITEM

2. Apologies

Apologies for absence were received from Simon Parkes, Ian Reekie

8. Quoracy

It was noted that the Committee was quorate.

9. Declarations of Interest

There were no Declarations of Interest declared.

10. To Approve the Minutes of the Meeting held on 21 September 2022

The minutes of the meeting held on the 21 September were reviewed and agreed.

11. Matters Arising / Action Log

5.1 The action log was reviewed and updated as follows:

- 5.3 Terms of Reference: CEO had confirmed that Exec Directors are not members, action to be closed
- 5.3 Terms of Reference confirm Business case upper and lower financial limits – remains outstanding
- 7.3 Planned Care: this had been referred to Q&S and a discussion had taken place with COO and Medical Director. Noted there were multiple routes. A deep dive had taken place and a template will be produced for primary cancer focus on patient harm and patient safety. Fiona Osborne suggested that the F&P Chair and the Q&S Chair keep this on the radar for duplication between the two. Action now closed.

21/09/22

- 5.5 Medical Gas Pipeline - Action closed

- 5.5 Medical Gas Pipeline - Additional repairs to workplan ongoing
- 6.1 CQC Progress Report - Action closed
- 6.1 CQC Progress Report – Action closed on the basis this will be picked up as part of the special measures work
- 7.1 Finance Report M05 – need to understand exactly what the Committee will triangulate with workforce
- 9.4 PAT Delivery – Action closed as part of diagnostic review workplan. It was noted however, that there was lack of clarity of the diagnostic figures within the report. Shaun Stacey would work with Abdi Abolfazl to include more information within the reports.

5.2 F&P Committee Workplan

The Committee received the F&P Workplan and Lee Bond added that the HC&V finance results can now be shared monthly and will be built into the monthly finance reports. Referring to the Cost Efficiency section Lee Bond added that this was also included within the Finance reports. Use of Resources had been paused and Lee Bond suggested it now be on an annual basis. It was agreed that Reference Cost Submission would now be called "National Cost Collection". Trust priorities would also be reviewed.

5.3 Terms of Reference

The Committee received and noted the Terms of Reference.

5.4 Action Plan

The Committee received the Action Plan noting that work was ongoing in completing the outstanding actions. Gillian Ponder and Richard Peasgood would further review prior to the next meeting.

ACTION: Review Action Plan Gillian Ponder/Richard Peasgood

2.00pm Jennifer Grainger joined the meeting

12. CQC Report

Jennifer Grainger joined the meeting and spoke to the circulated CQC Progress Report noting the following highlighted changes in the report since last month with the overall percentage being 85% of 145 actions currently rated as blue or green.

- One action had been submitted to the CQC (21S Fasting – Surgery Division). This action was previously rated blue therefore no change this month to ratings
- All actions closed before April 2022 have been reviewed quarterly to ensure they remain embedded and a summary of each action's updates (along with the sub-committee they are aligned to) were included in section 11
- Performance related CQC actions now following reporting template within this Report

The report detailed the progress that had been made over the last month and highlighted areas where assurance could not be provided due to lack of progress or high level of risk. There continued to be focus on addressing actions that were rated amber plus the completion of assurance papers and position papers to evidence progress. Discussions had focused on ensuring there was mitigation in place where actions had not yet been achieved and evidencing the sustainability of actions previously completed.

Fiona Osborne asked what was the meaning of the statement on page 13 Dermatology "mitigation states that clinical validation work is being undertaken to support the reduction of the follow up position". Jennifer Grainger confirmed that the reason for this was consultant sickness

which had increased the overdue follow ups, they then focused on reviewing those patients that were overdue and only those needing to come back were contacted.

Lee Bond referred to page 10 and the table which included an action relating to the development of a Financial Strategy. It was queried how this could be addressed in the current NHS operating environment. Jennifer Grainger noted that the new CQC report would be released that week and maybe worth waiting for this to see how the Trust move forward on this.

2.10pm Jennifer Grainger left the meeting.
2.10pm Simon Tighe joined the meeting.

7. Estates & Facilities (SO1.4)

7.1 Asbestos

The paper was taken as read, received and noted by the Committee and they acknowledged that the omitted incident report would be circulated to members. Fiona Osborne suggested if the risks for each report could be included rather than the whole of the E&F risk register. Jug Johal confirmed that this would be done going forward.

7.2 Medical Gas Pipeline SI Report

The report was received and noted by the Committee. Simon Tighe noted that the paper had been presented to the Trust Board and noted that all actions derived from the incident had now being closed. There had been full consultation between HSIB and Trust stakeholders with regards to the accuracy of the report. Namely, Trust stakeholder representatives came from, Estates, Estates Compliance and Statutory Safety, Clinical, Pharmacy and Operations. The recommendations from the HSIB report: Oxygen Issues During the COVID-19 Pandemic were not specific to the Trust and were aimed at a CQC and NHSE/I level. However, in line with the pending STEIS 21251 incident report, future recommendations pertinent to the Trust would be provided and acted upon accordingly.

Gillian Ponder went on to ask how the Trust satisfied itself that the system was regularly tested and that plans and tests were taking place going forward. Simon Tighe confirmed that this would be picked up under the Emergency Preparedness Report with regular reports being presented to sub-Committees.

ACTION: Simon Tighe to advise the Committee how the assurance could be obtained.

Fiona Osborne noted that this should have gone through Q&S initially and was not being presented at Q&S until next week; why was SI Process not followed? Jug Johal confirmed that this was presented to the SI Panel and followed the normal process but did not know why it had not been to Q&S. Fiona Osborne suggested that Q&S look into this further.

ACTION: Fiona Osborne to confirm why the SI had not gone to the Quality and Safety Committee, in line with the normal SI process

7.3 Public Sector Decarbonisation Scheme

The circulated paper was taken as read. Simon Tighe went on to give a brief summary of the report; the coal fired boilers at Goole hospital were replaced in 2022 alongside other energy schemes such as loft and wall insulation, water system upgrades and replacement of the Building Management System. The energy centre at SGH provided the primary heat source for the whole of the hospital site and was circa 32 years old, failure of this equipment would result in the loss of heating and hot water throughout the site.

The PSDS 3b grant funding (£32,251,274 with a total Trust capital fund of £8,538,190 spread over 4 fiscal years) offered the Trust an opportunity to apply for funding to replace the energy

centre with a carbon neutral ground source heat pump system that used the heat within a geothermal layer sited 550mtrs beneath the hospital. The funding would also allow additional energy schemes to be completed, these include PV, window replacements and building management system upgrades. If the grant funding application was unsuccessful, the Trust would still be required to replace the existing energy centre and associated steam system.

It was noted that this paper was presented at TMB on the 17 October for approval and would be presented to the Trust Board.

Lee Bond went on to note that there would be no capital issues that year associated with this plan. Lee Bond asked if we did the "business as usual" option the annual energy usage would reduce which creates a saving of circa £170k. If all the windows and insulation work was carried out, the report indicated the energy bill stayed the same; although the kilowatt usage reduced; and queried how that would affect the revenue costs noting that there would be an improvement in the carbon footprint. Simon Tighe confirmed that that was the "adverse" part of decarbonising the estate; the ground source heat pump was purely driven by electric and so the savings on gas were offset by the cost of electricity. The only real savings therefore were in carbon terms, not financial. Lee Bond added that this needed to be clearly communicated; it would not save the Trust money. Fiona Osborne asked if the Trust commitment could be afforded within our current capital plan. Lee Bond confirmed that work had been done around the capital forecast over the next 4 years and that it was affordable, although there would have to be some degree of re-prioritisation.

Subject to the various items discussed, the Committee were happy to receive, note and agree for the paper to be presented at the Trust Board. Thanks were noted to Simon Tighe and the team for the huge amount of work that had gone into this.

2.40pm Simon Tighe left the meeting
2.40pm Abdi Abolfazl joined the meeting

7.3 Assurance Confirmation

The Committee were assured on all the Estates & Facilities items that had been reviewed noting that the reports were very concise and thorough informing valued debate and discussion.

14. Review of NLaG Monthly Performance & Activity Delivery IPR (SO1.2 /SO1.6)

14.1 Unplanned Care

Shaun Stacey took the circulated paper as read and went on to highlight the key headlines noting that there continued to be a challenge in the emergency care position at the front door, in spite of the new Emergency Department at Diana Princess Of Wales Hospital being operational; particularly around length of time to be moved from the ED once a decision had been made to admit. Another factor was the continuation of poor performance of ambulance handover which had now become a concern of NHSE for the performance score.

On a positive note, the Trust had seen SDEC service continuing to improve along with the 7,14 and 21-day LOS with a further reduction seen in October. There were still a high number of patients occupying medical beds and the continued high use of agency nursing. Bed occupancy remained steady and stable. It was noted that COVID patients were increasing.

Gillian Ponder asked what benefits were being seen with the opening of the new ED. Shaun Stacey confirmed that there were 50% more cubicles which enabled the Trust to accommodate patients in a safer way than before but, unfortunately, until transformation in patient flow was achieved the benefits that the new ED should bring would not be realised. A lot of work continued on managing and improving flow and preventing people coming into ED.

Gillian Ponder questioned page 17 on the IPR in relation to Planned Care, where it indicated that the target on elective LOS had increased. Shaun Stacey confirmed that that was not the

case for elective; it was purely that medical outliers were on elective wards, the elective LOS had not increased. Fiona Osborne went on to query page 17 and extended stay patients – could the Trust be assured that this was a real reduction. Shaun Stacey confirmed that it was holding well overall, particularly for 21 day although 14 day was increasing. Shaun Stacey noted that there were several actions for this, the length of time to get someone discharged was a real challenge with domiciliary care packages bringing numerous issues. The Trust continued to work with North East Lincolnshire but still facd challenges discharging people in Lincolnshire and East Riding.

14.2 Planned Care
14.3 Planned Care Improvement Programme

Abdi Abolfazl was welcomed to the meeting; the presentation was taken as read due to time restrictions and Abdi Abolfazl opened for questions on the IPR. Gillian Ponder went on to refer to the plan section on the scorecard at the front of the paper, if 100% of our in-patient waiting list had been risk stratified, how could 42.6% be overdue? Shaun Stacey confirmed that once a patient had been risk stratified, it would come with an associated to be seen by date, this then automatically prioritised the patient and it was those dates that were overdue.

Gillian Ponder then moved on to page 13 of the IPR and the 62 day performance for cancer and noted that it looked like it was continually worsening and asked what actions were being put in place to address the decline. Abdi Abolfazl went on to note that it was a challenging area, several actions had already been put into place including;

- Tumour deep dives to improve efficiency and pathways
- Best practice
- Selected samples
- Alternatives for patients with suspected cancer waiting 42 days+
- All clinical leads had ownership and continued to work closely with HUTH where patients were referred for specialist services

Gillian Ponder acknowledged the work being done and asked at what point the Trust expected these actions to translate into improvement in performance. Abdi Abolfazl expected to see improvements a couple of months ago, but it was all interlinked with other challenges including COVID; the trajectory was there and we need to ensure we align to it. Fiona Osborne reiterated Gillian Ponder's concern over the decline in performance and noted how the improvements and plans had been in place for a number of months with very little improvement. Abdi Abolfazl added that he was unable to provide much by way of assurance for the cancer 62 day. The Trust faced issues in recruitment of clinical leads for cancer. Fiona Osborne referred to detailed discussions held in July and requested more information on the diagnostic deep dive and individual pathways.

Action: Abdi Abolfazi to provide the Committee with additional information on the diagnostic deep dive and individual pathways

8.4 GIRFT High Volume Low Complexity

The circulated paper was taken as read. Gillian Ponder asked for a plan showing what the Trust was doing, with milestones and dates. It was agreed for this to be brought back to the January 2023 Committee.

ACTION: Abdi Abolfazl to provide plan for the January 2023 Committee meeting

8.5 Winter Planning Timetable

Deferred to the next meeting, as no paper had been submitted for that meeting.

8.6 Assurance Confirmation

The Finance and Performance Committee were not assured on Cancer performance and requested further deep dives. Although there were actions in place for elective recovery, the Committee also requested more information on individual pathways.

ACTION: Abdi Abolfazl further information to be provided on deep dives and individual pathways

9 Review of NLAG monthly Financial Position Finance Report (SO3.1/SO3.2)

Brian Shipley provided an overview of the Month 6 financial position highlighting some of the key points contained within the circulated report:

- The cash balance at 30 September was £36.22m, an in-month reduction of £6.5m
- The Trust had a £1.42m deficit in September, £1.17m worse than plan
- The Trust now had a £4.01m year-to-date deficit, £4.91m worse than plan. National pay awards were paid in the month, funding received resulted in a £2.3m annual cost pressure, £1.15m year to date.
- The Trust was formally forecasting a balanced financial position but was highlighting a deficit risk of £9.6m. This was predominantly driven through increased usage of temporary staffing, escalation beds and pay award pressures.
- Loss of elective recovery funding and non-achievement of CQUIN income were further risks but at that stage not included within the headline forecast deficit risk of £9.6m
- Overall income was £3.60m above plan mainly due to £3.6m year-to-date pay award funding received in the month
- Pay was £4.65m overspent in month
- Medical staff was £1.33m overspent. £0.7m was due to the pay award
- Other Pay was £1.17m overspent in month due to the pay award

Brian Shipley noted that the Trust was currently £4.9m behind plan at the end of month 6. If no mitigating actions were taken, forecast assessments project a potential £9.6m end of year deficit risk. A paper had been presented to TMB that week which outlined a series of mitigating actions, none of those actions had, as yet, been agreed as they were still work in progress.

Brian Shipley went on to highlight that the ERF income plan was again recognised as fully achieved, per system requirements. The Trust did not achieve the 104% activity target for September (88% achieved), despite spending the Capacity Reserve set aside in the plan, meaning an estimated £3.55m Elective Recovery Funding received year-to-date would have been at risk if penalties were enforced for the H1 period. CQUIN income was also recognised as achieved, however there remained a risk of £0.7m CQUIN clawback year-to-date.

Fiona Osborne referred to the forecast and asked for assurance that clinical risk was being included within discussions. Lee Bond highlighted the additional burden associated with the continued use of the Independent Sector whilst our core capacity remained under utilised. It was noted that Lee Bond and Shaun Stacey would be exploring how that area of spend could be limited in the second half of the year.

A brief discussion took place around the use of agency out of hours use and using the correct process. Shaun Stacey noted that he was confident with current processes in booking agency staff, but added that clinical risk was the driver in booking through some of those agencies.

The Committee received and noted the Month 6 Finance Report and the highlights and risks contained within.

9.2 Recovery Support Programme Letter

Letter received for Information.

9.3 Use of Resources

It was noted that NHS Use of Resources initiative had been paused.

9.4 Business Case Assurance

No Business Cases were due for review by the Committee that meeting.

9.5 Assurance Confirmation

The Committee agreed they were assured on actions being taken, but acknowledged there were some significant risks to be brought to the Board's attention

10 Finance & Performance Governance Documents

10.1 SO1-1.2 BAF Review

The BAF deep dive had been carried out, but there were no questions or issues arising that required further discussion at the meeting, as the Committee were assured by the controls and mitigations for gaps in controls as noted in the latest update to this strategic risk on the BAF. The Committee also accepted that the risk scores were a fair representation of the position for that risk.

11 Items for Information

Noted.

12 Any Other Urgent Business

None raised.

13 Matters to Highlight to other Trust Board Assurance Committee

None.

DATE & TIME OF NEXT MEETING:

Wednesday 23 November 2022 1.30pm TEAMS

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6 December 2022	
Director Lead	Kate Wood, Medical Director Ellie Monkhouse, Chief Nurse Fiona Osborne, Non-Executive Director	
Contact Officer/Author	Fiona Osborne, Chair of Quality & Safety Committee	
Title of the Report	Quality & Safety Committee Minutes – September and October 2022	
Purpose of the Report and Executive Summary (to include recommendations)	The paper includes the minutes of the Quality and Safety Committee (QSC) meetings for September and October 2022.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 25 October 2022 from 1.30pm to 4pm
Via MS Teams

Present:	
Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Susan Liburd	Non-Executive Director
Kate Truscott	Associate Non-Executive Director
In attendance:	
Dr Kate Wood	Medical Director
Ellie Monkhouse	Chief Nurse
Jennifer Granger	Interim Associate Director of Quality Governance
Fiona Moore	Head of Quality Assurance
Shaun Stacey	Chief Operating Officer
Nicola Foster (item 259-260/22)	Deputy Head of Midwifery
Miss Preeti Gandhi (item 259-260/22)	Associate Medical Director, Women & Children's Services
Simon Tighe (item 264/22)	Deputy Director of Estates & Facilities
Kelly Burcham (item 263/22)	Head of Risk & Clinical Audit
Ian Reekie	Governor (Observer)
Diana Barnes	Governor (Observer)
Laura Coo	PA to the Medical Director **(minute taker)**

253/22 Welcome and Apologies for Absence

Apologies for absence were received from: *Peter Reading, Jane Warner (Nicky Foster to rep), Jan Haxby, Kate Wood (30 mins late)*

254/22 Opening remarks

Fiona Osborne welcomed Sue Liburd and Kate Truscott as new Non-Executive Committee members. This was now a brand new Committee.

The Committee has a new set of guidelines for papers and agenda sets for the next meetings would be held immediately after each meeting to keep momentum and give people enough time to put their papers together.

For this meeting, all papers would be taken as read and the focus would be on questions on the paper.

There were three paper deferrals this month;

- End of Life Update (EoL) was only delayed to bring the reporting in line with the quarterly QGG timetable.
- Cancer & Learning was not received before the deadline
- Diabetes Management was not received before the deadline.

255/22 Declaration of Interests

The Quality and Safety Committee would not be quorate until Dr Kate Wood was in attendance therefore any decisions would be made once Kate had joined the meeting.

There were no declarations of interest related to any agenda item.

256/22 To Approve the Minutes of the Previous Meeting held on 27 September 2022

The minutes were accepted as an accurate reflection of the previous meeting.

257/22 Matters Arising

At the September meeting the Committee discussed a letter from the Chair of the Finance and Performance Committee, Gill Ponder, with regards to concerns about Cancer performance measures and whether the poor performance could lead to potential patient harm. Fiona Osborne had sent a formal response which stated that the Committee was focused on patient care and whilst the performance statistics were important to the Trust, the Quality and Safety Committee would use the statistics for the wider element to deep dive into the services. This Committee wanted a rounded picture of the services and Fiona had worked with Dr Kate Wood to put a template together that drew out the information needed by this Committee going forward.

258/22 Review of action log

175/22 – DOLS – Fiona Osborne had spoken to Vicky Thersby regarding the Paediatric Liaison and it appeared there had been a significant process for mitigating that risk therefore Fiona had asked Vicky to review the rating on the risk register. Vicky was due to provide her regular update at the December meeting and that action could be closed once that report was received. Ellie Monkhouse noted that the risk would be reviewed and updated through Ellie's mechanisms so the risk might not be updated by December but agreed the action could be closed for this Committee.

197/22 – Pharmacy & 202/22 - Nursing Assurance - The actions have been transferred to Fiona Osborne. Fiona had written to the Chair of the Workforce Committee however the next Workforce Committee was not until November so these actions would remain open until then.

216/22 – PSIRF – The Committee received the paper at the last meeting therefore this action could be closed.

Following Septembers meeting a new action would be added regarding risk stratification for Fiona and Kishore Sasapu to pull together an assurance report suitable for this Committee.

Regular Reports

259/22 CNST update

Nicky Foster joined the meeting at 1.40pm

Nicky Foster referred to the document distributed which was taken as read and informed that of the ten safety actions that needed to be met there were two elements of non-compliance; Safety action 6 – Saving Babies Lives and Safety action 8 – Training compliance.

Nicky invited any comments or questions.

Kate Truscott asked what *'achievement anticipated*' meant in the green boxes. Nicky clarified that meant that there were not any concerns for achievement and they were on track to achieve that safety action.

Kate Truscott referred to number 8 about the local training plan and asked what the current rate of compliance and trajectory were.
Nicky informed that the issue was specifically with the PROMPT training and the difficulty for the Anaesthetic colleagues being able to complete the training. They were approx. 46% compliant. They did have a training support clerk who had contacted nearly every person who needed to complete the training and dates were all diarised.

Preeti Gandhi joined the meeting at 1.45pm.

Preeti Gandhi informed that the data she had received for consultants showed it was the junior areas that were not compliant but reiterated what Nicky had said that everybody who was out of compliance had dates booked for training. The problem was because Anaesthetists were pulled in all directions they were not always able to attend the training but Preeti felt they now had it in hand. Kate Truscott was happy with that response.

Kate Truscott referred to Safety Action 6, regarding compliance for Saving Babies Lives and noticed that under element 2 at DPoW the report stated the Sonographer was not trained to undertake Uterine Artery Dopplers for all at risk pregnant women and asked what they were doing about that. In response Preeti advised that it was something new linked to Saving Babies Lives and they were lucky that they had a very senior Fetal Medicine Consultant who had retired and returned at SGH but none of the Sonographers were trained for this, they had advice from the maternity improvement advisor which was useful to have feedback to see how it was being handled nationally.

Sue Liburd noticed a trend in being unable to extract data relating to Safety Action 6 for elements 1 and 2 and asked was what was the challenge in terms of being able to provide the information.
Nicky informed that since the report had been written a solution had been found and they could now extract that data.

Sue asked about element 2 of Safety Action 6 where the report mentioned not capturing those at risk at their 20 week anomaly scan and asked what was stopping the 20 week anomalies being picked up.

Nicky informed that they had met with the Sonographers last week and found they could do that now as well but the report was written prior to that information being known.

Shaun Stacey asked Preeti whilst the Sonographers were being trained if the training to undertake Artery Dopplers could be incorporated and if not how were they managing that. Risk stratifying and identifying patients was the intermediate approach but was that alongside that training.

In response Preeti explained that because of the lack of training at DPoW they are not able to do the Artery Dopplers but they were being sent to SGH. They had taken some help from Sonographers in the Hertfordshire team because without capacity we could not do all the Uterine Dopplers, they were quite happy to help with the training and suggested that it would only take two sessions for the Sonographers to become trained. Shaun felt that Preeti had demonstrated the assurance for the patients and this Committee despite the training issue, and the fact this was a national problem not isolated to NLaG but felt the Committee would benefit from having sight of that pathway.

Ellie Monkhouse appreciated the challenges looking into the detail but advised that the CNST had to be submitted at the beginning of February 2023, the full review was due to take place 24th November 2022 to highlight if there were any rapid actions they needed to be taken. It would be taken to the Board the first / second week in January however it might not be finalised at that point. The Committee could have that level of detail if they wished but it was probably not for this Committee. Fiona suggested that given Sue Liburd was aligned to the process as Maternity Safety Champion, that Sue review further with the team and provide this Committee with that level of assurance.

Action: Preeti Gandhi to provide Sue Liburd with details of the Artery Doppler Training and potential for patient harm to allow Sue to feedback to the Committee.

Fiona Osborne referred to Safety Actions 5, 7 and 10 and noted that in the June report presented to the Committee they showed as green (on-track) but now showed as amber (off track) and asked what had changed noting the detailed progress analysis were still the same for all of them. Fiona queried if the granular detail was not there to show progress or if there had not been progress.

With regards to Safety Action 5, that was about the Midwifery workforce and Safety Action 10 Nicky advised that the RAG rating in June should be amber. Ellie added that Safety Action 5 was because although Birth Rate Plus was completed they were working with NHS Improvement and Birth Rate Plus going forward.

With regards to Safety Action 7 the Maternity Voices Campaign (MVP) that was was green and Nicky knew that should have always been green and should have been in June. Fiona requested that the report to the Committee going forward reflects progress from the last report which may mean greater granularity of detail if the progress narrative is potentially the same as the previous report.

For Safety Action 4, Fiona asked what had changed to make that green (on track) as the narrative on progress was the same as June. Nicky thought that was probably about the Anaesthetic staff on the rota and that was what made it compliant. Preeti added that it was amber (off track) before because they did not have the audit results for assurance and then the rating had been updated.

260/22 Ockenden update (verbal)

Nicky Foster gave a brief update and highlighted the key points.

From our first Ockenden report the Trust had seven immediate and essential actions to complete. They had six completed actions and one that was very nearly compliant and was expected to be by the end of month. An SOP was due to go through Governance this month and the audit for personalised care plans was on the action plan this month.

The second part they had 22 green actions and 16 amber actions and were waiting for guidance on seven of the actions.

The second Ockenden report was larger with 92 actions and they had started to work through the action plan; had 24 green actions, 10 amber actions, 56 red actions and two awaiting guidance.

Ellie Monkhouse added that we had received the East Kent Report and needed time to collate the actions from that as well so there would be quite significant actions to go through.

The teams had been visited by the Regional Chief Nurse who provided assurance on our progress.

There had been significant progress around the induction of labour and quality of triage. A triage telephone service was commencing on 31st October to ensure women were supported hoping to then very soon afterwards move on to phase two which would be a physical triage to review them and ensure they were in the right place etc.

Induction of labour there were different methods being used across the Trust so work was ongoing to amalgamating all the guidance with the help of the Quality improvement team to ensure there were no differences in patient experience and safety across the sites.

Fiona Osborne thanked Nicky and Preeti for the update on CNST and Ockenden progress.

Nicky Foster and Preeti Gandhi left the meeting at 2.10pm

262/22 Nursing Assurance Report

Ellie Monkhouse referred to the report distributed which was taken as read and invited any comments or questions.

Sue Liburd referred to page nine of the report which showed sickness absence rates in red which looked particularly high on Ward C3 and asked if there were any

patterns/trends for that, if there any mitigations in place and what were the potential risks of having nearly 20% sickness. Ellie Monkhouse put some context to the situation; it was during the summer holiday season and the escalation beds had impacted staffing levels and the Trust was mainly working on Opel 4 throughout the summer months.

There were some positives Ellie wanted to draw out of the report. The recent HCA rapid recruitment event was very successful, Ellie had campaigned quite hard for the Nursing Apprenticeship scheme and had received 180 applications for the 45 places on the programme, collaborative work continued with recruitment.

From an Infection Control point of view the number of *C.Diff* cases remained well below the trajectory but that was not say they were not aware of how difficult this winter would be.

Complaints – a PRIM meeting had been set up dedicated to complaints and they had already seen a difference from those meetings.

C2 remained in special measures

Ward 23 had come onto the radar and would be picked up.

In terms of sickness levels, extra support was provided through the CPD team, extra audits and work from the 15 steps team.

Sue Liburd queries Page 16 of the report about the risk of the inability of recruiting nurses from non-red list countries; African countries including Ghana, Niger and Nigeria which were countries from which most of our future pipeline was made up. Sue Liburd asked what the potential impact was to the Trust from that, were there different routes and was there a difference in the standard of Nurses from those countries.

Ellie had done a deep dive into that and found NLaG were getting a lot of qualified Nurses with the necessary skillset through from talent acquisition in those countries and we had a very healthy international recruitment coming through mainly by word of mouth but Ellie still felt we were not as diverse as we should be and worried that European Nurses tended to go to London then America but not here.

Action: Fiona Osborne to refer Sue Liburd to raise at the Workforce Committee

Kate Truscott thought it was a comprehensive report and very useful and thanked Ellie for that.

Looking at the Community Nurse situation, Kate Truscott asked if she was right in thinking that Ellie had implemented a new case load management system and asked how that had worked. Ellie explained that in Community there was a lot to go at, the data in this report had been a long time coming and the dashboard was still developing. A system called Malenco had been put in place which was supposed to look at our productivity, visits missed etc and there was further work around making inroads into what a modern community service looked like. Ellie thought there needed to be closer working with the care homes too. NLaG are an early adopter

for the Community Safer Nursing Care Tool but NHSI had insisted that everybody was trained in that before they would release the tool to us. The hope is this would increase the nurse's productivity and improve their working lives. Fiona Osborne would include this in her highlight report.

Kate Wood joined at 2.20pm

With regards to the vacancy levels Ellie explained there were two humps in the vacancy levels, one for Community and the other for the whole establishment, that was when the establishment reviews were enacted and the system would not let us recruit to full establishment and they had managed to get rid of that. Ward reviews would take place in December with Ellie. They were now in a position to be able to recruit bands 4 and 5's in Maternity.

Fiona noticed the overall substantive fill rate trend in Women and Children's showed a downward trend and asked if that was a concern.

Ellie thought we should always be concerned; Midwives were leaving the profession at rapid rates for varying reasons. There was quite extensive mitigation in place Midwifery units were not always full so they had quite a specific daily way of reviewing the equity. When they struggled with staffing it was generally Community that came off worse. Had introduced Opel levels for Community which were included in discussions in terms of whether they needed to close the unit but they did have quite a significant daily process in place which was something this Committee should be aware of as time goes on and Ellie though it needed to be kept on the radar.

Fiona Osborne would include this in her highlight report to the board listing some of the mitigation.

Fiona Osborne asked if the work to recruit HCA staff would continue as this had clearly been an exceptionally successful. Ellie advised that Pre Pandemic 'one stop shops' for recruiting HCAs were held quite often and Ellie was relying on the Recruitment team to support a continual cycle going forward.

Sue Liburd asked about hospital acquired pressure ulcers and asked for assurance that there were mitigations in place. Ellie informed that this month the number had reduced again but it seemed to relate to the influx in our Opel levels and escalation beds however there was lots of mitigation in place but they were finding that a lot of patients were coming in with red areas already.

Fiona Osborne suggested having a focused item on Pressure ulcers and mitigation at a future meeting. Kate Truscott was interested in that area and supported the idea.

Action: Fiona Osborne to include a Pressure Ulcers Deep Dive update in the workplan review for a meeting in the near future.

263/22 Annual SI Report

Kelly Burcham referred to the report distributed which was taken as read and invited any comments or questions.

Kate Wood thanked Kelly for a great comprehensive report. On page 13 of the report it talked about skull fractures of the neonates and there were comments about getting external input to look into that but Kate Wood felt it had been left open. Kelly explained that they did have an external review with input from an external clinical. It had since been determined that two were not fractured, one had already been finalised but was not a fracture, another they had asked for a delog and the remaining two were different modes of delivery, a manual rotation which the investigation was still on going and an instrumental delivery which had been reviewed and nothing would have been done differently. The positive was that there were not any themes being highlighted.

Kate Wood referred to page 23 and the 2022-23 objectives and the risk identified of moving to Ulysses and the Power BI reports needing to be re-established.
Kate Wood knew the amount of work that went into pulling out the themes to extract the data and asked what the position was with those reports from the digital team to be able to extract that information from Ulysses.

Kelly explained that the Power BI reports were originally set up for Datix and the they gave us that instant information, however with Ulysses they needed to know exactly where to look so it was not as straight forward. Kelly had spoken to Phil Croft in the Information Team who had said they were not taking on any more pieces of work in regards to Power BI development while the Data Warehouse was under construction and they were not able to give a timeframe.

Fiona Osborne asked that given there was ongoing learning as a result of the Power Bi's was this impinging on learning and creating a potential for patient SI's in the future. Kelly informed that the team themed and trended as matter of course but they had hoped to identify things before they became SI's from Power BI charts where things would look alarming but they had now lost that ability.

Fiona Osborne felt this Committee had limited assurance that the team were able to identify potential SI's and that increased potential patient harm and risk.

Action: Fiona Osborne as Non-Executive Digital Lead to raise the need for Power BI reports with Shauna McMahon.

Fiona Osborne referred to Section 8, Learning in relation to point 7.3. The root cause analysis referred to communication and following the process and Fiona asked if the methods of Learning in section 8 had been changed due to lack of communication, process and lack of knowledge. Kelly clarified that the root cause analysis related to things within the investigation, lack of knowledge could be around an admin staff who did not know they had to get clinical input for cancelling an Ophthalmology appointment for example. Themes were picked up from the learning group but this was more around the individual SI's the root causes were outlining what were determined as the main contributing factors. They picked out lots of different methods for sharing the learning.

Fiona Osborne stated she asked because 7.3 identified root causes asked if there was a wider exercise to address how that was fed into the initial education and communication.

Kate Wood felt that was a valid point about how did we get those things done, of how could we spot the incidents rather than them becoming SI's what everybody wanted was for the themes to be picked up early. It reinforced the risk that Kelly had raised that they needed the information and the resource to address that.

Fiona Osborne thought it would be useful to understand the entire picture; what SI's had been brought forward, what had caused problems, what had improved etc. and asked if the annual report for the following year could be updated to include this wider information. Kelly replied that this could be done as it gave the opportunity to demonstrate what did not show on the report such as the various themes that had dropped off and the extensive improvement work that was on-going.

Kelly Burcham left the meeting at 2.50pm

264/22 Medical Gases

Simon Tighe referred to the paper distributed which was taken as read and invited any comments or questions.

This report had already been to the Trust board so was out of sync but as part of that Trust Board update there was a point about having Nursing Duty Medical Officers and we did have them.

Kate Truscott asked about the process, noting it was about the progress of the situation did it go through the usual SI mechanisms.

Fiona Osborne added that she had talked to Kelly Burcham about the timeline to escalate outside of the SI process. What appeared to have happened back in January 2021 was that it was removed from the SI process and Kevin Oxley was appointed but it was still coming to this Committee in terms of quality of care and to ARG from a risk perspective. In January 2022 it came to QSC and was included in the highlight report to the Board where it was noted that an off-site discussion would be had however Fiona could not find where the decision had been finalised. Fiona stated she supported the escalation as it was appropriate however the documenting of the decision was lacking and there was a learning opportunity for the future.

Kate Truscott presumed it was felt to be so significant that the board should take over. Simon confirmed there was a decision to take it to Trust Board but Simon did not know how that decision was made. Upon reflection this was the first Estates and Facilities led SI so they needed to reflect amongst themselves with how they managed that process but it was fair to say that there was a lot of learning that came out of that.

It was just the ability to see a transparent evolution of the issue, Fiona gain stated she did not disagree with the escalation given the enormity of it but it was the process to document the escalation where there was a learning opportunity.

Considering that the risk rating was very high about business continuity and serge plans, Sue Liburd asked if the Medical Gases Committee was agile enough to respond to future surges should similar situations occur.

The Medical Gases Committee met regularly and worked with the Wards where any medical gases issues were picked up on a daily basis and surge plans were tested.

Simon Tighe left the meeting at 2.58pm

265/22 IPR

Dr Kate Wood referred to the report distributed which was taken as read and invited any comments or questions.

No questions were raised.

266/22 Key SI Update including Maternity

Jennifer Granger referred to the report distributed which was taken as read and invited any comments or questions.

Fiona Osborne asked about the reference to a Neonatal Resus Proforma being changed and asked why that needed to be changed. Jennifer was not able to answer due to her only just starting in the interim post but would find out and update Fiona outside of the meeting.

Action: Jennifer Granger to feedback on Neonatal Resus Proforma changes

267/22 CQC Framework

Jennifer Granger referred to the report distributed which was taken as read and invited any comments or questions.

Fiona Osborne mentioned in terms of the narrative in the executive report the narrative was the same as the previous month so did not give the Committee the progress in the month. Fiona asked if that was because we were not getting the right granularity or was it that things had not moved on. Jennifer advised this was a matter of granularity and she would address this with the teams providing detail going forward.

End of Life (EoL) had a big focus now but Fiona commented that the position statement in the paper had remained the same since June stating it was under Executive Review. Fiona asked if this process was an extended process of scrutiny or if this had stalled.

Jennifer Granger advised this was a robust process of scrutiny which could take a great deal of time to ensure the processes were complete.

268/69 Potential Deviations from National Documentation (verbal)

Fiona Moore advised that a paper went to QGG for Breast Services NICE guidance not routinely offering breast screening surveillance. QGG had for this to go back to their Divisional Governance Group as QGG did not feel there was a deviation.

Kate Wood explained the process that Divisions would bring papers to QGG who would challenge and consider whether the paper should then come to QSC for us to

be able to confirm or challenge so Fiona Moore had followed the right process to use the QGG as a buffer to stop it coming here.

269/22 Quality Priorities

Fiona Moore referred to the report distributed which was taken as read and invited any comments or questions.

Sue Liburd commented about complaints and PALs and the consistent issue about how staff communicated with other staff and relatives. Fiona Moore knew there was ongoing work to address that, this was at a stage to see what we could do to reduce other work but that did not mean work was not already happening to reduce issues with communication.

Ellie Monkhouse made a plea about the long list and the ability to apply metrics. It would be difficult to be able to pull out data to be able to show outcomes for some. Fiona Moore agreed they would meet with all areas to discuss and ensure they pulled out the appropriate outcomes they wanted to achieve.

269/22 Register of External Agency Visits

Jennifer Granger referred to the paper distributed which was taken as read and invited any comments or questions.

Kate Wood asked about the close down of the Antenatal and Newborn screening as she was a little bit perplexed as the screening people came to the organisation on the 22 July and there were two recommendations made at that visit and asked if the plan was to close this down and open a new one. Jennifer clarified that was the case, now the full visit had happened they wanted to start a new timeline.

Fiona Osborne did not think the form matched with what Jennifer was asking for and thought it needed to be re-presented to say it had been superseded by another set of actions.

Action: Jennifer Granger to represent the Closure report at subsequent meeting.

Kate Wood commented that she could still not access that document through the hub page even though it had been re-uploaded as a word version. Fiona Osborne stated that the Committee had asked for no embedded documents to be included in the papers as this was an issue for most Committee Members.

272/22 QIA update

Fiona Moore referred to the report distributed which was taken as read and invited any comments or questions.

There were no questions.

273/22 Deep dive paper on PROMs

Fiona Moore referred to the report distributed which was taken as read. Fiona highlighted that the paper distributed showed the findings of the Deep Dive that was carried out to establish if there were any issues that may have contributed to the

Trust's deteriorating rates for patient reported outcomes for total hip replacement. Although the Trust fell outside the 95% control limits the data for individual consultants did not highlight any issues that needed further investigation

Conversations with clinicians around this were presented to QGG, they had spoken to their peers at other Trusts and it was found that other Trusts did things differently for example taking into account a patients BMI when deciding whether or not to operate which could explain why NLaG fell outside of the control limits as it did not align with other Trusts.

Fiona Moore invited any comments or questions.

Shaun Stacey immediately went to equality of access so was pleased that it was not the case for NLaG.

Kate Wood and Kate Truscott agreed that the report was easy to understand and Kate Wood wanted to thank Anne Hickenson in the Audit Team for pulling this together, this was publicly identifiable so the fact that the team had spent the time to look into and understand why we were an outlier, the team had done a fantastic job and had tolerated Kate Wood's constant questioning.

Fiona Osborne asked what happened now. Fiona Moore advised that as we did not receive an official outlier alert this was purely an audit deep dive for our information to monitor the Trust's position.

274/22 BAF

A discussion took place about the BAF report distributed.

Kate Truscott did not think the report was very clear or informative but mentioned depravation of liberties. Kate Truscott was not meaning to be critical but wanted to get a sense of how NLaG was reporting etc.

Fiona Osborne commented that the format had evolved to include a number of key components but she was not clear about what the Committee should to be worried about from the information. As Dr Kate Wood and Ellie Monkhouse are the Executive owners Fiona asked for their feedback on what the Committee should be worried about.

Kate Wood noted this was a board assurance framework so not really a conversation for this committee but her concerns were due to care quality issues, lack of staffing, the risk of our patients that were deteriorating but not being noted. We did not have the data to be able to report on sepsis for example another concern which was being very ably managed was about the risk of patients coming to harm due to long waits whether that was due to emergency care or elective care.

Ellie Monkhouse agreed with Kate Wood and added that the understanding what could potentially be round the corner in terms of Infection Control and respiratory illnesses in the future was a concern. Ellie did not feel things were being triangulated properly and could potentially have to go back to segregation in departments which would impact operational delivery. Staff were emotionally and physically tired and Ellie thought that needed to be articulated better. We did not

take things off as they were achieved but Ellie assured Kate Truscott about her previous comment that the liberty protection rules that had been deferred several times would be a risk to the organisation.

Fiona Osborne asked if the scoring with a consequence of 5 but likely hood of 3 was the right score given this conversation. Ellie stated this conversation had been had many times and it was the right question and Ellie's personal view was the score should fluctuate. Kate Wood agreed with Ellie but if thought if were looking at a likely hood it should be higher. Kate Wood was happy to hear other views but the risk of 3 was annual which did not seem quite right.

Kate Truscott clarified her point was around context which it needed as things had changed so considerably. The other was around partnership and the system issues as well.

Picking up on what Kate Truscott had said, Ellie explained that how the Trust used the BAF was a constant strive to get the risk/score down but as Kate Truscott had said we could be doing everything possible and more so that should not be a reflection of the systems or on Kate Wood and Ellie as it was ok to say it was going to be a huge risk to delivery in this organisation.

Fiona Osborne suggested if this needed to be a seasonal view. Sue Liburd endorsed the seasonality idea; it would show movement if the seasonality was included and the Committee could be assured.

Shaun Stacey made an observation about the seasonality conversation this had already been monitored and since 2020 it had made no difference; Shaun did not think it was seasonality those things had gone but thought it was about managing the infection control. We were in new territory that had not been seen before and we did not have a grip on virus management, frailty, out of hospital care etc so Shaun did not think this was something that was naturally managed and thought it was difficult to record as it was multifactorial.

There was something for Ellie about how the BAF drives Board conversations, those conversations should be driven by the risks that the Exec Directors and BAF were showing but Ellie thought there were a lot of process parts of the Board and was finding this a really helpful conversation to triangulation all of the risks the Exec Directors were concerned about.

Fiona Osborne thought this went back to the initial question about whether we were getting a sense of what we were worried about from the BAF.

Kate Wood found it really gratifying that Fiona Osborne and the Committee had listened and accepted what had been said and hoped maybe through different routes the BAF could be refresh what it reflected on and look to other organisations to see what we do well. Fiona Osborne would reflect this discussion in the highlight report to the Board. Fiona would also raise the discussion with the Director of Corporate Governance as for any board the BAF and the risk register were key tools for any organisation

Action: Fiona Osborne to raise the BAF discussion with the Director of Corporate Governance.

Highlight reports

275/22 Quality Governance Group (QGG)

Jennifer Granger referred to the highlight report distributed which was taken as read.

276/22 Patient Safety Champions Group (PSG)

Jennifer Granger referred to the highlight report distributed which was taken as read.

Items for information

277/22 Quality Governance Group (QGG) minutes

Distributed for information

278/22 Patient Safety Champions minutes

Distributed for information

279/22 Any Other Business

Newborn audiology issue

Kate Wood had received a letter about some concerns raised about our low reporting rates for issues relating to neonatal audiology. Nationally they had been looking at the rates and a few months ago NLaG were identified as a low reporter. NLaG was fully engaged and provided a lot of data which appeared to show we were ok however Kate had received a letter to say that NHSE wanted to do some further investigations. There had been a national concern raised NLaG were engaging with the screening team and Kate would be attending the initial meetings with the public health teams to provide the initial report. Fiona Osborne asked about the likely timescale for the data coming back to QSC. Jennifer Granger was unsure at this stage. Kate Wood suggested putting it as an action on the QSC tracker or workplan to provide a monthly update. It was agreed that a verbal update on progress in the workplan would be more appropriate.

Action: Fiona Osborne to update the Workplan to include neonatal audiology.

280/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

Fiona Osborne agreed to add the following points to the highlight report to the Trust Board .

- Audiology Letter
- Highlights from the BAF discussion
- Medical Gases process and documentation of escalation decisions
- Lack of Power BI to report incident themes as an early warning to prevent SIs
- Nursing Assurance Report– the staff verses caseload in community therapies
- CNST – the doppler training aspect
- Pressure Ulcer plan

281/22 Meeting review

Ellie Monkhouse made reference to the new format and commented that whilst she understood why the changes were being made as the Executive Lead Ellie needed to be able to highlight things to give the Committee assurance and was concerned that it might be missed opportunity to tell the Committee the good things as well.

Fiona Osborne agreed with Ellie's comments that the Execs needed to provide context but also thought that by reading the papers it was showing respect for the people who had taken the time to put the papers together.

Ian Reekie agreed with the principle but his only concern was if there were things included in the executive summary of the papers they would not be minuted and therefore there would not be an audit trail.

Fiona agreed that the new format should be updated as the teams needed an opportunity to present their key highlights in a whistle stop tour of key points.

282/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 22 November 2022
Time: 1.30pm – 4pm
Venue: Via MS Teams

The meeting closed at 4.02pm

Annual Attendance Details:

Name	Oct 2021	Nov 2021	Dec 2021	Jan 22	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022
Michael Proctor	x	✓	✓	✓	x	✓	✓	✓	✓	✓	✓		
Michael Whitworth	✓	✓											
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maneesh Singh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	
Dr Kate Wood	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓
Ellie Monkhouse	✓	✓	x	✓	✓	✓	✓	✓	✓	x	✓	x	✓
Dr Peter Reading	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	x	x	x
Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Jennifer Granger												✓	✓
Helen Harris	x	✓	x	x	x	x	x	x	x	x	x	x	x
Jan Haxby	✓	x	x	x	✓	✓	✓	✓	x	x	✓	x	x
Shaun Stacey	x	x	✓	x	x	x	✓	x	x	x	x	✓	✓
Susan Liburd													✓
Kate Truscott													✓

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 27 September 2022 from 1.30pm to 4pm
Via MS Teams

Present:	
Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Maneesh Singh	Associate Non-Executive Director
In attendance:	
Dr Kate Wood	Medical Director
Melanie Sharp	Deputy Chief Nurse
Jenny Hinchliffe	Deputy Chief Nurse
Angie Legge	Associate Director of Quality Governance
Ian Reekie	Governor
Jennifer Granger	Head of Compliance & Assurance
Jane Warner (item /22)	Associate Chief Nurse, Midwifery, Gynae & Breast Services
Fiona Moore	Head of Quality Assurance
Debbie Bagley	Associate Chief Nurse, Surgery & Critical Care
Jenn Orton	Associate Chief Operating Officer, Surgery & Critical Care
Kishore Sasapu	Deputy Medical Director
Stuart Baugh	Consultant Physician
Jill Mill	General Manager, Medicine Group
Karen Smith	Lead Chemotherapy Nurse
Prakash Gowda	Consultant Dermatologist
Rachel Wright	PA to the Chief Nurse **(minute taker)**

220/22 Welcome and Apologies for Absence

Apologies for absence were received from: *Peter Reading, Ellie Monkhouse (Melanie Sharp & Jenny Hinchliffe reps), Jan Haxby*

221/22 Opening remarks

Fiona Osborne explained the previous chair of the Committee, Mike Proctor had now left his position. This would also be Maneesh Singh's last meeting. Two new NEDs Sue Liburd and Kate Truscott will be joining the committee from October.

222/22 Declaration of Interests

The Quality and Safety Committee was quorate and there were no declarations of interest related to any agenda item.

223/22 To Approve the Minutes of the Previous Meeting held on 23 August 2022

The minutes were accepted as an accurate reflection of the previous meeting.

224/22 Matters Arising

Mike Proctor referred to the letter from the CEO relating to the oxygen supply at the last meeting. The committee was specifically asked to look at the quality of care provided and whether it meets national and best guidance practice. Fiona Osborne has spoken to Jug Johal and Simon Tighe and a report will be submitted to the committee for assurance in October 2022. Fiona added that going forward, items of this nature will go through the formal SI process rather than individual committees.

The Committee has received a referral from the Chair of Finance and Performance with regard to concerns about Cancer. Performance measures are not delivering to a standard that the Finance & Performance Committee expect and they have asked for feedback on whether poor performance is resulting in patient harm. This Committee are reviewing each cancer service and although Performance is dealt with under the Finance & Performance Committee, the letter allows us to address this specific question. Dr Kate Wood, Ellie Monkhouse, Shaun Stacey and Fiona Osborne will be meeting on 30th September to discuss how to coordinate assurance on cancer services to best effect. ; Fiona will respond to the Chair of Finance & Performance on the outcome of the meeting and this will be shared at the October.

225/22 Review of action log

175/22 – DOLS – Fiona Osborne is awaiting a response from Vicky Thersby regarding paediatric liaison and will follow up with Ellie Monkhouse when she returns from leave. Melanie Sharp will send an update to Fiona.

197/22 – Pharmacy – Fiona Osborne has not received confirmation from either Michael Whitworth or Mike Proctor. The lead for this action will be transferred to Fiona Osborne who will write to the new chair of the Workforce Committee.

202/22 – Nursing Assurance – no confirmation has been received. This action will transfer to Fiona Osborne who will follow up.

216/22 - PSIRF action – due for discussion at today's meeting (item 7.1). This action was closed.

Regular Reports

226/22 Surgery update

Debbie Bagley referred to the document distributed which was taken as read and highlighted the key points relating to deteriorating patient and sepsis. Data in the report was not reflective of what was included in the IPR and current manual audit processes are being reviewed to address this. Debbie gave the following assurances that patients are safe; all data is triangulated i.e. NEWS scores, structured judgement reviews with learning escalated to the Deteriorating Patients

Group (DPG) and learning cascaded through the Divisions; incidence across all Divisions is escalated to the DPG and SI panel. All complaints are also reviewed by the Group and cascade learning and support given to the wards. Learning identified through the Ward Assurance Tools completed by ward managers is cascaded to staff. The Nursing Assurance Dashboard, daily stop and check and matron huddles also provide assurance.

The Division have a new CQUIN relating to unplanned critical care admissions and ensures patients are escalated appropriately. The Division are also working with the Digital Strategy Team to develop electronic systems. All patients are added to the critical care outreach database and reviewed. Training has been delivered on all wards which has highlighted missed opportunities for recording sepsis - the clinical educator has also visited wards to check staff understanding and this has improved since June.

Dr Kate Wood added that sepsis was a key area for the Trust as a whole and Debbie had highlighted the discrepancy between data and patient care and it was clear that an electronic solution was needed.

Fiona Osborne queried whether the comments on the IPR could be changed as they don't match the data and appear to show that actions and mitigations are failing. Dr Kate Wood explained she was working with the Surgical team to review the processes for pulling information together for the IPR. Fiona Moore will be meeting with divisional IPR leads to triangulate the data prior to the IPR narrative being due.

Fiona Osborne asked whether the following points from the previous S&CC highlight report had been fully mitigated:-

End of life training - Respect training being rolled out. Further awareness of end of life is required in regard to senior decision making, implementation of Respect. Debbie Bagley confirmed the risk has been mitigated although further work was still needed. End of life and palliative care patients are also reviewed and discussed at daily huddles.

QI initiative on pain management – Debbie explained the acute pain nurses were still linked into the project which has been rolled out to all surgical wards across the Trust with a targeted approach on B7. The electronic pain assessment tool is also starting show positive results. Debbie will update any outstanding points in future reports.

Fiona shared concern regarding the amount of work required by digital services on areas highlighted including Deteriorating Patient & Sepsis and asked how this had been escalated. Debbie confirmed the Division were linking into the digital services team and have allocated a deteriorating patient/sepsis educator. The Division are also preparing an options paper on improving digital support for the Digital Strategy Board. Debbie said the current risks were mitigated as the Division are monitoring the information.

227/22 Risk Stratification & Clinical Harm

Mr Kishore Sasapu referred to the document distributed which was taken as read and highlighted the key points. Mr Sasapu explained the purpose of risk stratification and the progress made in the Trust to the benefit of patients. During the Covid pandemic, it was unclear what the risks were for patients therefore the Trust targeted resources allocating patients with a priority of 1, 2, 3 & 4 was allocated to inpatients; red, amber or green was allocated to outpatients. There is now a need to minimise the risk and decrease the size of the PTLs and pathways are being prepared to work with specialist nurses, primary care and other health groups to decrease the burden of patients on the PTLs. A number of different streams are now being reviewed as part of the outpatients transformation project. The first meeting of the Outpatients Transformation Board is scheduled for early October and going forward a highlight report will be submitted to provide assurance to the Committee. Risk assessment is continually monitored through PRIMS and clinical speciality meetings. Mr Sasapu referred to learning that has been implemented from the changes to the pathways from Lucentis injections. As a result of CNS led stratified pathway clinics no patients have missed a clinic or delayed investigation.

Fiona Osborne added that Mr Sasapu had presented to the committee in April with further information presented in May 2022. The Committee expressed support for Risk Stratification as a principle however at both the April & May meetings the Committee had requested examples to support ongoing evolution of the process and details of learning which changed the decision criteria for risk stratification. As an assurance committee the Committee need evidence of continuing improvement for development.

Mr Sasapu explained that the purpose of risk stratification was to assess the risk to the patient and did not lead to any changes in the pathway. Mr Sasapu agreed to meet with Fiona Osborne to agree the best approach to provide evidence for the next meeting. Fiona Osborne added it was important to be able to move from the current project development stage to the business-as-usual stage.

Action: Mr Sasapu & Fiona Osborne to meet to define a Risk Stratification assurance report for the committee

Maneesh Singh felt there had been some resistance from clinicians regarding PIFU and asked how this could be overcome. Mr Sasapu felt the issue wasn't around resistance, but the PIFU model wasn't suitable for everyone. The team are now working with the different specialties to ascertain whether PIFU is suitable for them.

228/22 Lung Cancer Update

Dr Stuart Baugh referred to the report distributed which was taken as read and highlighted the key points.

Dr Baugh felt patients with lung and head and neck cancer were amongst those most affected by the Covid 19 pandemic. Areas with poorer performance at the start of the pandemic did badly during the pandemic which will reflect in the figures. Figures released by the national team in 2021 showed the reception rate had fallen below 10% across NLAG/Hull. In order to perform well against the national targets, Dr Baugh explained the stages which must be achieved including dedicated clinical

time for lung cancer services (a ninth chest physician based at DPOW is being recruited), more timely diagnostics, radiology turn-around times, adequate endoscopy capacity. These factors would allow the 28 target to be achieved for most patients. Hull's position has improved with the recruitment of 2 new oncologists with an interest in lung cancer and are supporting the DPOW site.

Fiona Osborne referred to the statistics in the report showing 14 patients with confirmed cancer were on the pathway for over 42 days, 6 being over 104 days. Fiona asked how these patients were being pulled through system and risks mitigated. Dr Baugh explained there were various delays to diagnosis such as patients needing multiple tests which prolongs the diagnostic phase. Some diagnostic work is also be done in Hull using navigational bronchoscopy putting delays of 4-6 weeks in the process leading to definitive surgery.

The team are monitoring patients undergoing navigational bronchoscopy as there is a risk they will upstage during the diagnostic process. Currently delays are noted and recognised by the Hull team which Dr Baugh is monitoring for potential upstaging via MDT meetings and was aware of one person upstaging currently.

Fiona Osborne asked how the development of a single lung cancer service across the Humber and wider Yorkshire was being progressed. Dr Baugh explained there were differences in outcomes depending on whether patients had been referred to either a tertiary or secondary centre. Historically Hull's reception rates were higher than NLAGs, Hull being a tertiary centre. Both Dr Baugh through the cancer alliance and Hull are pushing for a single model and plans for a joint North/South Bank MDT are still being worked through. Dr Baugh added that lung health checks also need to be provided as a single service across the region.

Maneesh Singh asked what proportion of patients will have lung cancer at their 2 week referral appointment. Dr Baugh confirmed that approx. 30% of patients will have cancer and 70% would not. Fiona Osborne said it would be useful for the Committee to have an understand of the patient pathway at a future meeting.

229/22 Skin Cancer Update

Dr Gowda referred to the report distributed which was taken as read and highlighted the key points. Dr Gowda explained that NLAG was not currently commissioned for skin cancer services with 717 referrals received since August 2021 predominantly from the Lincolnshire CCG area. The dermatology service has an establishment of 2.5 WTE and one consultant retiring in March 2022 leaving a 40% deficit. Prior to this the team were reviewing 91% of all cancer referrals within 2 weeks of referral. Performance has since dropped to 88% although there has not been an increase in demand.

Delays were identified due to samples not being stamped although there were no missed cancers. Performance against the standard for a decision to treat within 31 days for 2021/22 was 94.7% with 59 treatment and 9 patients breaching this threshold, this performance for 2022/23 currently sits at 88.2% with 17 treatments and 2 breaches. Performance for patients waiting for a subsequent treatment (wider excision surgery etc) in 2021/22 was 100%, performance currently sits at 50% for 2022/23.

Dr Gowda explained referrals (including a photograph) are received via ERS, triaged by the consultant team and patient are then offered either an in person or video call appointment. Patients with a suspected lesion are then invited to a one stop clinic for removal of the lesion. Discharge and other treatment are then discussed during an MDT meeting. There are currently 75 patients on the cancer PTL for NLAG, 46 patients waiting over 28 days and 29 less than 28 days.

Maneesh Singh asked why NLAG still received patients despite the service being decommissioned. Dr Gowda explained there were difficulties nationally recruiting consultants on the specialist register. Virgin Care were commissioned by the CCG although they don't have a substantive consultant and Dr Gowda provides part time cover. There are no services commissioned in Goole.

Fiona Osborne asked what mitigation was in place to ensure all samples on the 31/62 pathway are marked going forward. Dr Gowda explained the whole dermatology team have been instructed and are now responsible for ensuring samples are stamped to avoid delays.

Fiona Osborne shared concerns regarding patient safety and the potential for patient harm due to the lack of consultant support in NLAG and Hull and whether the situation would improve from November with a combined pathway. Dr Gowda felt capacity and demand would not improve unless NLAG or Hull recruit another consultant and the situation would remain the same or become worse.
Dr Gowda confirmed one incident of patient harm however this was a delay in referral to plastics for a Basal Cell Carcinoma which is a form of cancer which is unlikely to metastasise.

Dr Kate Wood asked what the interaction was between the NLAG dermatology service and the changes implemented through the interim clinical plan and informed the Committee that James Haeney had been appointed as the dermatology lead for Yorkshire and Humber. Dr Gowda explained Hull used a different model to NLAG and James Heaney was the lead for both dermatology and plastic surgery services. Going forward, Dr Gowda felt there would need to be regular discussions between NLAG and Hull to take the service forward.

Fiona Osborne summarised her concerns that the current staffing was fragile (reducing from 2.5 to 1.5 WTE) despite the same number of patients being dealt with and the risk to patients was not improving and should be highlighted to Trust Board. Fiona asked Dr Gowda to provide an update in the next review on how things have changed as a result of the changes that are being implemented in November.

Maneesh Singh asked whether the difficulties in recruiting consultants were due to there being a shortage in dermatologists. Dr Gowda explained that consultants tend to prefer to be located in areas with more academic activity i.e., London/Birmingham which affects recruitment to district general hospitals.

230/22 Ockenden update

Jane Warner explained the first Ockenden Report was published in December 2020 and the Trust were asked to comply with 12 immediate and emerging actions. The Trust have completed 11 actions and evidence is still being gathered through audit

for the one outstanding action (risk assessment throughout pregnancy). The Trust have received funding from NHSEI to support the audit work although there are difficulties recruiting to the post. Tracey Cooper, Regional Chief Midwife carried out an assurance visit to NLAG on 4 May 2022 and the initial feedback was positive. Formal feedback also gave assurance that serious incidents are being shared with the Trust Board and LMS. Good collaborative working including cross trust support of SIs was also noted. The report also complimented the maternity team on the clear evidence of co-production by the Maternity Voices Partnership and excellent service user involvement.

Recommendations for further progress included:-

- Strengthening the audit process for Board assurance
- Continue gathering further evidence as the processes mature and demonstrate sustainability
- Continue with cross site learning
-

As the visit took place in May, many of the recommendations have now been met.

The more recent Ockenden report published in March 2022 contained 92 national, regional and local actions. Evidence of compliance is not required until the East Kent Maternity report is published in October. Developments from some of the actions include:-

- Funding bid submitted to support clinical leadership for the Ockendon work
- Increase bereavement midwifery provision from 5 to 7 days a week (currently 5 days)
- Money to support enhanced training for midwifery support workers
- Local universities are designing an academic course for labour co-ordinators. The report stated labour co-ordinators are required to undertake a fully funded evidence based course.
- The local LMNS have drafted a policy to manage conflict of clinical opinion which is currently out for comments

231/22 Nursing Assurance Report

Jenny Hinchliffe referred to the report distributed which was taken as read and highlighted the key points.

CHPPD remained at 7.9% despite low fill rates. Some maternity had fill rates below 95%. The midwife to birth ratio for both sites was below the 1:28 national standard and the team are maintaining 1:1 care in labour (100%).

Vacancies for Registered Nurses and HCAs remain high partly due to an increase in establishments and due to an increase in turnover in the unregistered workforce. Work is ongoing around recruitment and retention.

The number of patients needing 1:1 supportive care remains high.

Community nursing vacancies increased in July. Benchmarking data shows nationally NLAG receive the second largest number of referrals per 100,000 population and the lowest utilisation of remote consultations. Work on service transformation is planned and the team are reviewing activity data.

The number of reported falls increased significantly in July in in-patient areas and were a combination of single and repeat falls. It was felt the low fill rate and high activity across sites contributed to the increase.

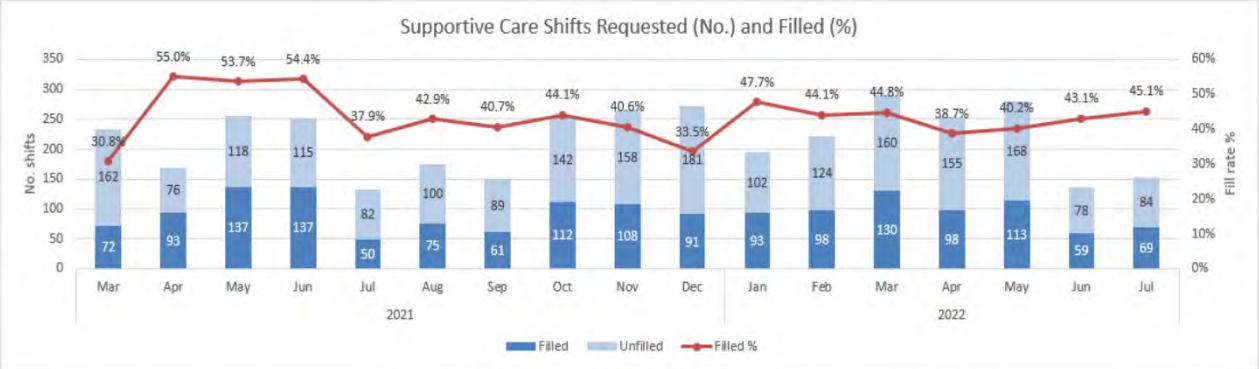
The number of reported pressure ulcers on in-patient wards reduced in July. Pressure ulcer incidence in Community is not significantly reducing therefore the team are doing detailed work to understand any themes and trends and learning from SIs.

There were 22 mixed sex breaches in July with 6 patients involved, all occurring when the Trust was on Opel 4 and there was a lack of HDU step down capacity.

There have been positive results following the QI collaborative on safe storage of medications with 57 areas achieving over 85% with a Trust average of 87% compliance. Two further QI collaboratives on pain assessment and improving the quality of discharge are under way.

Fiona Osborne highlighted that Amethyst, Ward 17 and Ward C3 all had low substantive fill rates and high sickness rates over the last 3 months; C3 also had poor 15 steps and patient experience results. Fiona asked if these wards were now an area of focus. Jenny explained Amethyst had moved from 'Intensive Support' to 'Requires Improvement' for 15 steps; a new ward manager has also been appointed and the ward have received additional support. A number of vacancies have also been filled which will have a positive impact on fill rates. The Chief Nurse also chaired a number of quality summits. C3 continue to receive additional support; a clinical sister has been appointed and ward huddles have been increased. It was agreed at the September Nursing Metrics Panel that no further support was needed at this stage. Ward 17 has high numbers of international nurses who are receiving additional support to get them through their OSCEs; the ward was awarded 'Requires Improvement' at the last 15 steps visits relating to documentation; the ward manager also requested increased support for the international nurses around documentation.

Fiona Osborne asked if there was any background to the pattern of activity between May – July (see graph below) for supportive care shifts. Despite the number of shifts requested falling significantly in both June and July the %age of shifts filled remained at the same percentage. It would be expected that the number of shifts filed would be in line with April and May and therefore the percentage fill should have gone up.



Jenny explained there were currently high numbers of HCA vacancies and turnover. The number of HCSW shifts requested through the Bank Office have been consistent as has the fill rate. Over the last few months, the same number of shifts have continued to be requested and requests to cover vacancies has increased therefore it does not show an increase in fill rate of supportive care shifts. Jenny will ensure this is reflected in the next report.

232/22 15 Steps Annual Report

Michelle Drinkell referred to the report distributed which was taken as read and highlighted the key points. Michelle explained themes, actions, improvement plans and ratings were reviewed regularly and a more significant annual review including a review of toolkits/updating questions to reflect changes in practice. The purpose of the reviews was to ensure the 15 steps process remains consistent.

All areas visited have an individual improvement plan and the 15 steps team carry out supportive visits to review the plan and gain further assurance on completed actions. Improvement plans are shared with the ward manager, matron and Division with final sign off by the Chief Nurse/Deputy Chief Nurse.

The priority going forward is to introduce star accreditation awards for areas that continue to maintain high standards of care over 3 consecutive visits. The team will also undertake a desktop review over a 12 month period as part of the process. The team are also in the process of running a PDSA cycle in OPD and community as visits have now been running for 1 year in these areas.

Angie Legge suggested the 15 Steps Report was shared with the CQC as it shows a good monitoring process within the organisation.

Fiona Osborne asked whether there were any plans for a formal review panel to undertake the reviews in the future. Michelle said a more structured review process could be considered and was gaining insights from other Trusts on their review processes.

Fiona Osborne commented that the 15 steps team were very successful in managing the process and that this was largely due to them as individuals, however the team is very small and asked whether succession planning had been considered going forward. Michelle explained one member of the team attended every visit for consistency and that 15 steps had to be owned by everyone to be successful and there were good communication processes in place between team members.

233/22 Patient Experience Report

Jo Loughborough referred to the report distributed which was taken as read and highlighted the key points. Volunteer numbers continue to grow and recruitment processes are being reviewed to streamline the process. The patient experience team are working with Haris Sultan, Chair of the National Network of Youth Forums to develop a youth forum in the Trust. The patient panel has been expanded to tie in with the development of the patient experience strategy which is being expanded to include engagement. Work in quarter 2 will focus on the equity of remuneration of volunteers.

Friends and Family Test data remained in a static position due to the Band 7 post having to step in and manage the complaints team due to unforeseen circumstances. The complaints manager was now back in post and the Band 7 would now be working with 'I want great care' to deliver the improvement plan and will also help Divisions to improve their own internal positions.

There was a decrease in complaint response timescales at the end of quarter 1 which has continued into quarter 2. The team are now sighted on a weekly basis and an action plan has been agreed. The decrease was due to long periods of leave over the summer along with the increasing complexities of complaints which has led to the time taken to investigate increasing. Jo felt this position would continue therefore the team are developing a winter plan to ensure timescales do not become unmanageable over the winter period.

The Trust achieved 8 out of 9 actions from the 2021 National Inpatient Survey from 2021.

Fiona Osborne queried why Community and Therapy (C&T) services and OPD FFT data was at 0%. Jo felt most Trust were not achieving the same results as they were pre Covid 19 and due to the age of the client group particularly in C&T the team are looking at looking at alternative ways of gathering feedback i.e., postal returns/SMS.

Fiona Osborne highlighted that a number of actions on the action plan had gone past their target date. Jo explained that the team had not appreciated that they would need a full year to elapse to gain assurance. Jo will update the timescales accordingly and retain the original date for reference. The action plan will be reviewed at the next Patient Experience Group meeting.

234/22 Annual Infection Prevention & Control DIPC report

Linda Barker referred to the report distributed which was taken as read and highlighted the key points. Linda informed the Committee that during 2021/22 the IPC team gave priority to the management of Covid 19 surges caused by the new variants and waves. Good engagement from the whole Trust allowed the team to introduce the new guidance in the most effective way. The team also continued with local and national surveillance programmes and audit programmes. Highlights included:-

- There was a reduction in CDiff cases of 29% from the previous year against a case threshold of 31%; there were 20 cases of hospital onset healthcare cases and no lapses in care were identified in any of the cases
- To date the Trust has gone 21 months with nil MRSA bacteraemia cases
- Gram negative blood stream infections remained a challenge however the Trust performed well in E.coli Bacteraemia compared to peers
- Good performance with orthopaedic primary hip and knee surgical site infections
- Infection Prevention and Control Board Assurance Framework Assessment completed which showed overall good performance
- Prioritisation given to the management of COVID-19 surges caused by new variants – flow of new national guidance managed in a proactive robust manner
- IPC shortlisted for a HSJ Patient Safety Award for management of COVID-19
- IPC presentation of a poster at International Conference (ECCMID) in Lisbon

The report recommends as part of the Trust's Estates Strategy, future builds and refurbishments take consideration to IPC requirements including enhanced ventilation, oxygen demands and isolation capacity.

Maneesh Singh asked whether filtration systems/HEPA filters/UV lights were being incorporated into new builds i.e., new Emergency Departments to reduce the level of infection. Linda explained that ventilation was now being considered for all new builds and the new Emergency Departments fully meet requirements. Work is also ongoing work across the Trust to look at critical ventilation. Linda explained the Trust had purchased a number of Hepa filters which were extremely beneficial for patients with Covid 19 and other infections are used on a daily basis.

Maneesh also asked whether Microbiologists could be accessed as there wasn't currently any on site provision. Linda explained there was national shortage of Microbiologists and there was still a vacancy on the DPOW site. During the pandemic Dr Peter Cowling retired and returned and supported the team and continues to do locum work. There is no onsite Microbiologist provision although there is 24/7 support through Path Links. Dr Kate Wood congratulated the IPC team on the report and said NLAG were fortunate to have Microbiology input from within the Trust as many Trusts don't have this provision. Fiona Osborne asked if the lack of on-site Microbiologist provision needed to be on the risk register. Dr Kate Wood was unsure there was a risk as appropriate mitigation is in place and there is no evidence that patients are suffering as a result. Angie Legge added that unless a risk scored above 8 or actions were required it was not necessary to be on the risk register.

Fiona Osborne referred to the estate's challenges in the Executive Summary and how they were being progressed as part of the long term plan. Linda said that Estates could be invited to include some narrative in next year's annual report. Linda said relationships between the IPC and Estates teams continues to strengthen and IPC are now involved in all refurbishment/new build projects and had been heavily involved in the oxygen works. A sub-group of the Critical Ventilation Group will also report directly to the Antimicrobial Infection Prevention &

Control Committee. The team recently worked closely with Estates around the installation of additional hand hygiene sinks at DPOW and had an input on a review of the Trust's bed base.

235/22 Patient Safety Incident Response Framework (PSIRF) Implementation

Angie Legge referred to the report distributed which was taken as read and highlighted the key points. Angie explained that PSIRF is replacing the current serious incident framework published in 2015 and is significantly different to what was expected. A paper was previously submitted to the committee highlighting the themes which was approved but need revisiting. PSIRF investigates based on themes and where there is significant learning rather than declaring an investigation based on strict criteria in accordance with harm. Angie has reviewed the documentation and pulled together an action plan to enable the Trust to meet the deadline to deliver by September 2023. All lead investigators will need to be trained by accredited trainers which NLAG would not qualify for. However, HSIB are offering PSIRF compatible training so there may not be any financial implications if the Trust can access the HSIB training.

Maneesh Singh asked whether the deadline was achievable. Angie said the deadline was feasible and had discussed the need to maintain progress with Dr Kate Wood and Jennifer Granger and recommended a monthly update to the Committee to provide assurance. Ian Reekie asked whether Governors would be included as key stakeholders consulted on the themes. Angie confirmed that Governors will be included as key players. Fiona Osborne asked how the project would be progressed if funding didn't become available. Angie confirmed a business case would be needed to establish funding.

236/22 Annual SI report

This item was deferred to the October meeting.

237/22 CLIP Report

Angie Legge referred to the report distributed which was taken as read and highlighted the key points. The purpose of the CLIP report was to triangulate intelligence from a number of areas i.e., incidents, claims and look at the broad themes. Themes tend to stay the same i.e., communication, documentation. The thematic overview (pg. 5) indicates some of the assurance and ongoing work to address and reduce the risk involved. The only element not currently recorded is the level of harm associated.

Fiona Osborne asked whether there was a risk around the timeliness of information and if there was a potential for patient harm. Angie explained there wasn't a risk to patient harm but more of a capacity issue for Angie's team. Once the data warehouse is developed the team will be able to access the data through Power BI. There is no risk around patient information being passed on to the relevant division.

Fiona Osborne highlighted that end of life was no longer a theme; GI Bleed/Blatchford Scoring in ED was still listed as having limited assurance. Angie explained the actions had to be completed before re-auditing. The digital team are delivering a huge programme of work and once this is completed the re-audit can take place.

The recording of patient weights also gave limited assurance. Fiona Osborne asked if any themes had been identified. Angie explained this had been audited regularly and there had been no improvement on weights being recorded in patient notes or on EPMA. Dr Kate Wood said the Trust needed to focus on patient weights following the death of a patient who was prescribed the wrong dose of paracetamol. The investigation found patients were not being weighed effectively. Weighing of patients has been included in the proposed Quality Priorities for the coming year to increase its visibility. The plan is for the IPR to be discussed at Trust Management Board - the quality priorities will be included in the report for scrutiny and discussion. Dr Wood added it would be beneficial for the QI team to run a collaborative project but they were limited to the number of projects they can undertake. Fiona Osborne added that recording of patient's weights should be included in the highlight report to Trust Board on 4 October.

238/22 IPR

Dr Kate Wood referred to the report distributed which was taken as read and highlighted the key points:-

- Sepsis – previously discussed
- Weight recording – previously discussed
- Structure judgement reviews – monitored through both the Committee and the Mortality Improvement Group (MIG)

Fiona Moore explained the data was skewed as there are unavoidable delays with screening and coding. The IPR reports the month the death occurred but should be when the SJR was allocated to give a more accurate representation. A proposal was presented to MIG that the time lag would be a 4 month delay period to take into account the different factors impacting on achieving the compliance rate. MIG supported that the IPR will be backdated for the 4 month period. Dr Kate Wood added it was important the data was reported in a meaningful way.

Fiona Osborne asked whether there had been any improvement in the flow of information. Dr Kate Wood felt there was still room for improvement as lot of IPR information was still produced manually but felt the information presented to the Board had improved. Fiona Moore is working with the Digital Team to deliver further improvements.

239/22 Key SI Update including Maternity

Angie Legge referred to the report distributed which was taken as read and highlighted the key points. A new maternity case involves a baby that received fractures to their head and subarachnoid haemorrhage following Caesarean Section at full dilatation with an impacted head. Due to the level of harm an SI was declared. One of themes identified that only one site uses a fetal pillow. There is no national guidance but it was agreed the fetal pillow should be used on both sites.

The 2 never events have been closed and assured by the CCG. The learning was attached to the report. Theatres are working through the action plan and report.

Fiona Osborne asked if there was any commonality with any of the fractured skull cases in maternity. Angie said the SI panel did not identify any commonalities. Through the investigation process, the radiologists have confirmed 2 were not fractured skulls. The Division are now engaging for independent review of the cases. Maneesh Singh added that he had no concerns from a quality and safety perspective in terms of themes.

240/22 Potential Deviations from National Documentation

Angie Legge confirmed there were no deviations to discuss this month but one would be shared with the Committee at the next meeting. NICE guidance 164 will be shared at the Quality Governance Group and will come back to the panel for their support for continued deviation.

241/22 CQC Framework

Jennifer Granger referred to the report distributed which was taken as read and highlighted the key points. Five actions were closed last month, 4 relating to the Committee:-

- PEWs audit for Family Services
- Infection control – Critical Care
- Access for theatres – Surgery
- Document control – Medicine

There were no red actions remaining for the Committee. The 5 'ambers' were detailed in the report. Fiona Osborne highlighted item 4b 'identifying recurrent funding for the financial cost of implementation for some funded actions' and asked which items were impacted. Jennifer confirmed there was a Trust wide action for financial planning and will be meeting with Lee Bond to discuss further and will update the Committee at a later date.

242/22 Quality Priorities

Angie Legge referred to the report and asked the Committee whether there were any broad themes that should be added for consideration. At the last meeting, Ellie Monkhouse raised that the PEG tube was no longer an issue – Dr Kate Wood agreed with Ellie's proposal to remove this but added that documentary evidence was needed for any priorities that are removed to ensure relevant stakeholders are informed. Angie Legge proposed that the paper should include details of the decision to remove an area and where it was agreed. The Committee supported this proposal.

Highlight reports

243/22 Quality Governance Group (QGG)

Angie Legge referred to the highlight report distributed which was taken as read.

244/22 Mortality Improvement Group (MIG)

Angie Legge referred to the highlight report distributed which was taken as read.

245/22 Patient Safety Champions

Angie Legge referred to the highlight report distributed which was taken as read.

Items for information

246/22 Quality Governance Group (QGG) minutes

Angie Legge highlighted that excellent progress is being made regarding organ donation. Most CQUINS are progressing well. QGG were informed that further work was needed to achieve CCG9 (newly diagnosed patients with alcohol).

247/22 Mortality Improvement Group (MIG) minutes

To follow.

248/22 Patient Safety Champions minutes

The terms of reference for the Patient Safety Champions Group had been reviewed by the group. Angie Legge asked the Committee to ratify the terms of reference. The Committee agreed to ratify the terms of reference.

249/22 Mental Health update paper

Attached.

250/22 Any Other Business

Dr Kate Wood formally expressed her thanks to Angie Legge who was attending her final Quality & Safety Committee and said she would be sorely missed. Dr Wood said that Angie had helped to improve the overall quality governance structure in the Trust and Angie was leaving behind a fantastic legacy. Jennifer Granger will be supporting until Angie's replacement is in post.

Maneesh Singh was also attending his last meeting and thanked the Trust for their support. Fiona Osborne thanked Maneesh for his contribution to the Committee.

251/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

Fiona Osborne to put the highlight report together after the meeting. It was agreed to include the following:-

- Patient weights
- Digital aspects
- Organ donation

252/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 25 October 2022
Time: 1.30pm – 4pm
Venue: Via MS Teams

The meeting closed at 4.10 pm

Annual Attendance Details:

Name	Oct 2021	Nov 2021	Dec 2021	Jan 22	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022
Michael Proctor	x	✓	✓	✓	x	✓	✓	✓	✓	✓	✓		
Michael Whitworth	✓	✓											
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Maneesh Singh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	
Dr Kate Wood	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	
Ellie Monkhouse	✓	✓	x	✓	✓	✓	✓	✓	✓	x	✓	x	
Dr Peter Reading	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	x	X	
Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Helen Harris	x	✓	x	x	x	x	x	x	x	x	x	X	
Jan Haxby	✓	x	x	x	✓	✓	✓	✓	x	x	✓	X	
Shaun Stacey	x	x	✓	x	x	x	✓	x	x	x	x	x	

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 6 December 2022
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jenny Hinchliffe, Deputy Chief Nurse Melanie Sharp, Deputy Chief Nurse
Title of the Report	**Nursing Assurance Report**
Purpose of the Report and Executive Summary (to include recommendations)	The Board is asked to note the content of the report. The overall CHPPD was 8.2 in September compared to 8.9 in August. The Midwife to Birth Ratio data for both units is DPOW 1:25.6 and SGH 1:26 which is below the acceptable ratio of 1:28. There is a total of 277.03 WTE (15.01%) Registered and 148.41WTE (15.71%) Unregistered vacancies across the Trust. 87 newly qualified nurses and midwives are due to commence in post over the autumn, with a further 20 to start in January and February. International recruitment continues. 180 applications have been received for the 45 places on the nursing apprenticeship programmes and interviews are underway. The total for Acute is 47 staffing red flags in September compared to 81 August. The total for Community red flag incidents for September 2022 is 9, 5 of these relate to a shortfall in nurse staffing. Maternity red flags fell to 13 from 16 in August. The total number of falls reported has decreased significantly for the second consecutive month. There has been an increase in the number of reported falls at the Scunthorpe site. There number of pressure ulcer incidents reported has decreased. Both the Grimsby site (DPOW) and the Medicine division continue to report higher numbers of pressure ulcers. The incidence of pressure ulcers in the Community has seen a significant reduction from 53 to 33. The staffing challenges for all networks has improved slightly in October 2002 with the newly qualified nurses commencing in post. New formal complaint numbers remained consistent for a third month in a row, at 26 received during September with a total of 100 open complaints, which is a slight decrease on August's total of 116. Complaints over 60 working day timescale remains the same level as August. The Trust declared one mix sex breach at DPOW which involved three patients. One action plan was commenced which contained all the actions for all patients affected. Eight 15 Steps Challenge visits were completed. Six in the acute schedule (with four areas receiving Good and two receiving

	Outstanding). Two in community and therapy received one Good and one Outstanding. The Trust has reported 14 C.Difficile onset cases since 1st April with antimicrobials shows to be the main predisposing factor, all broadly justified. The case threshold has been exceeded for Pseudomonas aeruginosa with an investigation report for each case with no trend identified so far. It is 2 years since the last hospital onset MRSA bacteraemia case. 'Living with COVID' principles are in place within The Trust in line with national guidance, with the pausing of asymptomatic patient swabbing and monitoring but not isolation, of positive COVID-19 contacts. The annual audit for safe and secure storage of medication in 2020 showed 12 areas achieving over 85% compliance with average compliance of 73%. In 2021 19 areas above 85% with an average of 75% compliance. In 2022 the annual audit showed a large improvement with 57 areas achieving over 85% with a trust average of 87% compliance.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Quality & Safety Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		

Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Assurance Report November 2022 (September data)

1.0 Introduction

This is a routine report in accordance with the requirements of the updated National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance (July 2016), the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014 and Developing Workforce Safeguards (2018).

Trusts must ensure the three components are used in their safe staffing processes:

- evidence-based tools (where they exist)
- professional judgement
- outcomes

The Trust is committed to providing safe, effective, caring, responsive and well led care that meets the needs of our patients. It is recognised that decisions in relation to safe clinical staffing require a triangulated approach which consider Care Hours per Patient Day (CHPPD) together with staffing data, acuity, patient outcomes and clinical oversight. This report provides evidence that processes are in place to record and manage nursing and midwifery staffing levels on a shift by shift basis across both hospital and community settings, and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care, thus enabling the Trust to demonstrate compliance with safer staffing guidance. It also seeks to provide information on vacancy rates and nursing metrics across all ward areas.

Oversight continues to be provided to the Quality and Safety Committee on nursing and safe staffing. The changes to ward configurations and zoning throughout the pandemic has made it challenging to make comparisons and benchmark. It is worth noting that this will affect any Model Hospital metric comparisons.

As we continue to reset ward configurations and utilise escalation beds across the Trust, any data should be viewed with caution and for this reason we continue to review individual metrics and apply professional judgement. In line with the document published in February 2021, Deployment and Assurance of Clinical Nursing Workforce during Covid 19 emergency, quality impact assessments are undertaken with final sing-off by the Chief Nurse prior to additional wards being opened. The self-assessment assurance framework for nursing and midwifery staffing can be found in appendix 1.

The Nursing Metrics Review Panel is chaired by the Chief Nurse, meets monthly and is attended by the senior nursing team for the organisation. The panel review the information provided by the nursing dashboard and commission any work required to investigate and support any areas of concern.

2.0 Safe Staffing

2.1 Shift Fill Rates and Care Hours per Patient Day (CHPPD)

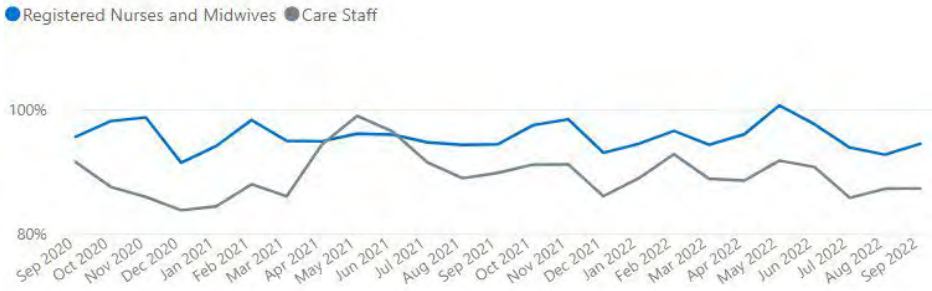
The information presented shows data on inpatient wards only.

Shift Fill Rates Summary Sep 2022

Overall	Registered Nurses and ...	Care Staff	Nursing Associates
91.6% ▲ 1.1%	94.4% ▲ 1.8%	87.2% ▲ 0.0%	

Overall Fill Rate

Fill Rate by Staff Group



Overall Fill Rate by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Sep 2022	DPoW	91.2%	3.8%	87.4%	
Sep 2022	GDH	98.3%	-11.0%	109.3%	
Sep 2022	SGH	91.5%	-1.1%	92.6%	

Overall Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Sep 2022	Medicine	95.0%	2.7%	92.3%	
Sep 2022	Surgery & Critical Care	91.3%	-2.7%	94.0%	
Sep 2022	Women & Children's	83.7%	1.6%	82.1%	

Shift fill rates are reported against ward establishments. Staffing reviews take place at intervals throughout the day, including a trust wide review of SafeCare Live information at 10am.

The Chief Nurse establishment review is planned for November/ December 2022. The Safer Nursing Care Tool (SNCT) data was collected during May/June 2022 following the increase in establishments and is being collected on 20 days during October/ November to account for seasonal variation. Meetings will be held with ward and department managers to review the SNCT data and nurse sensitive indicators.

The graphs above show the fill rate trends from the Nursing Assurance Dashboard. The combined fill rate shows some variance from month to month, in September being 91.6% and below the target of 95%.

A mix split of 60:40 is aimed for, with a higher skill mix for midwifery. Registered Nurse and Midwife to HCSW ratio for the Trust has been above 60% for the last year. Medicine remains the lowest RN ratio in September at 57.1%. Surgery & Critical Care has the highest RN ratio and is reflective of the number of level 2 and 3 beds within the division.

RNMW Ratio Summary Sep 2022

RNMW Ratio

63.1% ▲ 0.3%

RNMW Ratio

RNMW Ratio by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Sep 2022	DPoW	61.1%	-0.3%	61.4%	
Sep 2022	GDH	57.7%	1.7%	56.0%	
Sep 2022	SGH	66.2%	0.6%	65.5%	

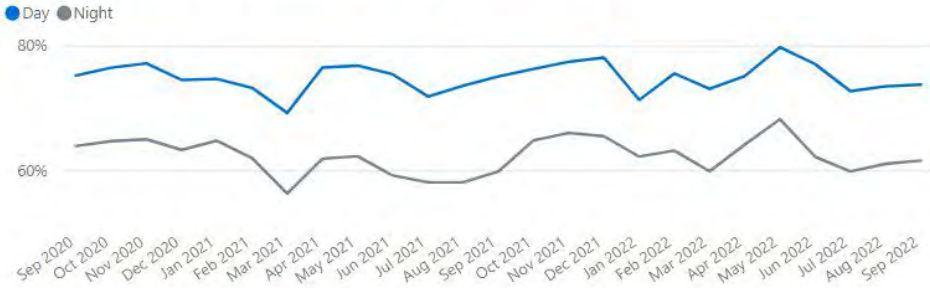
RNMW Ratio by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Sep 2022	Medicine	56.9%	-0.2%	57.1%	
Sep 2022	Surgery & Critical Care	72.6%	0.9%	71.8%	
Sep 2022	Women & Children's	68.1%	0.2%	67.9%	

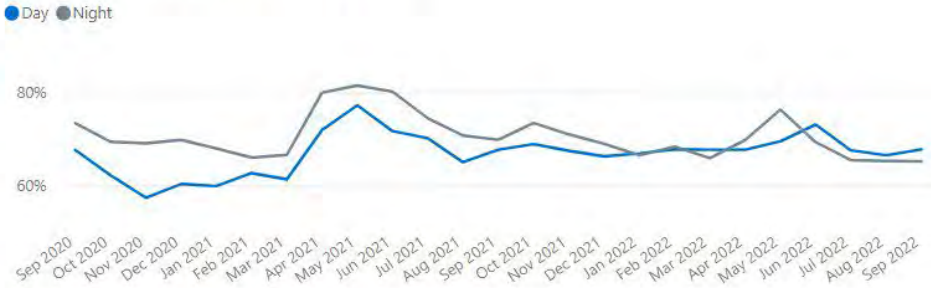
Substantive Fill Rates Summary Sep 2022

RNMW - Day	RNMW - Night	Care Staff - Day	Care Staff - Night
73.7% ▲ 0.3%	61.5% ▲ 0.5%	67.7% ▲ 1.3%	65.2% ▼ -0.1%

Registered Nurses and Midwives Substantive Fill Rate %



Care Staff Substantive Fill Rate %



RNMW - Day Substantive Fill Rate by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Sep 2022	DPoW	77.7%	✓ 1.3%	76.4%	
Sep 2022	GDH	90.3%	✓ 5.5%	84.9%	
Sep 2022	SGH	67.5%	! -1.3%	68.8%	

RNMW - Day Substantive Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Sep 2022	Medicine	72.3%	✓ 0.1%	72.2%	
Sep 2022	Surgery & Critical Care	80.8%	✓ 2.6%	78.2%	
Sep 2022	Women & Children's	67.8%	! -2.7%	70.4%	

Wards with Substantive Fill Rate Below 50% Sep 2022

Staff	Registered Nurses and Midwives	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
Central Delivery Suite	49.2%	-4.5%
Disney SGH	49.2%	0.3%
WARD 18 SGH	15.9%	-55.1%

Staff	Registered Nurses and Midwives	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD 22 SGH	48.9%	13.4%
WARD 23 SGH	48.9%	4.8%
Disney SGH	48.3%	2.3%
WARD C2	46.8%	3.1%
WARD 3 GDH	45.0%	-7.5%
Amethyst	41.1%	6.7%
WARD 24 SGH	38.7%	-11.7%
WARD 18 SGH	38.3%	-35.9%
WARD C5 DPoW	30.1%	3.3%
WARD 17 SGH	25.3%	-6.9%

Staff	Care Staff	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
WARD B6 DPoW	49.4%	-3.9%
WARD 23 SGH	48.4%	-1.6%
LAUREL WARD DPoW	42.7%	-2.2%
WARD 22 SGH	38.5%	-18.3%

Staff	Care Staff	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD B6 DPoW	48.9%	4.8%
LAUREL WARD DPoW	46.7%	-1.9%
WARD C2	46.7%	9.0%
29 SGH	45.6%	-36.1%
WARD 18 SGH	45.0%	-40.7%
HDU DPoW	33.3%	17.3%
WARD 23 SGH	14.4%	4.8%

Substantive versus temporary staff fill rate is monitored and a slight increase in substantive staff fill rate is seen for days and nights for RNs and days for HCAs. Night shifts continue to be the shift with the lowest substantive fill rate for RNs with10 wards less than 50%. Disney ward continues to show a <50% substantive RN fill rate on days and nights and the data is being interrogated by the Resource Centre team as this is not accurate. Only a small amount of bank and agency staff is used on Disney.

Of the 10 wards reported in August that had RN substantive fill rate less 50%, 7 of these wards also feature in this month's report. All have high levels of sickness and vacancies and wards 17, 22, 23 and C2 re all receiving additional oversight and support from senior divisional nurses and the Chief Nurse team.

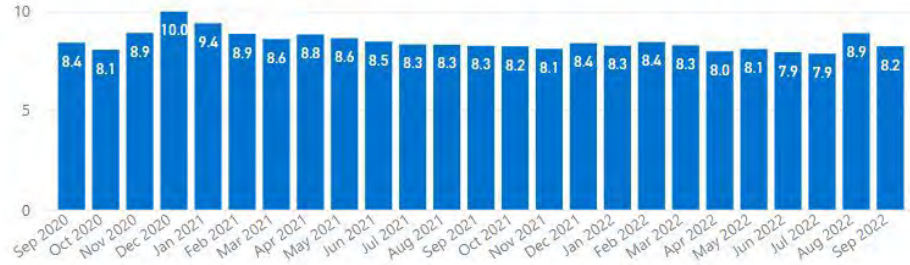
The information below demonstrates the level of sickness and vacancy in the areas with the lowest substantive fill rate:

Ward	Sickness	RN vacancy wte	HCA vacancy wte
Ward 22 SGH	6.24%	4.01	2.26
Ward 23 SGH	19.64%	2.65	6.27
Disney SGH	14.92%	2.90	-1.82
Ward C2 DPW	11.28%	2.01	-0.38
Amethyst DPW	13.16%	6.63	5.72
Ward C5 DPW	5.87%	5.08	4.10
Ward 17 SGH	6.79%	7.33	4.05

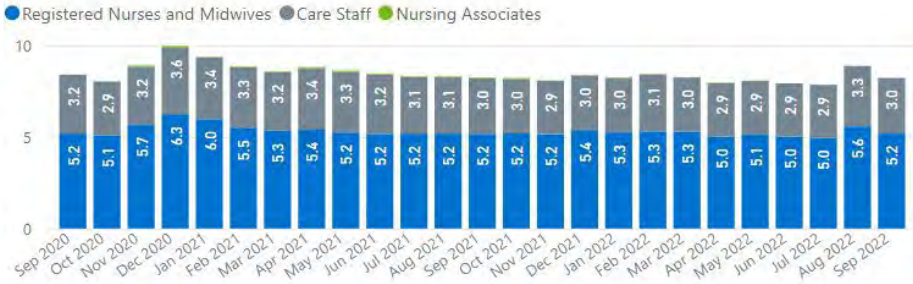
CHPPD Summary Sep 2022

Overall	Registered Nurse...	Care Staff	Nursing Associates
8.2 ▼ -0.66	5.2 ▼ -0.39	3.0 ▼ -0.27	

Overall CHPPD



CHPPD by Staff Group



CHPPD by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Sep 2022	DPoW	8.1	-0.8	8.9	
Sep 2022	GDH	7.1	0.2	6.9	
Sep 2022	SGH	8.5	-0.7	9.2	

CHPPD by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Sep 2022	Medicine	6.9	-0.7	7.6	
Sep 2022	Surgery & Critical Care	9.0	-0.3	9.4	
Sep 2022	Women & Children's	14.2	-1.1	15.4	

Wards with CHPPD Below 6.0 **Sep 2022**

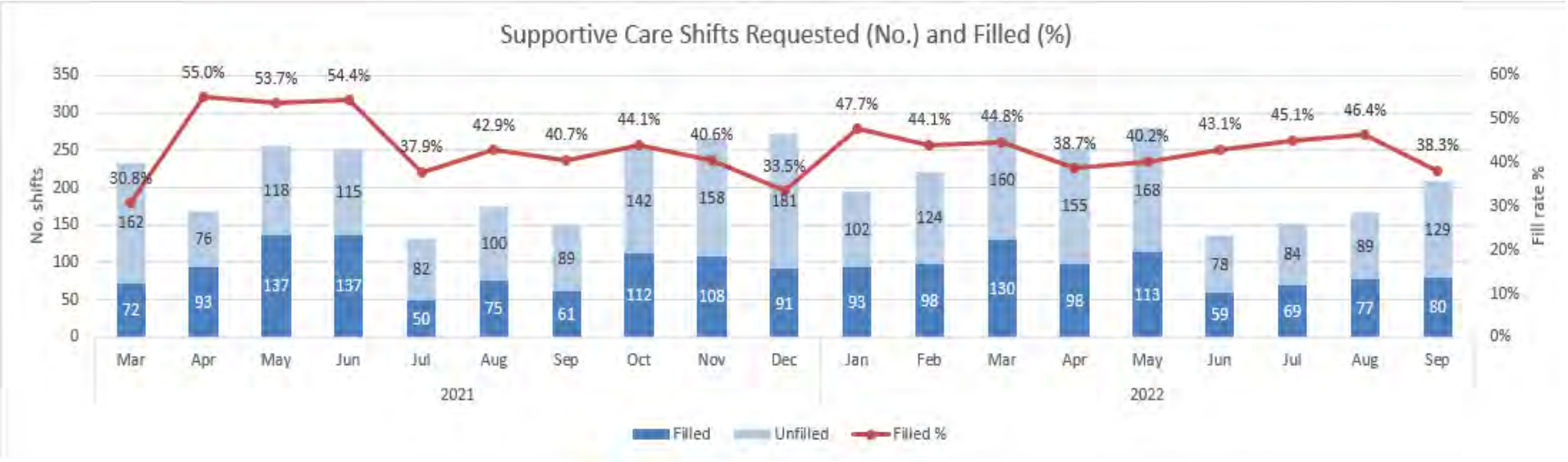
Staff	Registered Nurses and Midwives		Care Staff		**Total**	
Ward name	CHPPD	Change	CHPPD	Change	**CHPPD**	**Change**
Amethyst	3.1	▼ -0.07	2.4	▼ -0.31	**5.5**	**▼ -0.37**
WARD 22 SGH	3.2	▼ -0.26	2.3	▼ -0.26	**5.4**	**▼ -0.52**

The Care Hours per Patient Day (CHPPD) data is reported monthly and is included in the Trust's NHS Digital return. CHPPD is the total hours per day of Registered Nurses (RN), Midwives (MW) and care staff divided by the number of patients in the ward/department at 23.59 hours each night. This provides a score of the average care hours per patient per day. There are many factors that can affect the care hours required, for example, the proportion of single rooms.

The graph above shows the trend for CHPPD. The overall CHPPD was 8.2 in September.

The latest model hospital data for August 2022 indicates a provider median of 8.0 and peer median of 8.2 against the trust value of 8.9 in August which was in quartile 4 – highest 25%. The reason for the increase in CHPPD for August and to some extend September is due to the Central Delivery Suite (CDS) at SGH showing a high CHPPD (31) and is reflected in the increase in Women & Children's CHPPD. The bed occupancy data, used to calculate the CHPPD, is taken at midnight and in August there were only 36 patients and in September 86 patients. Due to the maternity model, patients are moved to ward 26 once delivered and staff are flexed between CDS and Ward 26. Historically CDS was not included in the return due to this issue, but now that it is included work is being undertaken to ensure that staff are moved on the eRoster to ensure CHHPD is accurately reported.

2.2 Supportive Care



The wards are seeing an increase in number dependent patients, several which require 1:1 supportive care. These shifts are not part of the ward establishment. Shifts are sent to the temporary staffing team to source unregistered cover via the Bank. Additional processes have been put in place for risk assessing our patients with tools such as AFLOAT to support prioritisation and decision-making regarding options available. All areas where 1:1 care need is identified have permission to access additional duties to try and cover this need. Additional allocate on arrival shifts are also booked centrally to help with providing a staff resource outside of the ward establishments to support 1:1 supportive care need. Matrons have a daily presence on the wards and can review patients and risk assessments and provide support and oversight of high-risk patients. This low fill rate impacts on the ward with core ward staff supporting. SafeCare Live supports deployment decisions which are based on the acuity and dependency of patients and available staff.

The above chart demonstrates that of the requested shifts, less than 50% are filled despite a significant reduction in demand over recent months. This has at times been a concern across all areas of the Trust and risks are identified and reviewed in safety huddles, staffing meetings and on operational calls. The overall shifts filled for Bank HCA requests to cover both supportive care and vacancies has remained fairly static suggesting that an increased number of the requests to cover shifts because of vacancies are being filled. These shifts may be being picked up before the supportive care shifts which tend to be requested at short notice.

Recruitment onto the Bank continues.

2.3 Escalation Beds

It is still not possible to obtain accurate escalation bed data against established beds from WebV or the Sitrep reports. Escalation beds which are not established are open on C3 (n4), B2 (n5), ward 24 (n6), IAAU (n12), SGH gynae (n2 D2A) – total 29 beds. This has an impact on staffing across all areas.

2.4 Staffing Indicators

2.4.1 Vacancies

The information presented below shows data on **inpatient wards** only.

Vacancies - Unqualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Sep 2022	DPOW	45.2	-8.4	53.7	
Sep 2022	GDH	7.3	-1.4	8.8	
Sep 2022	SGH	43.0	-10.7	53.6	

Vacancies - Unqualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Sep 2022	Community & Therapies	7.3	-1.4	8.8	
Sep 2022	Family Services	5.1	-1.2	6.3	
Sep 2022	Medicine	56.5	-12.8	69.3	
Sep 2022	Surgery	26.6	-5.1	31.8	

Vacancies on the inpatient wards in September for Registered Nurses show an increase however a decrease is seen for Healthcare Assistants.

The recent HCA rapid recruitment events have resulted in 131 employment offers (110.04wte) which are now being processed. Retention work continues, and as part of this the HCSW induction programme has been refreshed and career clinics have been established. Targeted recruitment work is ongoing with colleagues in POE and the QI teams. Career pathways have been developed along with nursing apprenticeships to support retention work which remains a priority.

There is a total of 277.03 WTE (15.01%) Registered and 148.41WTE (15.71%) unregistered vacancies across the Trust. 87 newly qualified nurses and midwives are commencing in post over the autumn, with a further 20 to start in January and February. 34 international nurses (INs) are commencing in post over Q3.

The overseas Pre-registration nurses who have joined the Trust continue to progress through their OSCE preparation and induction programme.

	Pass – 1st attempt (%age)	Pass – 2nd attempt (%age)	Pass – 3rd attempt (%age)	Overall pass rate (all attempts)
Cohort 12 April (15)	6 (40%)	9 (60%)	N/A	100%
Cohort 13 June (10)	2 (20%)	8 (80%)	N/A	100%
Cohort 14 Aug (10)	1 (10%)	8 (80%)	1 awaiting resit on 19/10/22	90% + 1 a/w 3rd attempt 27/10/22
Cohort 15 Sept (7)	4 (57%)	3 awaiting resits		

The national pass rate for the new NMC test of competence (*including resits*) is 61% for Q1 as published on the NMC website.

The Trust is on track to recruit 90 international nurses by December 2023 in line with the MOU for funding support agreed with NHSE/I. An additional bid has been submitted to support the appointment of 20 international nurses in Q4.

A risk associated with the ability to continue to support international nurse recruitment includes Practice Development team capacity to support OSCE prep and induction as temporary funding ends March 2023 (2 x Band 6 posts to support OSCE prep and induction). An additional risk is the availability of training rooms for OSCE prep which is resulting in additional costs associated with transporting IENs across sites.

Recruitment is underway for the nursing apprenticeship programmes which have proved to be popular.

A workforce plan and RN forecast has been developed with finance and workforce colleagues to support recruitment initiatives going forward.

2.4.2 Staffing Incidents

The information presented below shows data on inpatient wards only.

Wards with Incidents

Indicator	Staffing Incidents		Red Flags	
Site - Ward	Value	Change	Value	Change
DPOW - Rainforest	1	▲ 1	15	▼ -18
DPOW - C2	2	▲ 2	7	▲ 4
DPOW - Stroke DPW	1	0	4	▼ -4
SGH - CDS	4	0	1	▲ 1
SGH - ICU	0	0	5	▲ 2
DPOW - A1	2	▲ 1	2	▲ 2
DPOW - C3 Short Stay	0	0	4	0
DPOW - Maternity	3	▲ 1	0	0
SGH - Ward 24 Assessment Unit	2	▲ 2	1	▲ 1
SGH - Disney	1	▼ -1	1	▼ -1
SGH - Ward 17	1	▲ 1	1	▲ 1
SGH - Ward 26	2	▼ -1	0	▼ -2
SGH - Ward 27	0	0	2	▼ -3
DPOW - C1 Glover	0	0	1	▲ 1
DPOW - C5	0	0	1	0
DPOW - ITU	0	0	1	0
SGH - Ward 18	0	0	1	▼ -5

21 nurse staffing incidents were reported in September on the Ulysses system compared to 26 in August.

2.4.3 Red Flags

A total of 47 staffing red flags were reported (40 on Safecare Live and 7 on Ulysses) in September. This was a decrease compared to 81 in August however some fluctuation is seen month by month and it is too early to say if this decrease is sustainable.

Red Flags on SafeCare Live

Red Flag type, Ward	No.
Below Safe Staffing Levels	30
Rainforest	12
C3 Short Stay	4
Stroke DPW	3
C2	3
Ward 27	2
A1	2
C1 Glover	1
Ward 18	1
ICU	1
C5	1
Less than two trained nurses on a Clinical Area	3
Rainforest	3
Co-ordinators Non Supernumerary	3
ICU	2
ITU	1
Area outside of normal Footprint	2
ICU	2
Covid-19 +ve pts on Ward	1
C2	1
Less than 50% substantive staff on shift	1
C2	1

Red Flags on Ulysses

Red Flag type, Ward	No.
Less than 50% substantive staff on a shift	5
C2	2
Stroke DPW	1
Ward 17	1
Disney	1
Not Completed	1
Ward 24 Assessment Unit	1
Community staff have been called into work on the unit	1
CDS	1

Rainforest/PAU continue to be the highest reporters of red flags and is reflective of a good reporting culture.

3.0 Community Nursing

Activity data not available for September 2022.

Community Nursing Assurance Dashboard — Sep 2022

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator Category	Activity			Safety & Quality							Staffing	Infection Control	Friends & Family	End of Life Care
Team	Contacts Actual	Contacts Planned	Contacts Telephone	Red Flags	Falls - Total	Community Acquired PU - Total	Complaints	Weekly Assurance Tools	Caseload Reviews	Caseload	Vacancies - Total	Hand Hygiene %	FFT Recommended Rate %	Deaths with Care in Last Days of Life %
West Network				2.0 ↗	0.0	8.0 ↘	0.0	0.0	0.0		6.6 ↗			
East Network				1.0	0.0	17.0 ↗	0.0	0.0	0.0		12.0 ↗			
South Network				2.0 ↗	0.0	3.0 ↘	0.0	0.0	0.0		6.4 ↘			
West, East & South Networks											25.0 ↗			
Unscheduled Care Team (UCT) (incl rapid response)				2.0 ↘	0.0	0.0	0.0	0.0			0.8 ↘			
Macmillan Health Care Team				0.0	0.0	0.0	0.0	2.0 ↗			0.2 ↘			
Specialist Palliative Care Nurses (SPC)				0.0	0.0	0.0	0.0	0.0			6.0 ↗			
Palliative Care				0.0	0.0	0.0	0.0	0.0			1.0			
Single Point of Access (SPA)				2.0 ↗	0.0	2.0 ↗	0.0	0.0			2.7 ↘			
Continence Team				0.0	0.0	0.0	0.0	0.0			1.2 ↘			
Tissue Viability Team				0.0	0.0	1.0	0.0	0.0			0.6			
Long Term Conditions / Complex Care Matrons (Comm Matrons)				0.0	0.0	0.0	0.0	0.0			-0.3			
Intermediate Care Services (ICS) + Core Therapy				0.0	0.0	2.0 ↘	0.0	0.0			1.5			
Discharge Liaison Team				0.0	0.0	0.0	0.0	0.0			-1.0 ↘			
Locality Co-ordinators				0.0	0.0	0.0	0.0	0.0			-0.2 ↘			
Evening / Night Service				0.0	0.0	0.0	0.0	0.0			-0.9			
Chronic Wound Team				0.0	0.0	0.0 ↘	0.0	0.0			-0.8	100.0		
DN Students				0.0	0.0	0.0	0.0				-2.0 ↘			
Community Nursing													92.0	34.1 ↘

3.1 Community Nursing Workforce

3.2 Vacancies

There was a slight increase overall in our nursing vacancies for September 2022, several of which are a result of the nursing establishment uplifts and the posts identified in the community business case which have now been funded. Staffing capacity is an ongoing issue with work being undertaken to recruit to vacancies and retain existing staff and new starters. The vacancy position within the community networks links to risk 2921 on the risk register, this has been reduced from high to moderate because of the increase in band 4 and 3 unregistered nurses and is mitigated daily by using bank staff, staff undertaking extra hours, and support from other teams as able.

Work to improve our vacancy position includes:

- Recruitment Webinar preceding open day to encompass all C+T vacancies in plan for Nov & December
- Once minimum and optimum staffing levels agreed for each network, roster approval processes / confirm and challenge to be reviewed to ensure appropriate action is taken to mitigate risk in the event of unsafe staffing levels
- Establishment review of all 3 networks to ensure appropriate number of staff allocated to each network
- QI project to combine DN Hub & SPA into a True SPA with dedicated resource underway
- QI team supporting process mapping to determine focused workstreams to improve:

  Access & Navigation Patient Journey Staff experience

In the community nursing networks the vacancies are split as below, with East network showing the highest number of Registered Nurse vacancies. All vacant posts are out to advert or in the recruitment pipeline.

Planned Nursing Vacancies and Forecast

EAST NETWORK

	Est WTE	In post	Shortfall	Vacancy %	Due In	Leavers	Forecast	Vacancy %
B7	1	0	1	100%	0	0	1	100%
B6	5	4	1	20%	0	0	1	20%
B5	23.71	12.53	11.18	47%	0	1	12.18	51%
B4	6.78	2	4.78	71%	3	0	1.78	26%
B3	2.73	6	-3.27	-120%	0	3	-0.27	-10%

SOUTH NETWORK

	Est WTE	In post	Shortfall	Vacancy %	Due In	Leavers	Forecast	Vacancy %
B7	2	2	0	0%	0	0	0	0%
B6	6.6	3	3.6	55%	0.8	0	2.8	42%
B5	23.71	18.33	6	25%	0	0	0	0%
B4	6.6	5.6	1	15%	0	0	1	15%
B3	2.73	2.28	0.45	16%	0	0	0.45	16%

WEST NETWORK

	Est WTE	In post	Shortfall	Vacancy %	Due In	Leavers	Forecast	Vacancy %
B7	1	1	0	0%	0	0	0	0%
B6	3.8	2.8	1	26%	0	0	1	26%
B5	22.75	18.2	4.55	20%	0	0	4.55	20%
B4	6.78	3.93	2.85	42%	1.8	0	1.05	15%
B3	2.73	3.8	-1.07	-39%	0	1	-0.07	-3%

PHLEBOTOMY

	Est WTE	In post	Shortfall	Vacancy %	Due In	Leavers	Forecast	Vacancy %
B4	1	1	0	0%	0	0	0	0%
B2	4	5	-1	-25%	0	0	-1	-25%

Recruitment to vacancies in the Unscheduled Care team is on track, interviews have taken place with all posts appointed to.

The vacancies in the Intermediate Care Service, Single Point of Access, Continence team and Macmillan Health Care Team have all been appointed to and are in the recruitment pipeline.

The 3.0wte MacMillan Specialist Palliative Care Nurses which will enable the movement to a 7-day service in acute have recruited to 2.0wte, the remaining post will be going back out to advert.

3.3 Activity

There is limited activity information for September due to the BlueFish reporting contract ending.

Activity not delivered- Community Nursing Networks

Despite daily problems with capacity and demand, information from the electronic allocation tool shows a static position of visits deferred from the planned date.

Visits Allocated Aug 22	Visits Completed Aug 22	Visits Deferred Aug 22
13119	11919	1200
	91.0%	9.0%
Visits Allocated Sept 22	**Visits Completed Sept 22**	**Visits Deferred Sept 22**
12906	11799	1107
	90.7%	9.3%

So What?

- ✓ Housekeeping to ensure all traits are accurately assigned to staff
- ✓ E- Allocation coordinator overseeing the system and making “on the day” changes
- ✓ Cancelled visits- visits are prioritised throughout each day.
- ✓ Staff now have GPS active and are checking in and out of visits.
- ✓ Duplicated of visits on the system is being reduced
- ✓ Staff meetings focused on e-allocation to increase awareness and improve understanding in clinical staff

3.4 Community Nursing Red Flag incidents

The total nursing red flag incidents for September 2022 is nine, five of these relate to a shortfall in nurse staffing although this is not reflective of the workforce challenges particularly in Community Nursing. We have a high vacancy rate across the teams awaiting staff commencing in post, several which will be filled by the Newly Qualified Nurses starting in September and October 2022 and several others are in the recruitment pipeline. Work is underway to articulate minimum staffing numbers for community nursing based on capacity and demand methodology which aligns with the National Community nursing SNCT (CNSST). The Trust has the licence to use the CNSST and training is underway to train all community nursing staff to categorise patient visits.

4.0 Maternity Dashboard and Red Flag Incidents

4.1 Maternity Staffing

The Chief Nurse undertook a desktop maternity staffing establishment review in early March 2021 and the increases in establishments identified were included in the Trust's Ockenden Immediate and Essential Actions submission. An establishment review using Birthrate Plus workforce planning tool has been undertaken. A desktop review with ward managers took place at the end of May and a safer staffing paper is being prepared for Trust Management Board.

4.2 Maternity Fill Rates and CHPPD

Maternity Wards Fill Rates and CHPPD — Sep 2022

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**91.3%**	**▼ -0.2%**	**84.7%**	**▲ 1.5%**	**11.2**	**▼ -3.28**
Registered Nurses and Midwives	89.1%	▼ -0.3%	82.1%	▲ 3.2%	7.0	▼ -2.05
Care Staff	95.2%	▼ -0.1%	89.3%	▼ -1.4%	4.2	▼ -1.23
Central Delivery Suite	**77.7%**	**▲ 5.5%**	**57.8%**	**▲ 0.7%**	**38.3**	**▼ -49.58**
Registered Nurses and Midwives	75.1%	▲ 5.9%	53.0%	▲ 0.8%	31.0	▼ -39.56
Care Staff	90.9%	▲ 3.5%	82.5%	▲ 0.1%	7.3	▼ -10.01
Jasmine & Honeysuckle	**90.5%**	**▲ 0.2%**	**74.7%**	**▼ -0.4%**	**10.9**	**▼ -5.46**
Registered Nurses and Midwives	88.1%	▲ 1.0%	73.1%	▲ 0.8%	7.1	▼ -3.47
Care Staff	95.4%	▼ -1.5%	78.1%	▼ -2.7%	3.8	▼ -1.98
Ward 26 SGH	**81.5%**	**▲ 5.7%**	**64.1%**	**▲ 3.8%**		
Registered Nurses and Midwives	81.6%	▲ 12.1%	61.3%	▲ 7.7%		
Care Staff	81.1%	▼ -11.8%	72.0%	▼ -6.6%		
Total	**85.5%**	**▲ 2.6%**	**70.9%**	**▲ 1.3%**	**17.4**	**▲ 0.90**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	62.2%	▼ -0.1%
Central Delivery Suite	81.0%	▲ 0.7%
Jasmine & Honeysuckle	65.5%	▲ 0.6%
Ward 26 SGH	73.2%	▲ 6.2%
Total	**69.7%**	**▲ 1.7%**

The fill rate in maternity remains <95 %. Staffing shortfalls have been experienced across both sites and in the community due to COVID19 absence, sickness, and vacancies. Operational staffing meetings are held three times per day with review of issues and escalation of any risks that can't be mitigated, with senior oversight in the 10.00hour safe staffing meeting. Proactive requests for bank staff / agency staff are made as required. Escalation processes and plans are in place with daily oversight from the senior midwifery team.

Recruitment is ongoing and vacancies are reviewed regularly and taken to the weekly establishment review meeting. There is a rolling advert for rotational midwifery posts and international recruitment of midwives has commenced with the support of the regional NHS England workforce team.

4.3 Midwife: Birth ratio

Assurance that safety was maintained within the maternity units is supported by the Midwife to Birth ratio data. In September 2022 the data for both units is DPOW 1:25.6 and SGH 1:26 which is below the acceptable ratio of 1:28. Although the vacancy factor is high, the ability to cover shifts shows positively in the ratios. The Midwife to Birth Ratio has throughout the year been below the expected 1:28 for both sites. Neither unit had to close to maintain safety during the month of September 2022. There is a robust escalation policy that is utilised in times of high acuity and there are close links to the Operations team throughout both sites. Maternity services have commenced using the maternity OPEL status to provide an oversight of their current position. This is provided to the Trust Operational meetings and reported regionally.

4.4 Maternity Dashboards

DPOW Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022
Midwife to Birth Ratio	25.2	24.4	24.8	24.6	24.9	24.0	23.9	24.9	24.8	26.5	26.5	25.6
Red Flags	15.0	5.0	17.0	10.0	12.0	6.0	11.0	2.0	2.0	7.0	9.0	9.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	8.0	2.0	4.0	1.0	3.0	2.0	0.0	1.0	0.0	0.0	0.0	0.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	1.0	1.0	1.0	0.0	0.0	1.0	0.0	0.0	1.0	2.0	0.0	1.0
(c) Missed medication during an admission to hospital	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	2.0	2.0	4.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	1.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	4.0	0.0	3.0	2.0	4.0	2.0	2.0	0.0	1.0	2.0	4.0	2.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	2.0	1.0	8.0	2.0	5.0	1.0	9.0	1.0	0.0	0.0	2.0	2.0
Continuity of Carer %	23.0	20.0	20.0	17.0	24.0	19.0	20.0	21.0	21.0	23.0	24.0	24.0
In Receipt of %	15.0	11.0	9.0	10.0	23.0	9.0	14.0	10.0	15.0	13.0	14.0	15.0
CoC In Receipt of %	58.0	60.0	52.0	21.0	83.0	56.0	82.0	79.0	72.0	89.0	72.0	68.0
Continuity Team Caseload	348.0	347.0	326.0	342.0	334.0	319.0	347.0	314.0	314.0	305.0	305.0	295.0
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	90.7	92.7	90.1	92.8	91.5	95.1	94.0	91.5	92.2	86.0	86.0	89.0
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies	13.2	11.5	10.8	12.1	11.8	11.2	19.3	19.4	19.1	20.2	20.3	26.3
Vacancies - Registered	12.0	9.8	8.8	10.3	10.9	10.2	16.4	17.4	17.5	17.7	17.8	19.5
Vacancies - Unregistered	1.1	1.8	2.1	1.9	0.9	0.9	2.9	2.1	1.5	2.5	2.5	6.8
Serious Incidents	0.0	1.0	1.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	1.0
Complaints	1.0	2.0	1.0	0.0	0.0	1.0	2.0	1.0	1.0	2.0	1.0	0.0
PALS	1.0	8.0	7.0	5.0	1.0	2.0	3.0	4.0	3.0	1.0	5.0	2.0

SGH Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022
Midwife to Birth Ratio	24.7	23.6	24.9	24.2	23.9	23.9	26.4	25.3	25.5	25.8	25.8	26.0
Red Flags	13.0	14.0	43.0	23.0	24.0	17.0	19.0	22.0	15.0	27.0	6.0	4.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	0.0	0.0	9.0	1.0	3.0	0.0	2.0	0.0	1.0	5.0	0.0	1.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	4.0	1.0	3.0	1.0	2.0	0.0	1.0	2.0	2.0	0.0	1.0	0.0
(c) Missed medication during an admission to hospital	1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	2.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	3.0	4.0	11.0	1.0	2.0	3.0	1.0	11.0	5.0	11.0	1.0	2.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	1.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	2.0	8.0	19.0	19.0	16.0	13.0	15.0	9.0	7.0	10.0	4.0	1.0
Continuity of Carer %	17.0	20.0	22.0	14.0	16.0	21.0	18.0	20.0	13.0			
In Receipt of %	12.0	12.0	6.0	8.0	7.0	5.0	6.0	6.0	5.0	3.0		
CoC In Receipt of %	63.0	65.0	64.0	38.0	38.0	47.0	44.0	50.0	30.0	33.0		
Continuity Team Caseload	152.0	161.0	161.0	155.0	151.0	171.0	177.0	174.0	174.0	0.0	0.0	0.0
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0
Actual v Planned Staffing %	85.6	88.2	85.1	87.4	88.8	88.1	80.2	83.3	82.7	81.4	81.4	80.9
Labour Co-ordinator Supernumerary Status %	96.8	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies	16.9	13.6	18.3	19.3	18.3	20.5	27.9	28.5	25.1	24.9	25.5	26.1
Vacancies - Registered	15.8	12.0	15.7	16.7	15.7	17.3	22.3	23.5	21.9	22.7	23.4	23.2
Vacancies - Unregistered	1.1	1.6	2.6	2.6	2.6	3.2	5.6	5.0	3.2	2.2	2.0	2.8
Serious Incidents	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0
Complaints	3.0	0.0	0.0	1.0	0.0	1.0	0.0	0.0	2.0	0.0	2.0	1.0
PALS	3.0	1.0	1.0	2.0	3.0	2.0	2.0	2.0	1.0	0.0	1.0	3.0

Trustwide Maternity Dashboard

Indicator	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022
Midwife to Birth Ratio	25.0	24.1	24.8	24.4	24.5	24.0	24.9	25.1	25.0	26.2	26.2	25.8
Red Flags	28.0	19.0	60.0	33.0	37.0	23.0	30.0	24.0	18.0	34.0	16.0	13.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	8.0	2.0	13.0	2.0	6.0	2.0	2.0	1.0	1.0	5.0	0.0	1.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	5.0	2.0	4.0	1.0	2.0	1.0	1.0	2.0	3.0	2.0	2.0	1.0
(c) Missed medication during an admission to hospital	1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	2.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	2.0	2.0	4.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	1.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	7.0	4.0	14.0	3.0	6.0	5.0	3.0	11.0	6.0	13.0	5.0	4.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	1.0	0.0	0.0	3.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	4.0	9.0	27.0	21.0	22.0	14.0	24.0	10.0	8.0	10.0	6.0	3.0
Continuity of Carer %	21.0	19.0	21.0	16.0	20.0	20.0	19.0	20.0	18.0	12.0	12.0	12.0
In Receipt of %	14.0	11.0	8.0	9.0	16.0	7.0	11.0	8.0	11.0	9.0	8.0	9.0
CoC In Receipt of %	60.0	63.0	56.0	47.0	67.0	49.0	69.0	68.0	58.0	70.0	72.0	68.0
Continuity Team Caseload	500.0	508.0	487.0	497.0	485.0	490.0	524.0	488.0	488.0	305.0	305.0	295.0
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0
Actual v Planned Staffing %	88.5	90.8	88.0	90.5	90.3	92.1	88.1	88.0	88.1	84.1	84.1	85.5
Labour Co-ordinator Supernumerary Status %	98.4	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies	30.3	25.7	29.7	32.0	30.7	32.2	46.6	47.3	43.5	44.5	45.2	51.7
Vacancies - Registered	28.1	22.4	25.1	27.6	27.2	28.2	38.1	40.3	38.8	39.8	40.6	42.2
Vacancies - Unregistered	2.2	3.4	4.7	4.5	3.5	4.1	8.5	7.0	4.7	4.7	4.6	9.6
Serious Incidents	0.0	1.0	1.0	2.0	0.0	1.0	0.0	0.0	0.0	0.0	2.0	1.0
Complaints	4.0	2.0	1.0	1.0	0.0	2.0	2.0	1.0	3.0	2.0	3.0	1.0
PALS	4.0	9.0	8.0	7.0	4.0	4.0	5.0	6.0	5.0	1.0	6.0	5.0
Sickness Absence (Division) %	6.0	5.8	7.2	8.4	7.2	8.0	8.8	5.9	5.8	6.8		

5.0 Training and Development

5.1 Student Placement Hours

Work has been completed to ensure student placement hours are accurately recorded to support returns and receipt of the correct income. Work continues to determine where Non-Medical Clinical Staff Education and Training tariff income is currently allocated/ spent within the Trust and where the costs/ spend should sit for training nursing, midwifery and AHP students. An 80% increase in placement hours has been seen since 2018 for student nurses, midwives, paramedics and ODPs hosted by the Trust, and from September 2022 the clinical tariff the Trust will receive has been increased to £5,000 from £3,856 per FTE (1,530 hours – full tariff paid for each 40.8 weeks of placement activity, reflective of 37.5 hours per week).

5.2 Apprenticeships

Recruitment to the nursing apprenticeships has commenced at pace led by members of the Corporate Nursing Team who are working closely with divisional teams. 180 applications have been received for the 45 places available from January 2023 resulting in a very competitive recruitment process. These clinical apprenticeships will support career pathways, retention work and dependence on expensive temporary staffing in the future.

5.3 Advanced Clinical Practitioner Programme

High ACP turnover is a concern with qualified and trainee ACPs leaving for posts in primary care or the ambulance service. A survey was sent to ACPs to obtain their views about their experience of the programme and results have been shared with divisional leadership teams. Work is required to improve the trainee and qualified ACP experience, and to develop a vision and strategy for ACPs within the trust. Divisional feedback to inform this work is awaited.

5.4 Learning Needs Analysis (LNA) and CPD funding

Spend of the Trust's CPD allocation is progressing against the plan. The Nursing, Midwifery and AHP Learning Needs Analysis for 2023/24 is being collated for submission to HEE with the support of the Trust training team. It is unclear if the CPD funding will be available in 2023/23.

6.0 Quality

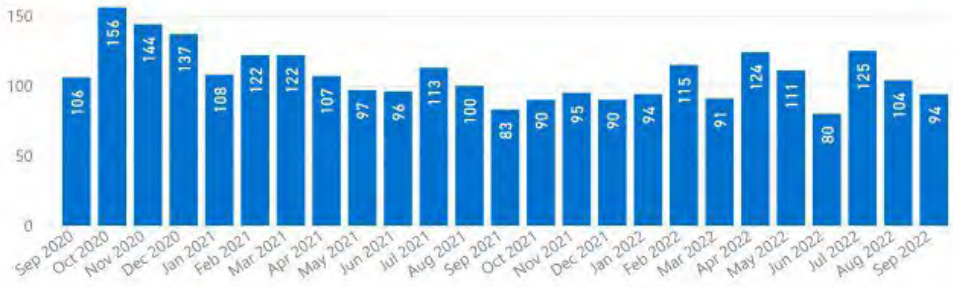
6.1 Reported Falls Incidents

The information presented shows data for inpatient wards only and is the standard throughout the report.

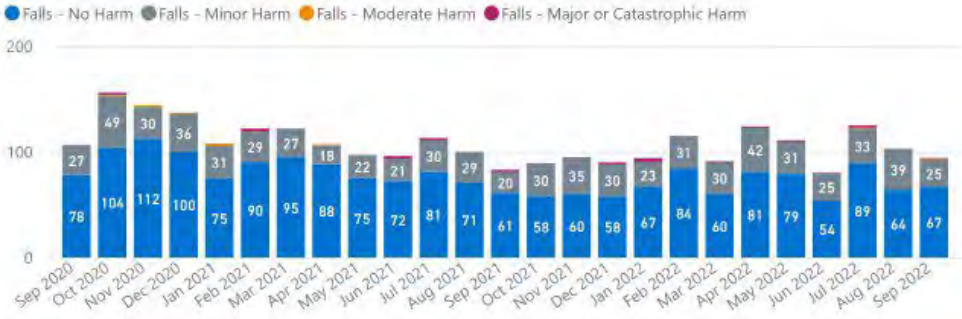
Falls Incidents Summary Sep 2022

Falls - Total	No Harm	Minor Harm	Moderate Harm	Major or Catestrophic
94 ▼ -10	67 ▲ 3	25 ▼ -14	1 ▲ 1	1 ▲ 1

Falls - Total



Falls by Category



Falls - Total by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Sep 2022	DPOW	41	-13	54	
Sep 2022	GDH	4	-3	7	
Sep 2022	SGH	49	6	43	

Falls - Total by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Sep 2022	Community & Therapies	4	-3	7	
Sep 2022	Family Services	2	1	1	
Sep 2022	Medicine	71	-10	81	
Sep 2022	Surgery	17	2	15	

The total number of falls reported in September 2022 has decreased significantly for the second consecutive month. There has been an increase in the number of reported falls at the Scunthorpe site.

There was one fall reported with moderate harm and one fall reported with major harm in September 2022.

The moderate harm fall occurred on Ward 16 at Scunthorpe and resulted in the patient sustaining a fractured shoulder. The falls huddle identified some local learning but did not identify any lapses in care.

The fall with major harm occurred on the Stroke Unit at Scunthorpe and resulted in the patient sustaining a fractured femur. The falls huddle identified lapses in care and a full serious incident investigation is being completed to identify learning.

6.2 Falls per 1,000 Bed Days

The falls per 1000 bed days across the Trust has decreased in September 2022. Caution should be used when interpreting the data as not all escalation beds are captured within the occupied bed days.

Falls per 1,000 Bed Days Summary Sep 2022

Falls per 1,000 bed days

4.8 ▼ -0.4

Falls per 1,000 Bed Days

Falls per 1,000 Bed Days by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Sep 2022	DPOW	4.1	-1.2	5.3	
Sep 2022	GDH	3.5	-2.0	5.4	
Sep 2022	SGH	5.7	0.7	5.0	

Falls per 1,000 Bed Days by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Sep 2022	Community & Therapies	3.5	-2.0	5.4	
Sep 2022	Family Services	0.9	0.4	0.4	
Sep 2022	Medicine	6.2	-0.7	6.9	
Sep 2022	Surgery	3.6	0.4	3.2	

6.3 Wards with Highest Incidence of Falls

Highest Reporting Wards with Falls Incidents Sep 2022

Indicator	Falls - No Harm		Falls - Minor Harm		Falls - Moderate Harm		Falls - Major or Catastrophic Harm		Falls - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
SGH - Ward 22	5	▲ 3	2	0	0	0	0	0	7	▲ 3
DPOW - C2	5	▲ 2	1	▼ -2	0	0	0	0	6	0
DPOW - C3 Short Stay	5	▲ 2	1	▼ -3	0	0	0	0	6	▼ -2
SGH - Ward 16	3	▲ 1	2	▼ -1	1	▲ 1	0	0	6	▲ 1
SGH - Ward 17	4	▲ 1	2	▼ -1	0	0	0	0	6	0
SGH - Ward 23 Short Stay	5	▲ 3	1	0	0	0	0	0	6	▲ 3

Highest Reporting Wards - Falls per 1,000 Bed Days

Site - Ward	Falls per 1000 Bed Days	Change
SGH - CDS	15.4	▲ 15.4
DPOW - C3 Short Stay	9.6	▼ -1.5
SGH - Ward 18	9.6	▼ -4.3
SGH - Ward 17	9.0	▲ 0.4
SGH - Ward 16	8.8	▲ 1.7

Ward C3 (Short Stay) Grimsby has triggered as a higher reporting ward for the third consecutive month. There has been a reduction in the number of reported falls in September.

Ward C2 has triggered as a higher reporting ward for the second month, although the number of falls reported has remained static.

None of the other higher reporting wards are demonstrating any trends at present.

~~The areas detailed above will be reviewed alongside other metrics at the Nursing Metrics Panel~~.

7.0 Pressure Ulcers

7.1 Hospital Acquired Pressure Ulcer Incidents

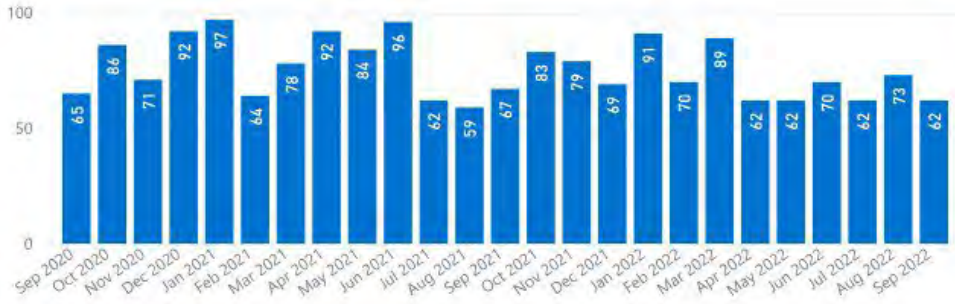
The data includes hospital acquired category 2,3,4 and unstageable pressure ulcers and is the standard throughout the report.

Data changes from month to month due to ongoing validation and these figures may contain un-validated pressure ulcers.

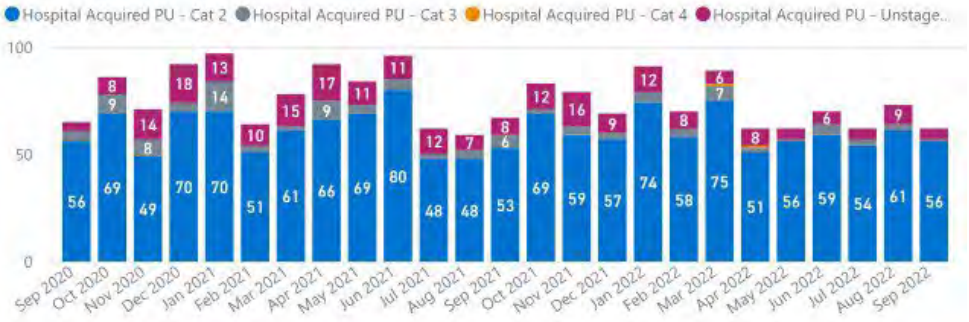
Hospital Acquired PU Incidents Summary — Sep 2022

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
62 ▼ -11	56 ▼ -5	1 ▼ -2	0	5 ▼ -4

Hospital Acquired PU - Total



Hospital Acquired PU by Category



Hospital Acquired PU - Total by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Sep 2022	DPOW	37	▼ -8	45	
Sep 2022	GDH	2	▼ -2	4	
Sep 2022	SGH	23	▼ -1	24	

Hospital Acquired PU - Total by Division

Latest Month	Divison	Result	Variance to Previous	Previous Month	Trend
Sep 2022	Community & Therapies	2	▼ -2	4	
Sep 2022	Family Services	0	◆ 0		
Sep 2022	Medicine	37	▼ -3	40	
Sep 2022	Surgery	23	▼ -6	29	

There number of pressure ulcer incidents reported in September 2022 has decreased. Both the Grimsby site (DPOW) and the Medicine division continue to report higher numbers of pressure ulcers. There was a significant decrease in the number of pressure ulcers reported by the Grimsby Site.

7.2 Hospital Acquired Pressure Ulcers per 1,000 Bed Days

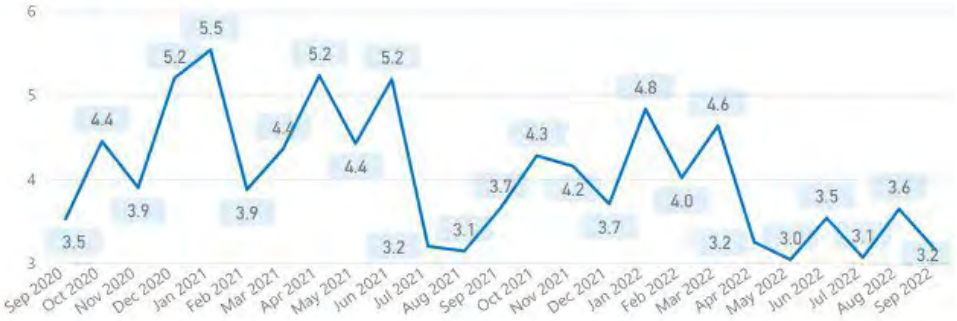
The incidence of reported pressure ulcers per 1000 occupied bed days has decreased in September 2022 and remains higher at the Grimsby site.

Hospital Acquired PU per 1,000 Bed Days Summary — Sep 2022

PU per 1,000 bed days

3.2 ▼ -0.5

PU per 1,000 Bed Days



PU per 1,000 Bed Days by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Sep 2022	DPOW	3.7	▼ -0.7	4.4	
Sep 2022	GDH	1.7	▼ -1.4	3.1	
Sep 2022	SGH	2.7	▼ -0.1	2.8	

PU per 1,000 Bed Days by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Sep 2022	Community & Therapies	1.7	▼ -1.4	3.1	
Sep 2022	Family Services	0.0	◆ 0.0		
Sep 2022	Medicine	3.2	▼ -0.2	3.4	
Sep 2022	Surgery	4.9	▼ -1.2	6.1	

7.3 Wards with the Highest Incidence

Highest Reporting Wards with PU Incidents Sep 2022

Indicator	Hospital Acquired PU - Cat 2		Hospital Acquired PU - Cat 3		Hospital Acquired PU - Cat 4		Hospital Acquired PU - Unstageable		Hospital Acquired PU - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
DPOW - B6	4	▼ -1	0	0	0	0	1	▼ -1	5	▼ -2
DPOW - C2	4	0	0	0	0	0	1	▼ -1	5	▼ -1
SGH - Ward 17	5	▲ 3	0	▼ -1	0	0	0	▼ -2	5	0
DPOW - Amethyst	3	▲ 3	0	0	0	0	1	▲ 1	4	▲ 4
DPOW - B7	4	▼ -1	0	0	0	0	0	0	4	▼ -1
DPOW - C3 Short Stay	3	0	0	0	0	0	1	0	4	0
SGH - CDU	4	▲ 3	0	0	0	0	0	0	4	▲ 3

Highest Reporting Wards - PU per 1,000 Bed Days

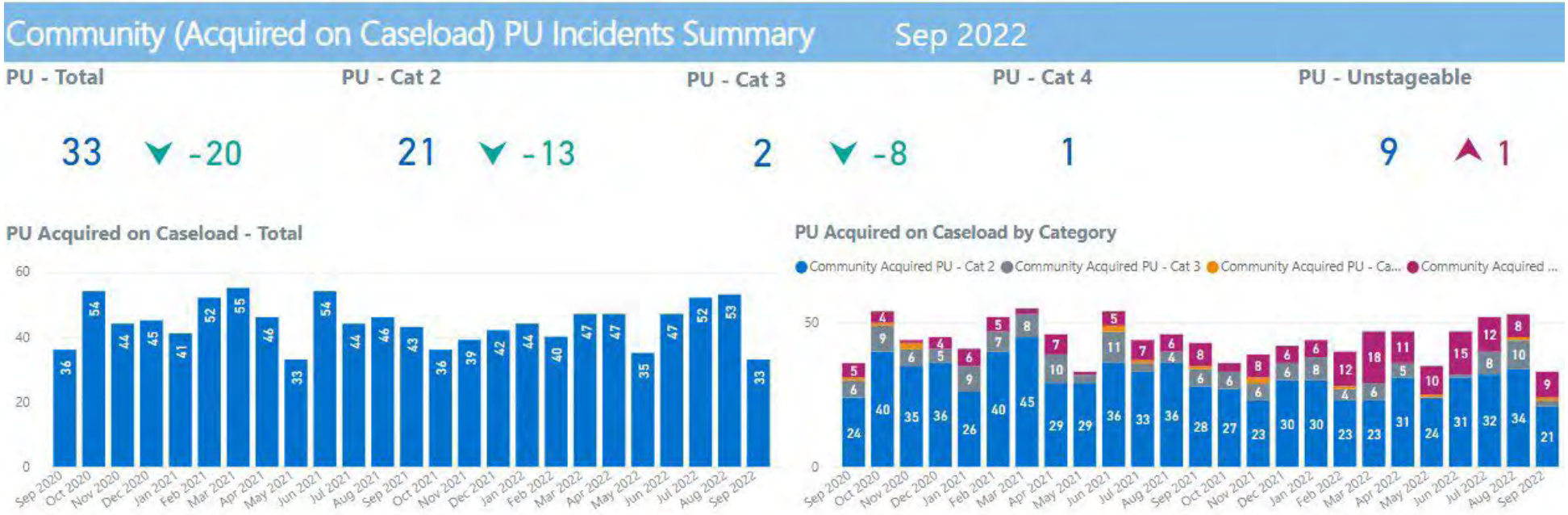
Site - Ward	Hospital Acquired PU per 1000 Bed Days	Change
DPOW - ITU	17.8	▲ 4.4
DPOW - B7	8.9	▼ -1.0
DPOW - B6	7.9	▼ -2.7
SGH - Ward 17	7.5	▲ 0.3
DPOW - C2	7.0	▼ -2.2

Wards B6, B7, C2 and Ward 17 have all triggered as higher reporting wards for the second consecutive month. The total number of pressure ulcers reported by each of these wards has remained static or reduced. Each of these wards has reported a lower number of unstageable pressure ulcers indicating that appropriate preventative measures are in place to prevent further deterioration.

There are no concerning trends for any of the other higher reporting wards. The areas identified above will be discussed in more detail at the Nursing Metrics Panel alongside other indicators.

7.4 Community (Acquired on Caseload) Pressure Ulcer Incidents

The information presented shows data on pressure ulcers acquired on community caseload. Please note this does not include category 1, suspected deep tissue injuries or moisture lesions. Data changes from month to month due to ongoing validation and these figures may contain un-validated pressure ulcers.



PU Acquired on Caseload by Team Sep 2022

Team	Community Acquired PU - Cat 2	Community Acquired PU - Cat 3	Community Acquired PU - Cat 4	Community Acquired PU - Unstageable	Total
East Network	11	1	0	5	17
West Network	4	1	0	3	8
South Network	3	0	0	0	3
Single Point of Access (SPA)	2	0	0	0	2
Intermediate Care Services (ICS) + Core Therapy	1	0	0	1	2
Tissue Viability Team	0	0	1	0	1
Total	**21**	**2**	**1**	**9**	**33**

The incidence of pressure ulcers has seen a significant reduction in September from 53 to 33. East network has reported the highest number of pressure ulcers during September, this could be due to the ongoing staffing challenges that East network have experienced during September which impacts on the frequency of patient reassessments and visits. The staffing challenges for all networks has improved slightly in October 2002 with the newly qualified nurses commencing in post. Further quality improvement work is underway to articulate minimum staffing numbers for community nursing based on capacity and demand methodology which aligns with the National Community SNCT due to be released later this year.

The most reported pressure ulcers overall are category 2 which is a consistent theme each month. This is suggestive that preventative interventions put in place by network teams have impacted on further deterioration of category 2 pressure ulcers. A decrease in the number of category 3 pressure ulcers from 8 to 2 has been seen. One Category 4 pressure ulcer was reported; this has had a review and there are no lapses in care identified. There has been a slight increase in the number of unstageable pressure ulcers from 8 to 9 in September.

A review of the network and place of residence for patients who developed a moderate harm pressure ulcer for September shows:

Pressure Ulcer	**Developed in patients own home/network**	**Developed in residential/care home setting (name if known)**
Category 3	0	1 in **West Network** at Greenacres Residential Home 1 in **East Network** at Eagle House Care Home
Category 4	1 **South Network** (patient non-compliant- no lapses in care)	
Unstageable	1 **East Network** 1 **West Network**	1 **East Network** at Carseld Residential Home 3 **East Network** at Castlethorpe Nursing Home 1 **East Network** at Eagle House Care Home 1 **West Network** at Phoenix Park Village 1 **Intermediate Care** at SJMH

3 of the unstageable pressure ulcers developed in Castlethorpe Nursing Home. On review with the Matron and Team Leader there are no specific concerns at this Care Home. The District Nurse Caseload holder has been made aware of this theme and she will monitor.

Thematic Analysis

Over the past 24 months the division has reported a stagnant position in relation to category 2 and category 3 acquired on caseload pressure ulcers and a significant increase in category 4 pressure ulcers. Current systems and process for managing pressure ulcer incidents, investigations and learning are not achieving any improvements in pressure ulcer prevalence.

A thematic analysis into the findings of the PUFFINS (Pressure Ulcer Fact Finding Information Notes) from the last year has been undertaken by the Quality Development Team to inform the next steps. 129 PUFFINS for the period 29/03/21- 29/03/22 have been included in the review which has determined 5 core themes as root causes for pressure damage:

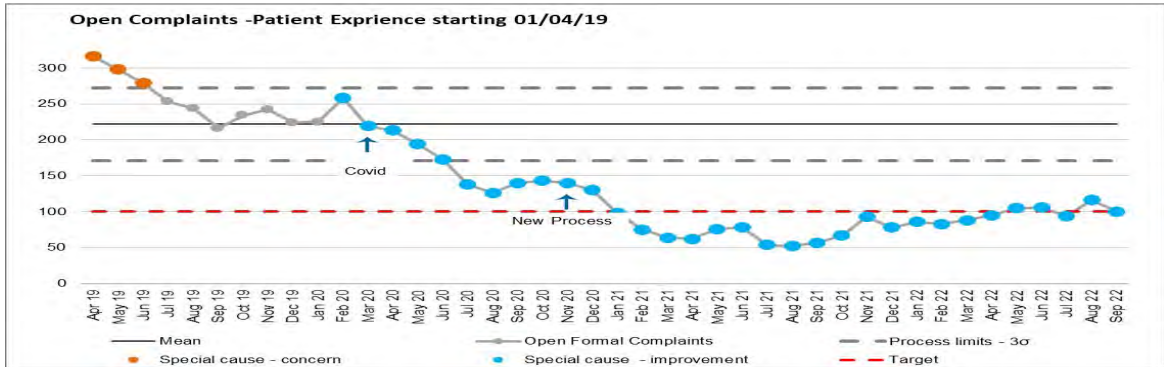
- Equipment
- Staffing/caseload pressures
- Relationships – 'More than just communication'
- Documentation
- Concordance/compliance

It is acknowledged that these are recurrent themes. There is a 6-month delay in PUFFINs being returned because the process has become an investigation rather than a fact find to inform whether an RCA is required. There will now be a review of the process through which we undertake the Fact Find, validate pressure ulcers, and record action plans.

A paper is being prepared by the Associate Chief Nurse for the Nursing, Midwifery and AHP Board to discuss next steps.

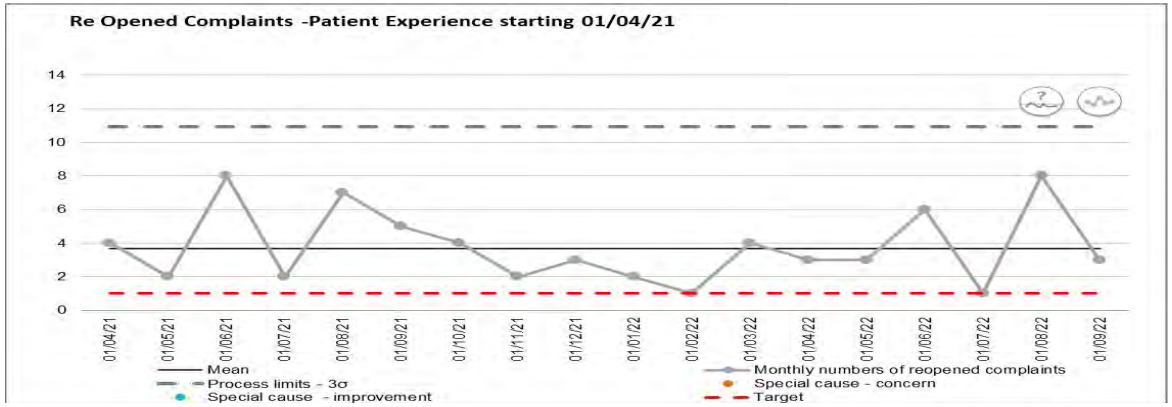
8.00 Patient Experience

New formal complaint numbers remained consistent for a third month in a row, at 26 received during September. At the end of September there were 100 open complaints, which is a slight decrease on August's total of 116. This data in seen in graph A below:



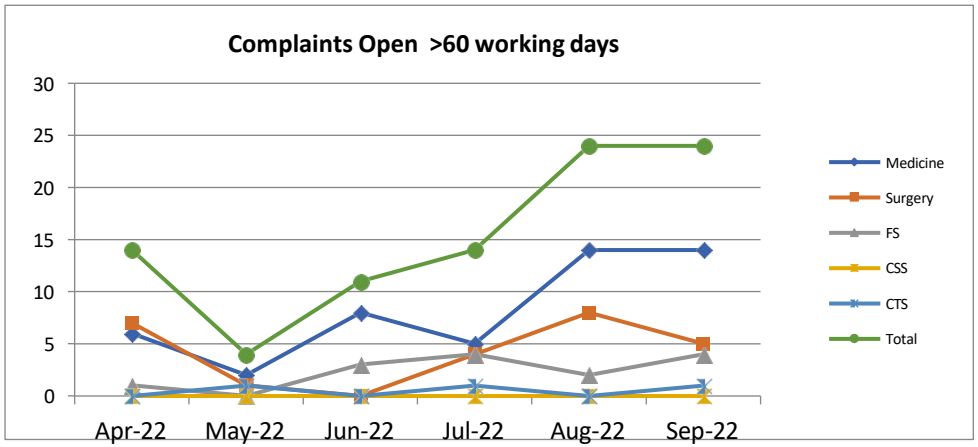
Graph A

There were 3 reopened complaints in September, and there is a "see saw" picture emerging with the early data collection as seen in graph B. All reopened complaints are reviewed in depth each month to ascertain whether they are avoidable or unavoidable, and what learning can be taken to improve processes. Of the 3 reopened in September 2 were unavoidable as the response generated new questions. The remaining 1 response could possibly have been prevented had more information been included in the first response so was avoidable.



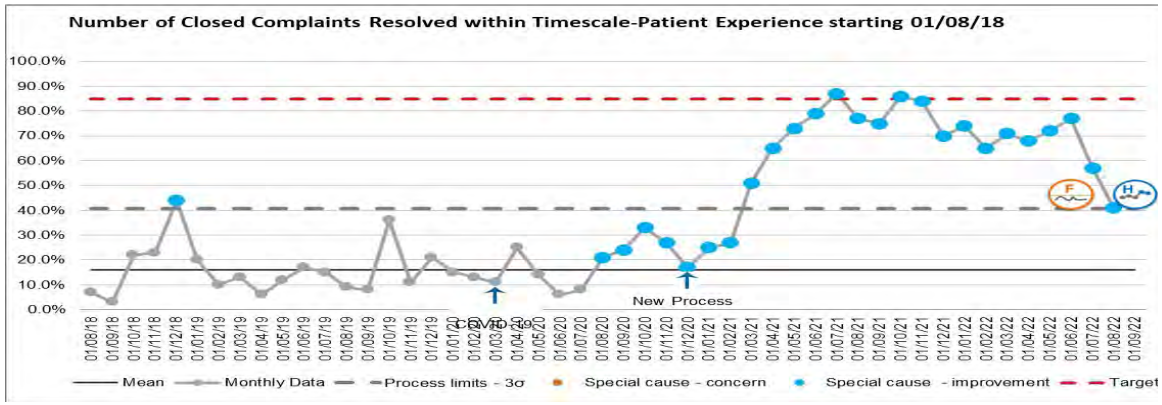
Graph B

Complaints over 60 working day timescale remains at the same level as August, and a peak from the instigation of the new complaint process, as seen in graph C:



Graph C

However, all central actions are now in place to support improving this position and divisions aware of the need to re energise their process. In September, 28 complaints were closed, of those 50% were in timescale as seen in graph D:

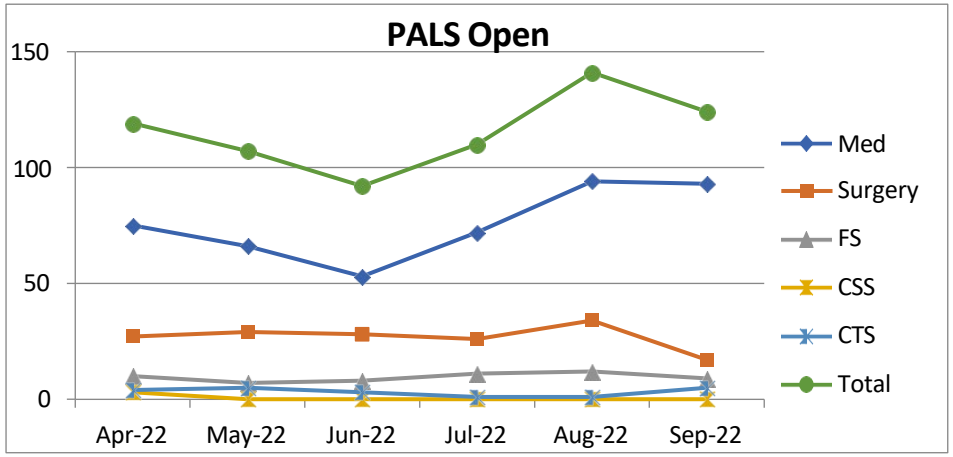


Graph D

Of the 15 that were out of timescale, 2 were over 100 days, 7 were over 70 days and 6 were within the close window of 61-69 days. The 2 main themes are delays in obtaining information when requested and clinical staff availability for meetings.

A meeting with Hull University Teaching Hospitals complaint manager and patient experience lead enabled sharing elements of good practice between sites including, from the NLaG model, the person-centred response. Collaborative working continues to evolve as patient pathways cross both trusts.

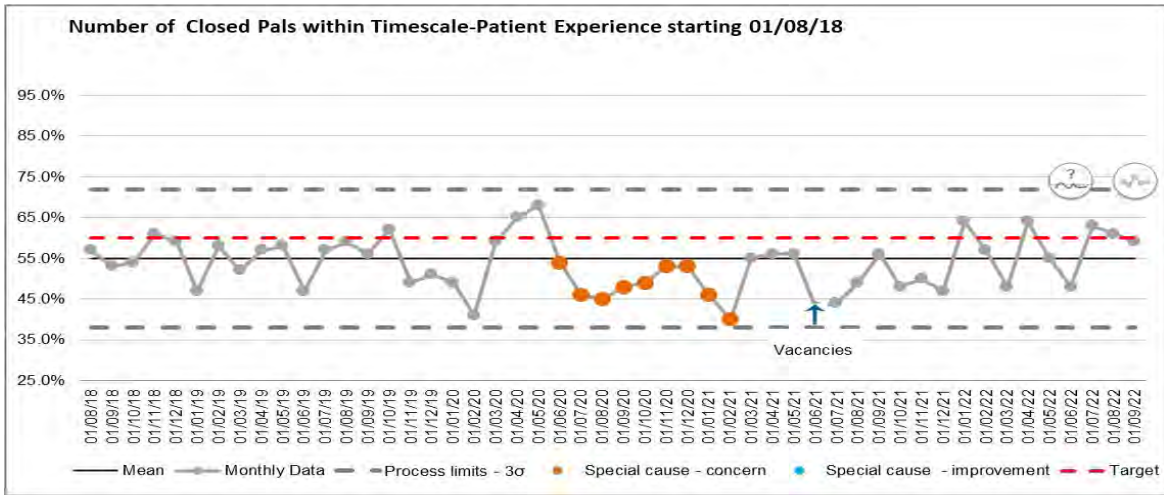
Trust wide the number of new PALs concerns received was 229, which is only slightly increased from 225 in August. Open concerns decreased by 12% as seen below in Graph E:



Graph E

240 PALs concerns were closed in September, the second month to see increased numbers. This may correlate with a vacancy in the central PALs team that is now filled. The KPI of 60% of PALs closed in timescale was recorded at 59% for September. This can be seen in graph F below.

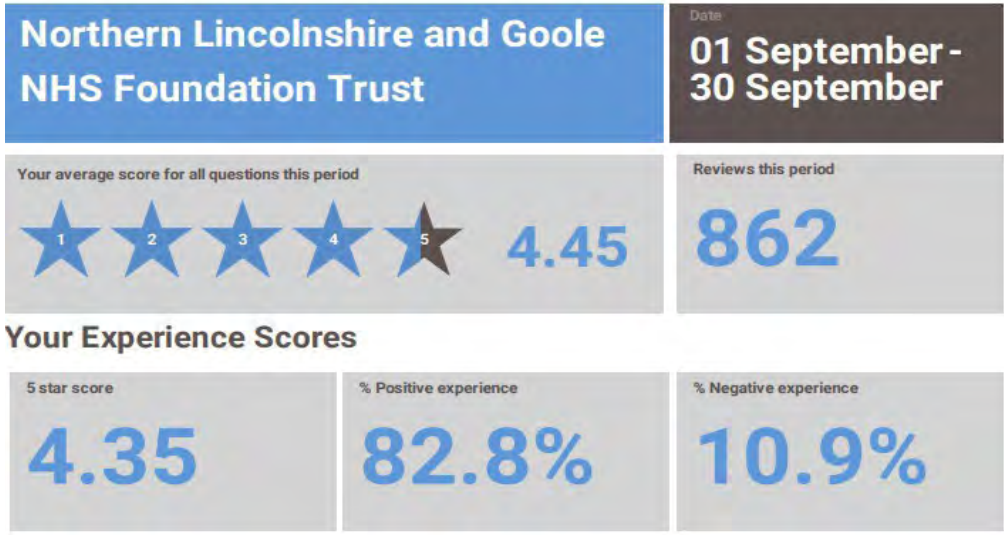
As highlighted in previous reports, there is an inconsistent achievement against this target, and it is hoped with the additional band 7 post in the central team until March 2023, focus can be fully applied to the PALs agenda. It has been acknowledged nationally that the PALs framework may need refreshing and conversations are taking place currently regarding this. As many other trusts separately manage their formal and concern pathways due to the completing complexities of both this is something that will be monitored, with the additional manager being in post, in respect of service improvement and support available.



Graph F

The Roundtable Meeting data has been reviewed in a deep dive methodology, and the sub level of the high occurring theme of appointments and delays surfaced. Following the deep dive these were further categorise into: informing patients about cancellations, informing patients when their next appointment or procedure is. Several high occurrences in key specialities were extracted and this data will help inform the next action of sharing this potential quality improvement information.

September saw FFT responses decrease by around a 100 from the previous month, as seen in the image below: -



The patient experience manager is now meeting with wards and divisions to understand how to improve their positions. Details from the FFT data has been added to the new patient experience Dashboard in PowerBI which will enable improved reporting once minor data collection issues are resolved.

The volunteering team continue to work at ensuring applicants are recruited in a timely manner as current timescales are around 3 months. This is mainly due to DBS delays and following discussions with other agencies the online DBS application process is now being explored. The request for volunteers to support the new ED at DPOW has resulted in 13 new volunteers wanting to be posted here which we know will impact positively on the patient experience. Younger volunteers make up 11% of the current volunteering workforce and, in line with the strategy, further diversity remains a desire. There are some challenges within the volunteering team with returning staff numbers at a manager and administration assistant. This follows the end of two NHSEI funded band 3 posts. Priorities are to recruit and support the volunteers, resubmit the business case again for an additional band 4 and liaise with HUTH to understand their volunteering model.

9.0 Mixed Sex Breaches

In September the Trust declared 1 mix sex breach at DPOW which involved 3 patients and one action plan was commenced which contained all the actions for all patients affected. The theme for these was that the Trust had declared OPEL 4 on all occasions and there was a lack of capacity in step down beds.

Site	Speciality	Date	Sex	No. that occurred	Reason
DPOW	HDU	22.09.22	F	3	OPEL 4 on site, capacity at DPOW and patient flow- unable to support step down- escalated at the time
DPOW	HDU	22.09.22	F	3	OPEL 4 on site, capacity at DPOW and patient flow- unable to support step down- escalated at the time
DPOW	HDU	22.09.22	M	3	OPEL 4 on site, capacity at DPOW and patient flow- unable to support step down- escalated at the time

10.0 15 Steps Challenge

Eight acute 15 Steps Challenge visits were completed during September 2022. Six in the acute schedule with 1 visit rescheduled due to the PLACE visit at DPOW and 2 visits rescheduled due to unforeseen cancelations by team members and significant operational pressures with the lead supporting clinically. Two community and therapy 15 Steps challenge visits were completed.

Acute 15 Steps Ratings September 2022			
Date of visit	Ward/ Department	Rating 22-23	Previous Rating
06/09/2022	Ward 26		
07/09/2022	Jasmine & Honeysuckle		
08/09/2022	Paediatric OPD, DPOW		
13/09/2022	Discharge Lounge, SGH		NA 1st Visit
20/09/2022	NICU, SGH		
29/09/2022	CDS, SGH		

Community and Therapies 15 Steps Rating August 2022			
Date of visit	Community Team/ Clinic	Rating 22-23	Previous rating
05/09/2022	Community TVN & React to Red, Beacon House, Scunthorpe		N/A
21/09/2022	Children's Therapy, CDC St Nicholas house, Scunthorpe		N/A

Outstanding	Good	Requires Improvement	Intensive Support

Themes for Areas of Consideration/ Action within the acute schedule (community and therapy themes are reported quarterly)

	Themes	Actions
Standard 1: Observations	• Safe/ secure storage of medication and stock rotation	• Staff reviewing dates of medication when replacing stock • Staff reviewing IV vials dates when replacing stock • Regularly review and send back to pharmacy unused/out of date stock
	• Storage of stock – cardboard boxes stored on the floor. Cluttered environments and broken equipment not effectively managed	• Reviewed storage areas for un-used or broken equipment, tidied areas and moved equipment to the correct and designated areas • Staff are responsible for managing the environment and storage areas on a weekend
	• Cleanliness checklists not complete or out of date labelling on dusty stored equipment	• Weekly clean for stored equipment added to safety checklist to be completed on specific day/ days of the week
Standard 2: Documentation	Minimal themes to report all, documentation across maternity wards and NICU of a consistently high standard	
Standard 3: Patient Feedback	Minimal themes to report • Patients not always aware of when they are planned for discharge • Long waits for discharge paperwork which can be frustrating	• QI project ongoing re: discharge planning and discharge processes
Standard 4: Staff Feedback	Minimal themes to report • Low staff moral due to increased staffing and operational pressures	• Wards/ departments recruiting into vacancies and senior staff supporting on the area

11.0 Infection, Prevention & Control

Alert Mandatory Organisms

The Trusts trajectory for 2022/23 of no more than 21 C.difficile cases is a significant challenge to achieve. The Trust reported hospital 14 onset cases since 1st April. Through the PIR process so far, antimicrobials shows to be the main predisposing factor, all broadly justified.

Hospital onset positive blood culture cases are in line with predicted numbers, however the case threshold has been exceeded for Pseudomonas aeruginosa. An investigation report of each case is in process, with no trend identified so far.

It is 2 years since the last hospital onset MRSA bacteraemia case.

Respiratory Viruses

Winter is predicted to be very challenging regarding isolation/cohorting hospital in-patients with expected high cases of Influenza A & B, Bronchiolitis – RSV, and a surge of COVID-19. Mitigation actions and controls remain in place to safeguard patients and staff safety. HEPA filtration units are in use on the wards. Maximising isolation facilities by the use of redirooms is required.

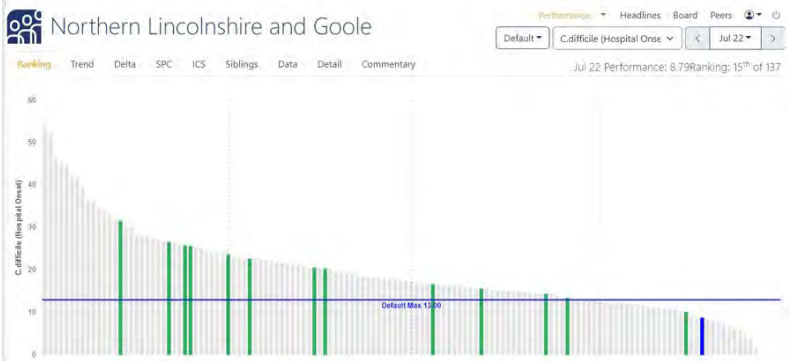
Children's services are currently experiencing high numbers of babies/children with Bronchiolitis/RSV infection.

We currently have low cases of Influenza A in our hospitals and is expected to rise

‘Living with COVID’ principles are in place within The Trust in line with national guidance, with the pausing of asymptomatic patient swabbing, and monitoring but not isolation, of positive COVID-19 contacts.

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

C. difficile Regional comparison

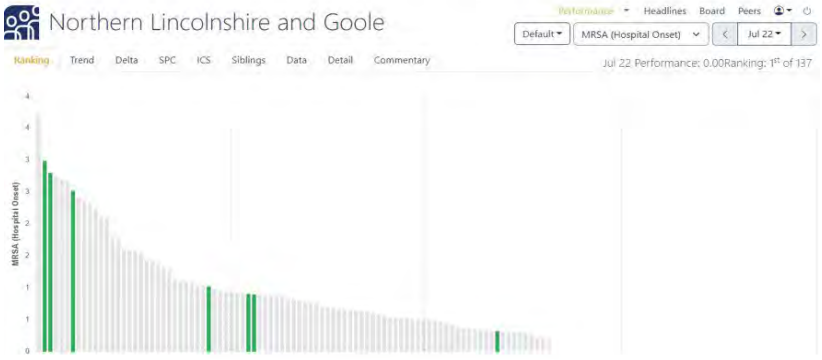


Key: **NLAG** **Peer Trust**

https://publicview.health/Auth/Performance/RJL/1

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

MRSA Regional comparison



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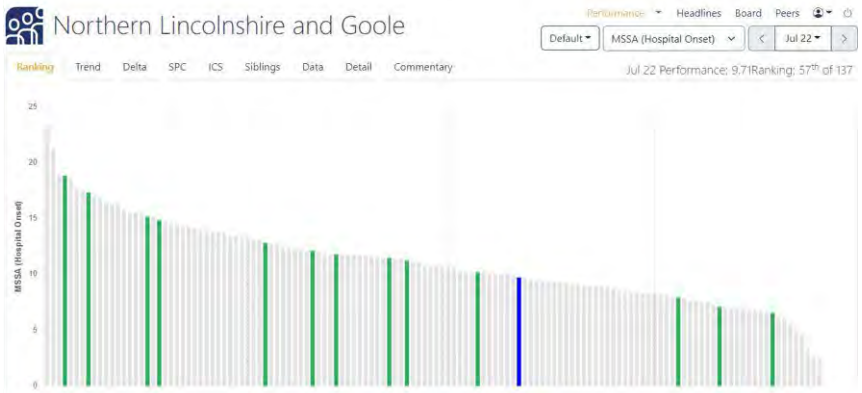
Northern Lincolnshire and Goole NHS
NHS Foundation Trust

MSSA Regional comparison



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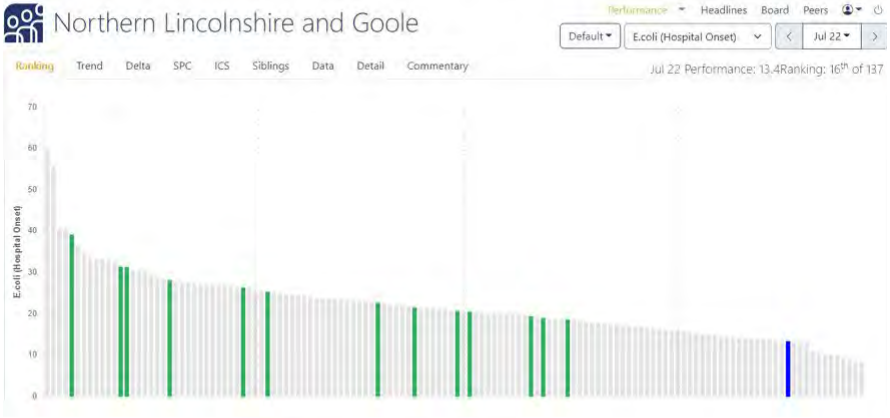
https://publicview.health/Auth/Performance/RJL/1

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

E. coli Regional comparison



Key: **NLAG** **Peer Trust**

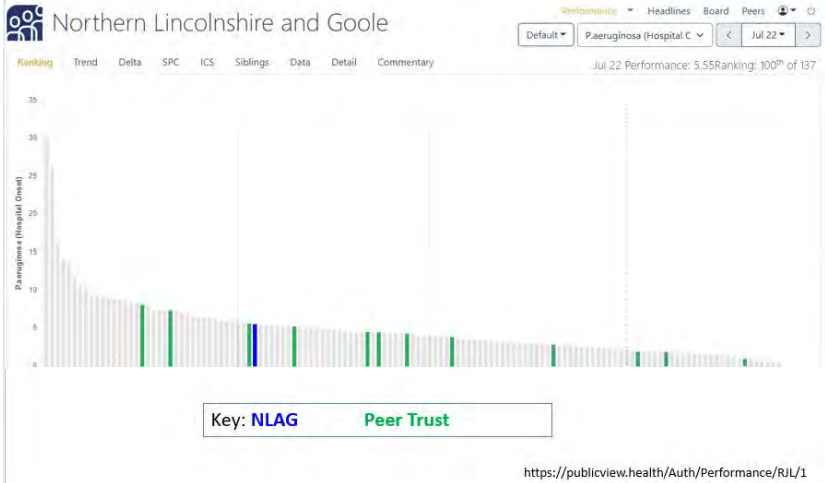
https://publicview.health/Auth/Performance/RJL/1

Klebsiella Regional comparison

Key: **NLAG** **Peer Trust**

https://publicview.health/Auth/Performance/RJL/1

Pseudomonas Regional comparison



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https://publicview.health/Auth/Performance/RJL/1

12.0 Quality Improvement

12.1 Safe & Secure Medication – QI Collaborative

The annual audit for safe and secure storage of medication in 2020 showed only 12 areas achieving over 85% compliance with average compliance of 73%, with 19 areas above 85% with an average of 75% compliance in 2021. A QI collaborative commenced in November 2021 working with frontline ward teams to test ideas to improve their performance. In 2022 the annual audit showed a large improvement with 57 areas achieving over 85% with a trust average of 87% compliance. Monthly audits and reporting are now in place to ensure that these improvements are sustained and early intervention can occur when performance dips.

In addition, these wards reduced their medication stock levels by ~£6,000 combined. One ward also saved 30min per day of nursing time by removing the need to search for treatment room door keys. These ward also saw a reduction in the number of medication related incidents.

Focus continues to be on sustainability of improvements made with 21 wards supported to date. Revisits and support are been undertaken where there have been slippages in performance.

Average audit position across all inpatient wards for June 85%, June 83% August 85% against target position of >85%. Reduced capacity in the pharmacy team has led to the September and October audits not been completed. Discussions with the Chief Pharmacist has resolved this and audits are expected to resume in November which there is high confidence this will reflect the continued positive work been undertaken.

12.2 QI – key activities since last update

Work has been undertaken to develop an area to capture QI activity across the trust. This has been achieved in the form of a section on the QI hub page call the “QI Showcase” with the aim of increasing transparency across the organisation of improvement activity and act as an area for teams to learn and share from each other’s improvement efforts. Work is underway to upload over 100 elements of QI work that the QI team has been involved in since Nov 2021. The QI Showcase has been formally launched ion 7th November to encourage all areas of the trust to share and celebrate their improvement works. In addition data can be pulled from the QI showcase to share with Divisions and Services to celebrate and support their improvement efforts.

13.0 Conclusion

The overall CHPPD was 8.2 in September compared to 8.9 in August. Work is ongoing to address inaccuracies with the CDS data at SGH which has increased the Women & Children's CHPPD.

Vacancies on the inpatient wards in September for Registered Nurses showed an increase but a decrease is seen in Healthcare Assistants. There is a total of 277.03 WTE (15.01%) Registered and 148.41WTE (15.71%) Unregistered vacancies across the Trust. 87 newly qualified nurses (NQNs) and midwives, and 34 international nurses (INs) are commencing in post over the autumn, with a further 20 NQNs to start in Q4. The recent HCA rapid recruitment events have resulted in 131 employment offers (110.04wte) which are now being processed. Targeted recruitment and retention work are ongoing.

Assurance that safety was maintained within the maternity units is supported by the Midwife to Birth ratio data. In September 2022 the data for both units is 1:25.8 which is below the acceptable ratio of 1:28. Although the vacancy factor is high, the ability to cover shifts shows positively in the ratios.

Staffing capacity is an ongoing issue in the community nursing teams and work is being undertaken to recruit to vacancies and retain existing staff and new starters. Work is ongoing to articulate minimum staffing numbers for community nursing based on capacity and demand methodology.

Ward 16 at SGH reported a fall with moderate harm and the falls huddle identified some local learning but did not identify any lapses in care. The Stroke Unit at SGH reported one fall reported with major harm and the falls huddle identified lapses in care and a full serious incident investigation is being completed to identify learning.

Ward C3 (Short Stay) Grimsby has triggered as a higher reporting ward for the third consecutive month however there has been a reduction in the number of reported falls in September, and Ward C2 has triggered as a higher reporting ward for the second month, although the number of falls reported has remained static. These have been discussed in detail at the nursing metric meeting and ongoing summit meetings for C2 are continuing with high levels of support being offered.

Wards B6, B7, C2 and Ward 17 have all triggered as higher reporting wards for pressure ulcers for the second consecutive month although the total number of pressure ulcers reported by each of these wards has remained static or reduced. Each of these wards has reported a lower number of unstageable pressure ulcers indicating that appropriate preventative measures are in place to prevent further deterioration.

Following detailed discussions in the Nursing Metrics Panel, wards 22, 23, 29 and 17 are all receiving close oversight and additional support from the senior divisional teams.

Community, and specifically the East network, has reported the highest number of pressure ulcers during September. This could be due to the ongoing staffing challenges during September which impacts on the frequency of patient reassessments and visits. Further quality improvement work is underway to articulate minimum staffing numbers for community nursing based on capacity and demand methodology which aligns with the National Community SNCT due to be released later this year.

There were three reopened complaints in September, with a “see saw” picture emerging. All reopened complaints are reviewed in depth each month to ascertain whether they are avoidable or unavoidable, and what learning can be taken to improve processes. Of the three reopened in September two were unavoidable as the response generated new questions. The remaining response could possibly have been prevented had more information been included in the first response so was avoidable.

Winter is predicted to be very challenging regarding isolation/cohorting hospital in-patients with expected high cases of Influenza A & B, Bronchiolitis – RSV, and a surge of COVID-19. Mitigation actions and controls remain in place to safeguard patients and staff safety. HEPA filtration units are in use on the wards. Maximising isolation facilities by the use of redirooms is required. Children's services are currently experiencing high numbers of babies/children with Bronchiolitis/RSV infection.

Work has been undertaken to develop an area to capture QI activity across the trust and this is on the QI hub page call the “QI Showcase”. The aim is to increase transparency across the organisation of improvement activity and act as an area for teams to learn and share from each other’s improvement efforts.

Appendix 1: Assurance framework – nursing and midwifery staffing

For quality (or other board level) committees and board members to support discussion and challenge surrounding the active staffing challenges faced and the potential impact this may have on patients.

Ref	**Details**	**Controls**	**Assurance (positive and Negative)**	**Residual Risk Score / Risk register reference**	**Further action needed**	**Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell**	**Ongoing Monitoring / Review**	**RAG Rating**
	Guidance notes	*Outline the current controls (controls are actions that mitigate risk include policies, practice, process and technologies)*	*Detail both the current positive and negative assurance position to give a balanced view of the current position* *Assurance is evidence that the control is effective – or conversely is evidence that a control is ineffective / there are still gaps* *Recurrent forms of assurance are audit results, key performance indicators, written reports, intelligence and insight.* *Effective Assurance should be a triangulated picture of the evidence (staff shortages, sickness absence,pt outcomes, complaints, harm reviews)*	*What is the remaining risk score (using the trusts existing risk systems and matrix)* *Are these risks recorded on the risk register?*	*Where there are identified gaps in either control or assurance, outline the additional action to be undertaken to mitigate the risk. Where the organisation is unable to mitigate fully, this should be escalated to the LRF/region/ national teams and outlined in the following column*	*Provide oversight to the board what the current significant gaps are* *Outline those risks that are currently not fully mitigated /needing external oversight and support*	*Due to the likely prevailing nature of these risks, outlines through what operational channels and how are these active risk being monitored (e.g daily silver meetings via safe staffing heatmap)*	
1. **Staffing Escalation / Surge and Super Surge Plans**								
1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB safe staffing guidance	Winter Planning Meetings and Plan /Surge Plan/ SOP for Staffing Escalation/Staffing plans for critical care areas through surge, which includes training plans	Each Division has a surge plan that sets out how staff and services will be managed in a surge/ Safecare Live used to review and apply clinical judgement if staffing below establishments and to support deployment of staff/ A review of establishment is completed with every ward move, change of demographic, bed numbers and purpose with the Matrons, Associate Chief Nurses and Deputy Chief Nurse with ultimate sign off by the Chief Nurse/ This is fed into the strategic incident command meetings and daily operational meetings. The Nursing Dashboard is reviewed at the Nursing Metrics Panel which has continued throughout the pandemic to ensure safe fundamentals of care/ Daily incidents and Red flags identified on Safecare Live/ training plans in place for deployment to ICU and respiratory areas	N/A	None	None	Staffing level reviews will continue to take place through surge and de- escalation processes. 3 times a day daily operational meetings/Safe Staffing meeting daily/use of safe staffing escalation process/red flag and incident reporting. Monthly Assurance Report to QSC.	G
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.	As above, included in Winter Planning, surge and Escalation plans. Short Term Staffing SOP updated.	Plans developed in conjunction with divisional teams and signed off by Chief Nurse. These are reviewed following every ward reconfiguration, alongside information from the nursing dashboard/red flags and IPC needs.	N/A	None	None	As above	G
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee	Information about staffing has been shared through many public meetings and assurances provided on mechanisms/ processes to regulators. They are also available on the Staff hub making them easily accessible.	Information about staffing has been shared through many public meetings and assurances provided on mechanisms/processes to regulators. They are also available on the Staff hub making them easily accessible. Representatives have access to this information	N/A	None	None	As above	G

1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	Quality impact assessments	Quality impact assessment are completed by Chief Nurse and Medical Director for services changes or schemes. This needs improving for changes to ward functions and roles. This need embedding into operational policy and surge plans. Evidence of completion by corporate CNO team.	To be added to risk register	Embed within existing structures for completion out of hours and include in Winter/Surge Plans. Review of QIAs to be undertaken within divisions and updated accordingly. Add to risk register	None	Through daily operations meetings	A

2.0 Operational delivery								
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.	Daily ops meeting/ daily nurse staffing meeting / Safecare Live review/ Nursing Metrics/ Red Flags and review of daily incidents.	Staffing discussed at the 3 daily operational meetings and safe staffing daily meeting. Proforma used to communicate and escalate risk that can't be mitigated. No risk assessment or quality impact completed for immediate shortfalls. Safecare live used to escalate staffing shortfalls, to raise red flags and to mitigate based on clinical judgement and acuity. Safety Stop at 2pm each day The daily Safe Staffing Meeting is led by a Divisional Associate Chief Nurse of Deputy Chief Nurse for oversight and to provide leadership. Overview is then sent to the CNO or verbal escalation if required. Have OPEL type escalation process for staffing in place.	N/A	Review requirement for documented risk assessment/ QIA of immediate risks.	None	SafeCare Live, Red flags, review of daily incidents being reported. We also have 'Stop and Check' which is a safety stop at 2pm each day, which includes oversight of fundamentals of care and staffing.	G
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained	Daily operational meetings 8:30, 13:00, 16:00. Safe Staffing meeting daily at 10.00	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Staffing plans shared with silver and gold on call. Escalation to CN or Gold if additional mitigation required.		Review Matrons staffing plans documentation to ensure this is clear and includes mitigation.	None	Safe Staffing meeting. Impact monitored through Safecare Live.	G
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.	Transfer Process/ handover checklist	Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained.		Require evidence that NIC is gaining assurances		Nurse staffing red flags are captured on Safecare. Midwifery red flags captured on Ulysses.	A
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients	Incident forms.	Concerns raised with line mangers. Staff would complete incident forms. Escalate to matron and site manager depending on time of day. Various ways to raise a concern through escalation process and Professional voice inbox and the Stop and Check process.	N/A	Test staff awareness of and process of red flags	None	Internal review, audit and 15 steps process	G
2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and	Agency induction checklist	High temporary workforce utilisation can result in staff being redeployed to areas of the Trust where they haven't worked previously, and this requires individual assessment on arrival to an area by NIC. Agency induction checklist available on the HUB for wards/ department to use. Local inductions are provided to agency staff on arrival to the area of work to include a full handover at the beginning of the shift. Induction checklist is completed with individual agency staff members and an orientation to the ward environment is conducted by a substantive staff member.	N/A	Ensure consistent use of agency induction checklist across divisions	None	Audit of agency induction checklist.	A

	patients that they will be supporting.							
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's scope of practice.	Incident forms Safecare live	Formal routes are available for raising staffing concerns through the incident reporting system. Concerns regarding patients' needs can be raised on operational calls. All incidents are reviewed and reported via the workforce report. As per 2.4 and 2.5.	N/A	None	None	As per Staffing review processes, where demographic of ward has changed a staffing review has taken place to review their establishments	G
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on	Workforce report	Incidents and trends are discussed in workforce report . Nursing metrics panel review incidents and triangulate with other quality metrics. As per 2.4,2.5 and 2.6	N/A	Review Safecare live to ensure red flags being actioned/ mitigations documented.	None	Review data in Metrics Panel	G

2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.	Vivup Employee Assistance Programme, Remploy Work Based Support HCV Resilience Hub Restorative Clinical Supervision	Comprehensive health and wellbeing offer is in place both at a Trust level and a system level through the HCV Resilience hub. Initiatives implemented to support staff wellbeing continue and staff encouraged to access. Effectiveness of HWB is measured through the staff survey. Trust taking part in the NHDE/I Trailblazer Pilot focusing on 7 areas of staff HWB: Personal H&W, managers & leaders, environment, professional support, relationships, fulfilment at work and data insights. ICU and respiratory wards receiving additional support. Professional Nurse Advocate Programme in place with initial PNAs trained.		Review of recent staff survey and understanding of staff feedback on their HWB and triangulation of findings. Collation of informal feedback	Requirement for additional support to respiratory wards.	This work is being led by PEO. Health and Wellbeing Steering Group in place.	A
2.9	The trust has robust mechanisms for	Safecare live and daily OPEL	Safecare live used during daily staffing meeting to support safe deployment of staff.	2421/ 2530	None	None	As above	G
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this	Incident report Safe care	Staffing incidents are reported via Ulysses. Safecare live is also available to raise red flags and add clinical judgments. Both reports are used on the workforce report to monitor staffing incidents and trends.	N/A	Continue to recruit and train PNAs and develop trust strategy to support role. Support debriefing with support from POE and HCV resilience hub. Encourage staff to raise concerns about the impact of the pandemic on their mental and physical health.	None	Monitoring of staffing incidents as above.	A

	intelligence.		The trust is increasing the number of staff trained as Professional Nurse Advocates in recognition of the burn out, mental health problems and widespread stress experienced by staff. The training provides practitioners with the skills to facilitate restorative supervision to colleagues. Daily Stop and Check safety checks introduced at 2pm.					
3.0 Daily Governance via EPRR route (when/if required)								
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.	This is done through various mechanisms, there is a trust wide HWB Steering group, but this is discussed through daily operations meetings	Health and Wellbeing Steering Group in place. Daily operational meeting with Strategic Meeting in place once per week as per EPRR guidelines	N/A	None			G
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).	Ops meeting and daily nurse staffing meeting	Staffing is recorded on the SITREP which is shared widely across the trust and with external partners. The Nurse staffing meeting report is sent to senior nurse team.	N/A	None	None	As per previously identified structures	G
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.	EPPR meetings Workforce report	Information and pressures shared in local health and care strategic calls - requests for mutual support are through this forum. Additional EPPR meetings are held to review staffing and activity over bank holiday periods. Work closely with HCV Resilience Hub to access H&W resources for staff.	N/A				A
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.	SafeCare / Roster Perform/E roster/ Short Term Staffing SOP	Safecare live is used by all wards to record patient acuity and reviewing staffing to ensure within agreed safe staffing establishment numbers and to support safe deployment of staff to areas identified as in need. Mitigation documented on Safecare Live. Staffing red flags reviewed daily. There are Safe Staffing & Effective Rostering and Nursing Recruitment & Retention Groups focusing on strengthening workforce information, staffing and workforce issues and the people plan. Includes temporary workforce utilisation.	2421/ 2530	None	None	Daily safe staffing reviews. Triangulation of data in Nursing Metrics Panel.	G

4.0 Board oversight and Assurance (BAU structures)								
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short and medium term solutions to mitigate the risks.	Nursing Assurance Report monthly	The quality committee, on behalf of the trust board, receive the Nursing Assurance Report. Any concerns about staffing are included as a highlight within the CNO and CMO highlight report to board.	N/A	None	None	Continue to provide report to Q&S Committee	G

4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.	Nursing Metrics Meeting/ Nursing Dashboard/ 15 Steps/ Ward Assurance Tool Monthly Performance Review Meetings/ Quality Governance Group monthly	Nursing Dashboard/ Ward reviews as a part of the establishment process.	N/A	None	None	Nursing Metrics Meeting/ Nursing Dashboard/ 15 Steps/ Ward Assurance Tool	G
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.		The IPR does not include specific data in relation to patients with Covid 19, however the daily sitrep provides this level of detail and data is received by the ICC and reviewed in the Covid 19 Strategic meetings/ The impact of Covid on staffing and quality and safety (nurse sensitive indicators) is triangulated in the Nursing Metrics Meeting and included in the Nursing Assurance Report monthly for QSC.		Review of IPR and reporting.	None	Daily sitreps/ Nursing Dashboard	A
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making.		Nursing Assurance Report	N/A	None	None		G
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care	CN discussed with the committee			Continuous review and triangulation of nurse sensitive indicators.	None		
4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.		not system wide					G
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.	Committee aware of Nursing workforce, other aspects monitored through and reported to workforce committee BAF and risk register aligned to elements within the BAF						G
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.erisks outside of the desired appetite are not tolerated without clear discussion and rationale and		EM will review with HH					A

	are challenged if longstanding)							
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework		EM will discuss with HH					A
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus							G
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing	CQC notification through Executives	There is a clear process of formal notification to the CQC regarding any quality concerns. There are regular engagement meetings with the CQC where concerns are discussed. Any concerns raised directly with the CQC or FTSU guardian are fully investigated.	None	None	None	Quality Report to Board	G

NLG(22)238

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	06 December 2022	
Director Lead	Susan Liburd, Non-Executive Director and Chair of Workforce Committee	
Contact Officer/Author	Susan Liburd, Non-Executive Director and Chair of Workforce Committee	
Title of the Report	**Workforce Committee Minutes - September 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	The Workforce Committee Minutes from the meeting held on Tuesday, 20 September 2022, and approved at its meeting on Tuesday, 29 November 2022, are for information.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Workforce Committee
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday, 20 September 2022 at 14:00 hours via Microsoft Teams

Present:

Michael Whitworth	Non-Executive Director (Chair)
Christine Brereton	Director of People
Fiona Osborne	Associate Non-Executive Director
Robert Pickersgill	Governor, Membership Office

In Attendance:

Sue Liburd	Incoming Non-Executive Director & Chair of Workforce Committee (observing the meeting)
Nico Batinica	Associate Director for Workforce Systems and Recruitment
Paul Bunyan	Associate Director for Workforce Operations
Alison Dubbins	Associate Director of Leadership, Culture and OD
Jenny Hinchliffe	Deputy Chief Nurse
Ashy Shanker	Deputy Director of Planning & Performance
Jennifer Granger	Head of Compliance and Assurance (agenda item 8)
Silas Gimba	Director, Medical Education (agenda item 9)
Liz Evans	Guardian of Safe Working (agenda item 10)
Jane Heaton	Associate Director, Strategic Medical Workforce (agenda item 11)
Claire Hansen	Programme Director, Humber Acute Services (agenda item 15)
Kerry Carroll	Deputy Director of Strategic Development (agenda item 15)
Wendy Stokes	Executive Personal Assistant to Director of People *(taking minutes)*

1 Apologies for absence

No apologies received.

2 Declarations of Interest

The Chair invited members to bring to the attention of the committee any conflicts of interest relating to specific agenda items. There were no declarations of interest.

3 Minutes of the previous meeting held on Tuesday, 19 July 2022

Page 5, item 8, amend first sentence to read: The Chair felt that the statistics don't make good reading as the Trust still has a long way to go before achieving WDES however the OD team are doing themselves a disservice in the commentary as there has been significant improvement.

Page 7, item 14, amend last sentence to read: The Chair advised that NEDs have asked for risks associated with each BAF item to be circulated with the BAF reviews to ensure that the BAF reflected these risks.

With the amendments above, the minutes from the previous meeting held on Tuesday, 19 July 2022 were accepted as a true and accurate record.

4 Matters arising from the previous minutes

There were no matters arising from the previous minutes.

4.1 Review of Action Log

Action 96 - Medical Education Report - 'Update on Progress Made'
Mr Silas Gimba is presenting the annual report today therefore, it was agreed to remove this item from the action log.

Action 97 - NHS People Plan - share the plan on one page detailing the four areas of work
Christine Brereton is still to share the one-page plan with the Committee.
Action: Christine Brereton

Action 98 - BAF - Look at Strategic Risk and make a recommendation to Trust Board
A discussion had previously taken place at Trust Board about whether to breakdown the workforce risk (SO2) as it covers a lot of areas and remains a high risk to this committee. Following consideration of this Helen Harris, Director of Governance felt it may not be appropriate to do that mid-year and it should be reviewed at the end of the year, as part of a wider review of the strategic risk. Therefore, Christine Brereton proposed leaving the risks as is until the end of the year and then look at breaking then down into sub-sections. The Chair agreed and stated due to concerns raised at Trust Board around safety levels and financial risks associated with workforce that weren't related to actions by the People Directorate, it was agreed to remove this item from the action log.

5 People Strategy Focus

5a Approach to Flexible Working

Christine Brereton stated that this item links directly to trust priorities around 'Our People' and the Trust Delivery Plan. Paul Bunyan explained that the report aims to start conversations around flexible working and what that might look like. The report is also being discussed at the Board Development Day on 01 November 2022 to enable wider discussion and get the views of the Board. Paul Bunyan proceeded to present the salient points of the presentation.

Paul Bunyan confirmed that the trust has been talking to Staff Side and has been involved in national conversations with the Staff Council. They would like to see more flexible working opportunities and Staff Side want to work with the trust on its delivery.

Fiona Osborne asked about the mechanisms for making sure there is consistency in similar roles. Paul Bunyan stated that the design of the system lets staff make decisions, and that is reported through ESR. If an application is declined there is an escalation process that will strengthen the consistency process.

Fiona Osborne went on to ask how flexible working will fit into the leadership programme.

Paul Bunyan confirmed it sits within the cultural delivery element and management styles and practices will feature in the leadership development programme.

Ashy Shanker reported there are retention issues in pharmacy and the directorate is struggling to recruit staff. She went on to ask if there was an approach to target some areas quicker than others to help with recruitment and retention issues. Paul Bunyan confirmed the trust wants to use a pilot approach with a soft launch on an individual team basis. If there are certain pressures in specific areas recruitment have done specific pieces of work with that area to see what can be done.

Paul Bunyan stated that the trust knows about some staff on e-Roster, but the current process within the flexible working policy is between manager and employee. There will be a signed form in the employees personal file and that cannot be reported centrally. The aim is to seek that information and for the trust to have a central position. Christine Brereton highlighted this is linked to cultural delivery and leadership development and is one of the overriding principles to make flexible working successful and key when applying for jobs.

The Chair stated that the emphasis is around supporting the objectives of the organisation i.e. delivering good health care and outcomes for patients and that will help the trust become a better healthcare organisation, although training and education of management can sometimes be barriers to flexible working.

5b Culture Transformation Programme Update - regular on WC) agenda

The Culture Transformation Programme and the Clever Together Platform were formally launched on 04 August 2022 and regular updates will be given going forward.

The Culture Transformation Board (CTB) convened in July and meets quarterly, and the Culture Transformation Working Group (CTWG) meets monthly. The launch event and Big Conversation has been supplemented with five pop up hubs, a total of 1,000 conversations have taken place with staff and there are some emerging themes. The Big Conversation is now closed with 471 unique ideas being put forward and 350 comments have been received over 5,000 data points. Clever Together are now looking at that data and looking to have a draft report in the next couple of weeks. A face-to-face event will be held, in October, with 40/50 staff to look at a traffic response action plan to the suggestions from the Big Conversation. Some green themes can be sorted straight away with some amber and red themes taking more time. The action plan will be signed off by the CTB and go to Trust Board for approval.

The national staff survey campaign is up and running and will be launched to all staff in October. This campaign will operate 100% digital for the first time this year and will close late November/early December.

The launch of the leader individual development tool kit allows existing and onboarding staff from November, with people leader responsibilities, to run through the core skills competencies. The people leader induction is launched next month to supplement corporate induction and the existing 640 staff will have one year to complete their development needs. The trust is starting to launch the values training and will target areas with bad behaviours, EDI issues or where staff are feeling really low.

6 People Directorate - Annual Delivery Plan - Q1 Update

The plan is for information and it outlines the huge agenda and progress that has been made in quarter 1. It links into trust priorities with a key focus on the just culture work and flexible working.

Christine Brereton added that going forward the aim is to overlay the plan and culture work with KPIs to see what has been achieved.

7 BAF 2022-23 - Quarter 1 Report

Christine Brereton confirmed she had updated the internal controls and identified some of the risks. Fiona Osborne questioned SO5, under gaps in controls it states 'No investment specifically for staff training/courses to support leaders work within a different context and to be effective in their roles as leaders'. Fiona asked if that should be under the one risk or both risks.

Christine Brereton stated there had been some investment in leadership development for next year and that is where it should be. She felt the comment was in relation to individual budgets for individuals to apply for courses. Christine stated she was happy to look at that.
Action: Christine Brereton

The Chair stated that ophthalmology is being managed day to day and some other risks may warrant a discussion. He felt that the BAF was much better now than it was previously.

8 CQC Update

Jennifer Granger reported that 85% of the 145 actions are rated green or blue with five being signed off last month. This committee has 25 actions, 0 red, 7 amber, 9 green, 9 blue and 0 retired/on hold. Jennifer went on to highlight some of the amber actions.

The Chair stated it was good to have no red actions and to see there was some funding in place and plans to address some of the amber actions. Some areas consistently do not hit the targets and this committee needs to be sure actions are being taken to address that and see how that fits into the delivery plan.

9 Medical Education Annual Report

Kate Wood stated last year there were several concerns and there has been a lot of improvement and commitment in the last year to do the right things.

Silas Gimba reported there had been challenges in the delivery of postgraduate medical education, and they have focused on systems and operations. Administrative staff in the medical education centre left the trust and that affected how much could be achieved. Some results were achieved in 2022, although that is not where the trust wants to be. There has been some positive feedback in terms of support from the organisation. PGME are still listening to staff and the main issues are supervision out of hours and during the daytime. Consultants came back with their own challenges and have been given time for educational support work and SPA time and they still don't always have time for 1:1s. The main issue is staffing, relying on temporary staff at all levels including consultants and locum consultants on short term contracts who may not have been trained as educational trainers. This results in not enough educational supervisors on the shop floor. Focusing on educational supervisors, they need to understand the curriculum, and make better use of the SPA time they have for training. PGME are working closely with collaborators such as the Guardian of Safe Working and the Freedom to Speak UP Guardian. Silas Gimba added that that he is confident that in the next two to three years NLaG will be comparative to its peers.

The Chair asked Silas Gimba about his level of confidence around PGME maintaining its momentum and whether there are any barriers that the committee might help with. Kate Wood

stated firstly, she wanted the committee to acknowledge the work done by PGME and divisions. It is tough to change the culture from just doing operational work to one that recognises the value of medical staff and their training. These are senior doctors of the future and if the trust trains them well, they will want to come back and work at NLaG. Secondly, in the future when there are very difficult discussions about the importance of protecting time for consultants and middle grades to provide training on an ongoing basis, there will be a financial cost, it is about the quality of that training and support from this committee. Medical education needs support in terms of money to be able to achieve success and sustainability.

Silas Gimba added they are seeking funding from Health Education England and later in the year from the Department of Health, it could be between £50k and £70k to supplement trainers to provide 1:1 training that they may need. Silas Gimba asked the Workforce Committee to help spread the word at other committees.

Ashy Shanker added from an operational perspective, there is a lot of pressure in Operations to improve performance and hit targets and everyone needs to be mindful that shouldn't be at the detriment of training. The trust needs to balance performance, and the welfare of its clinical workforce. The trust is just embarking on business planning for next year, and Ashy agreed to have conversations with divisions on behalf of all the clinical workforce, to have that buffer to support medical education.

Silas Gimba is also working on accountability on behalf of colleagues to make sure their actions are documented throughout the year to show how they spend their time on education and training. He is starting with clinical education leaders, and then looking at consultants and the time they have allocated.

Geriatric Medicine in DPOWH has received the most negative trainee ratings in the Trust over the last year, the committee asked if there is a focus on geriatrics and are there any risks with the plan other than resourcing and finance. Silas Gimba has identified Geriatric Medicine and Cardiology in DPOWH and is putting monitoring control measures in place to identify the problems and if due to skill mix, that will take some time to sort. One obstacle was that trainers were not aware where the organisation is in terms of training and had put their energy into service provision. Silas Gimba is supporting them, helping them to understand the curriculum and is closing the gaps with more senior trainers. It has not been done this way before, and this should allow them to be able to move forward.

Kate Wood stated that Liz Evans has been revolutionary in her role working closely with PGME and she is the bridge for trust junior doctors. Liz also needs to have the appropriate time, and she is also reliant on several people not always familiar with the NHS system. This is another different resource that is needed. The independent Guardian of Safe Working is another important role. Medical staff traditionally do not have a lot of sickness and do not report that. The trust needs to understand that and has had problems reporting sickness. Jane Heaton agreed, it is a problem with short term sickness, and the trust doesn't have that full overview because staff rotate through different departments. The trust is starting to manage that better than previously, even if doctors are working in GP practice.

Kate Wood thanked Silas Gimba for a fantastic report and asked the Committee for any feedback and what they would like to see for next year. Fiona Osborne would like to see any risks and opportunities and an indication of where Kate Wood would like to see support from this committee or Board.

The Chair thanked Silas Gimba and his team for the report.

10 Guardian of Safe Working Annual Report

Kate Wood reported that the Guardian of Safe Working Annual Report needs to be submitted to the Board as a statutory duty. Liz Evans, Guardian of Safe Working also presents a quarterly report to TMB and the main issue is engagement with junior doctors and work on that is ongoing.

Fiona Osborne stated that on page 6 of 9, it says 'exception reporting is similar across both years', but that actually doesn't look similar, it looks like a 40-50% rise from 2021 levels which is a cause for concern. Liz Evans explained that the peaks occur at the same time when new doctors rotate in August and February. Probably, because of all the engagement work that has been done and the push to make that better there has been an increasing number of people exception reporting. Fiona Osborne asked Liz Evans to clarify that before presenting the report to Board.
Action: Liz Evans

Silas Gimba added that 4 to 5 years ago there wasn't exception reporting within their departments, so rates were low, the increase is a result of the positive effort being put in. Kate Wood agreed that the rise in exception reporting is a good thing at this stage, and she feels that junior doctors will report and that will feed into discussions with PGME and operational teams. Junior doctors feel that they have a platform at the Junior Doctors Forum along with the engagement work that Liz Evans and Helen Fitzpatrick is doing. The trust needs to make sure junior doctors are trained and get appropriate supervision to keep patients safe and look after the doctors of the future.

The Chair confirmed that the Committee agreed to endorse the report with the amendments suggested by Fiona Osborne before being presented to Board, linking the increase with the ongoing engagement work.

11 Doctors in Difficulty Annual Report

The report is presented for information and assurance that the Medical Director has oversight of doctors in difficulty who potentially require additional support from a pastoral perspective rather than a formal practice. Some concerns are dealt with at the informal stage at divisional level working closely with HRBPs to make sure no doctors fall through the gaps.

Fiona Osborne stated that taking information from different sources, and the timing of that information, is important when presenting to the Committee. Fiona asked about getting data through quickly enough around the categories, particularly the 'other' category, and whether they were looking at that. Jane Heaton stated they only know what they know and because of the relationship with colleagues in HR and Operations that soft intelligence usually comes through very quickly. Intelligence is logged onto a spreadsheet followed by conversations to enable direct interventions to provide support. If it is in a formal process, things are picked up appropriately. Kate Wood added that if you see a particular doctor constantly cropping up in low levels, it provides the opportunity to see what else is going on and bring information from several resources to provide a different intervention if necessary.

12 Workforce IPR Performance Report - Trust and Directorate

Nico Batinica presented the headlines from the report. Christine Brereton emphasized the peak points data looks bad, to give the Committee some assurance with the activity that is in place over the next three months the performance should normalize.

Fiona Osborne stated that in other committees the IPR data has individual commentary with an action plan and breakdown of each issue. It would be helpful to have that explanation to

understand the mitigation and actions. Nico Batinica advised that some of the information had been lost in transmission and he has contacted informatics as he would expect to have tasks and mitigations in the report. Nico Batinicia assured the Committee they will be included in the report that goes to Board.

The Chair stated when there had been increases in establishment, realistically there should be a forecast to show where the trust is expected to be and some of that is provided in the report.

13 Recruitment KPIs/Dashboard

Nico Batinica presented the headlines from the report and explained what is planned for the next quarter. There is a lack of career development at the trust and the Registered Nurse Degree Apprenticeship Programme will help with that. The trust has been asked nationally to complete a self-assessment and a toolkit in Quarter 3 to make sure it is doing all it can and focusing on retention for nursing staff. Career development, cultures and behaviours are still the main issues and great ideas have been put forward from the Big Conversation. For information, the recruitment pipeline at present is healthy.

Fiona Osborne stated the pipeline is a healthy one, the concern was around the data now and KPIs to try and establish an overall focus, and the trust is assuming a static level of leavers. A forecast is what is believed will happen on the information that is available. There will be a peak shortly after people start at the trust, is there any suggested information on leavers to be able to tweak the activity to address a larger level of leavers and support new starters. Nico Batinica replied they have taken baby steps and will detail that more going forward. They have set up groups and set some targets, but the reality is they have been too ambitious, nursing is not realistic, and they have not seen the fruition that they hoped for. Fiona Osborne highlighted that information is key for the business planning process. Christine Brereton confirmed that the numbers had been generated from the business planning process. There has been a real improvement this year and more indicators can start to build in going forward.

Ashy Shanker felt the trust needs to understand more about the workforce and performance, it is a learning curve, and will be more robust next year. There is a clear connection between recruitment plans at divisional level and how that links into trust level workplans and operational plans in terms of activity and finance, the trust is aware of that and it is in development. Jenny Hinchliffe added there are some risks around the ACP workforce and the impact on medical workforce and they are doing that triangulation as part of the workforce plan.

14 Workforce Resource Centre - Bank/Temporary Staffing

Item deferred to the November 2022 meeting.

15 Humber Acute Services Review (HASR) Update

Claire Hansen reported that originally HASR was looking at planned care and given the elective recovery, changed their approach to planned care in that they had to make sure it aligned with the recovery plan for ICS. They are looking at hub and spoke models for high volume, low complexity (day case) hubs and specialist inpatient elective hub(s) that link in with diagnostic hubs. The risk for diagnostics hubs, the principles of that shared workforce making sure there is a dialogue about getting people into post and an understanding around risk thresholds in secondary and primary care.

Regarding out of hospital they were working towards a consultation in November 2022, but that is not going live because of a few things and the change in Government. They are looking at the risks with ICB and regional teams and suggesting moving the public consultation to go live in June 2023. The proposal went to ICB, Peter Reading and the Oversight Executive Group. It was agreed at ICB verbally that they would be more comfortable to go with the June 2023 date. They have drafted a timeline for assurance to identify what can be done gateway wise, and it does give a little more time to build the phase even more. From a workforce perspective it is essential; the Joint Working Group is crucial to enable the development of services in the way they are described. Activity cannot be moved to community and primary care there isn't the capacity there. To develop out of hospital and workforce numbers from an acute point of view, they know what they need and are discussing with universities how to commit to that from a training perspective. They will be sense checking that as they work with operational colleagues, universities and out of hospital.

The main focus is the significant impact on bands 1 to 4, in some of the proposals that impact on those staff groups would really impact negatively. The proposals have gone from 15 variables to 4 main options such as acute hospital on one site with a local emergency hospital on another, with or without an obstetric unit. The ability of staff to travel, staff would be destabilizing and destabilizing NLaGs neighbouring trusts. They have also looked at age profiles of staff, and it is important to work with schools, colleges, and universities. They have collected data around why people leave, if there are some shared roles with other colleagues that will start to develop people for their skill sets.

Christine Brereton felt it is about how to link all the above together and determine what needs to be done locally. The trust must recognise where it has come from with its recruitment plans. An event is taking place today that Christine has not been invited to, in fact she been excluded from, she asked how the trust joins the dots up without duplicating things. Claire Hansen stated if that is the case, she is more than happy to add that as an item for consideration.

Ashy Shaker stated there were specific issues to NLaG, when looking at universities to see basic numbers coming though in terms of what makes NLaG an attractive place to stay, it is that linkage as well. Claire felt it was important to make sure that whatever is being described, working across different providers, joint recruitment has been successful. HUTH and NLaG are much stronger together to attract posts and if it can maximize working across the North bank, South bank and across sectors that will be more attractive for people.

Robert Pickersgill felt that a starting point would be a deep dive into professional scientific and technical vacancy rates to see if they are within normal as NLaG turnover rate is high. Teams need to work together to get to the route cause of the issues. NLaG sickness rate is twice the private level, if all these things could be brought together, there would be a better strategy. Training providers and universities are a major challenge, and the constraints individual providers suffer from must be removed. Governors are trying to get involved in lobbying to help providers because that is an important issue. The Chair commented that HASR is making a good strategy better, and he suggested looking at the solutions and keeping a real focus on the data to make sure it is used correctly. Christine Brereton confirmed that current sickness levels are in line with other public/NHS organisations, which are better comparators.

Regarding the benefit of new ways of working, Jenny Hinchliffe asked Claire Hansen as work is progressing, is there the appetite for cross site working. Claire Hansen stated there are some pockets of people who really want to and there are some boundaries and drawbridges that need further work. Ashy Shanker felt that progress has been made at HUTH with joint posts, although the strategy does need to be longer term to make NLaG more attractive. Claire Hansen stated

their approach is to work with schools to align programmes together such as looking at what theatres may look like in the next 10 years. They are working on current workforce plans and solutions and have tried to join that with theatres to get colleges in to share the experience of what is being done, and to build and develop the plan for the next 5 years.

16 Staff Lottery Committee Annual Report

For noting, activities from this year will be in next year's report. Members have increased by 100 year on year and the trust is exploring how to expand scope and make the best use of that. The report was approved by the Committee.

17 Trust Board Highlight Report

People Strategy focus on 'Approach to Flexible Working' and 'Culture Transformation update' Guardian of Safe Working Annual Report endorsed

18 Items for information (not for printing)

18.1 Workforce Committee Annual Workplan

The workplan had been reviewed and a revised workplan with amendments is presented for information.

18.2 Minutes of Health and Wellbeing Steering Group meetings held on 28 June 2022 and 27 July 2022

Nothing discussed

18.3 Minutes of Culture Working Task and Finish Group meeting held on 27 June 2022

Nothing discussed

19 Any Other Urgent Business

The Chair thanked Christine Brereton and her team for development of a strategic approach and key aspects of the Workforce agenda. The Chair went on to thank Fiona Osborne and Robert Pickersgill, two real advocates of the workforce agenda that had been interfaced with other Governors. It has been a very enjoyable role and the Chair thanked everyone who has supported the process.

Christine Brereton went on to thank the Chair on behalf of her team for his support and for his constructive challenge, they all wished him well. Christine also thanked Fiona for her scrutiny and went on to wish her well.

Fiona Osborne thanked the Chair for his support and help since she started at the trust some twelve months ago. Fiona also thanked Christine and her team for the unrecognizable amount of work in the last year it has made a huge difference, although there is till some way to go.

Christine Brereton reported that Alison Dubbins leaves the trust at the end of October and she thanked her for the tremendous amount of work that she and her team have done around culture. The Chair agreed, he also thanked Alison very much for her outstanding work and high professionalism, it's been enlightening for the organisation.

20 Date, time, and venue of next meeting:

Tuesday, 29 November 2022 at 14:00 hours via Microsoft Teams

The meeting closed at 16:42 hours

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	6 December 2022
Director Lead	Dr Kate Wood
Contact Officer/Author	Dr Elizabeth Evans
Title of the Report	**Guardian of Safe Working Quarterly Report**
Purpose of the Report and Executive Summary (to include recommendations)	The Guardian of Safe Working is a role that provides assurance to the board that the doctors in training in the trust are working within their contract. This report provides information on the number and type of deviations from the contract and the steps taken to resolve any issues. Exception reports for the quarter 1st July 2022 to 30th September 2022 saw an increase from 43 to 74 exception reports. The majority of the exception reports submitted were in connection with working hours, with a small number also submitted around service support, educational opportunities and work patterns which the Director of Post Graduate Medical Education continues to oversee and discuss within the relevant Divisions/Directorates. There is still work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared. Once refresher training has been carried out on the allocate system for exception reporting and Educational Supervisors reminded of their responsibilities the time spent by the Guardian of Safe Working in relation outstanding exception reports should reduce.
Background Information and/or Supporting Document(s) (if applicable)	n/a
Prior Approval Process	✓ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:**

	☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	✓ 5 ☐ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Northern Lincolnshire and Goole NHS Foundation Trust

Guardian of Safe Working Quarterly Report

Dr Liz Evans
Guardian of Safe Working
1st October 2022

Contents

1. Executive Summary

Exception reports for the quarter 1st July 2022 to 30th September 2022 saw an increase from 43 to 74 exception reports.The majority of the exception reports submitted were in connection with working hours, with a small number also submitted around service support, educational opportunities and work patterns which the Director of Post Graduate Medical Education continues to oversee and discuss within the relevant Divisions/Directorates.

There is still work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared.

Once refresher training has been carried out on the allocate system for exception reporting and Educational Supervisors reminded of their responsibilities the time spent by the Guardian of Safe Working in relation outstanding exception reports should reduce.

Current numbers of Doctors in Training within NLaG is as follows:

Number of Training Posts (WTE)	311
Number of Doctors/Dentists in Training (WTE)	264.19
Number of Less than full time (LTFT) Trainees (Headcount)	N/A
Number of Training post vacancies (WTE)	47.9

Source Finance data

During the period of this quarterly report (1st July 2022 to 30th September 2022) there have been a total of 74 exception reports submitted through the allocate exception report system.

This showed an increase of 31 exception reports from the last quarter (1st April 2022 to 30th June 2022).

Of the 74 exception reports submitted, 54 were linked to hours. This showed an increase of 19 reports from the previous quarter.

The exception reports for this quarter relating to hours had been agreed by the Guardian of Safe Working (GoSW) for either payment or time off in lieu (TOIL).

Several of these exception reports remained open on the system beyond the 30th of September as information from rota co-ordinators was awaited. The majority have now all been closed successfully.

The below table is a breakdown of the exception reports over the last quarter (July 2022 – September 2022)

Exception Reports Open (ER) between 1st July 2022 – 30th Spetember 2022	
Total number of exception reports received	74
Number relating to hours of work	54
Number relating to pattern of work	6
Number relating to educational opportunities	5
Number relating to service support available to the Doctor	9
Number initially relating to immediate patient safety concerns	5

*Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support have the option of specifying whether the report constitutes an immediate safety concerns (ISC). ISC is not an exception by itself.

Exception Report Outcomes (ER) between 1st July 2022 and 30th September 2022	
Total number of exception reports resolved as at 30/06/2022*	55
Total number of exception reports unresolved as at 30/06/2022*	20
Total number of exception reports where TOIL was granted	23
Total number of exception reports where overtime was paid	22
Total number of exception reports resulting in a work schedule review	0
Total number of exception reports resulting in no further action	10
Total number of exception reports resulting in fines	0

"Note:

* Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.

* Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.

* Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded."

2. Immediate Safety Concerns

During this quarter there were 5 exception reports submitted where the Doctors raised an immediate safety concern in addition to either a concern around working hours or clinical supervision. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there is an immediate safety concern. An immediate safety concern is not an exception field on its own.

Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and progressed appropriately.

The reasons for immediate safety concerns being raised, as in previous reports, have generally concerned safe staffing at junior levels. Four of these concerns were due to a change made to the rota in surgery in Scunthorpe. Another report concerned staffing levels in medicine in Scunthorpe due to short notice sickness. These concerns were quicky dealt with at a divisional level and the reports closed.

3. Work Schedule Reviews

During this quarter there were no work schedule reviews required.

4. Trend in Exception Reporting

There has been an increase in exception reports received this quarter. This is likely to reflect improved engagement with the doctors during induction. This has taken a number of forms, including an improved induction talk, leaflets, welcome packs, and personalized invitations to the junior doctors forum. This pattern of increased reporting in the first few months of a new academic year is something that has been seen previously.

5. Fines Levied against Departments this quarter

During this quarter there were no fines levied against Departments.

6. Communication and Engagement

Work continues to look at the communication and engagement with our Doctors in Training.

The Guardian of Safe Working/Junior Doctors Forum has been up and running now for a year, has formal terms of reference, agenda and notes. Work to improve engagement and attendance at the forum is ongoing. The time of the JDF has been changed to lunchtime following consultation with some of the juniors at induction, which has had a positive impact on attendance. This has been re-discussed at a recent JDF, and the junior doctors have confirmed that this time is convenient for them.

The Guardian of Safe Working runs a drop-in session to allow for face to face contact with the Doctors in Training. In addition there is a regular quarterly newsletter which is circulated via e-mail. Information around the guardian office is available on the HUB, and there is a leaflet which is provided to all doctors in training on joining the trust containing details of the support available. There is also now a regular meeting between the Guardian of Safe Working, the Freedom to Speak up Guardian, and a representative of PGME. This enables the support mechanism for Doctors in Training to establish any common themes and co-ordinate an approach to finding solutions.

7. Support for the Guardian Role

There is a dedicated administrative resource for the Guardian of Safe Working which sits within the Medical Director's Office.

The Trust's Guardian of Safe Working, Dr Liz Evans, Specialty Doctor in Anaesthetics at DPOW, commenced in this role in June 2021.

8. Key Issues and Summary

Exception reporting during this quarter demonstrated an increase compared with the previous quarter. This is possibly due to improved engagement with the Doctors in Training. We will ensure that the engagement continues to maintain the level of reporting, as exception reporting provides real time information on the environment on the wards to allow timely troubleshooting, in addition to being a contractual obligation.

Continued engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to resolve most issues as and when they arise.

In summary, we appear to be in a positive position going forward.

Engagement of the Educational Supervisors still remains an issue which needs improvement- this will ensure a timely response to exception reports, in addition to providing improved support to the doctors in training, and contributing to our efforts to make the training experience at NLaG a positive one.

Dr Liz Evans - Guardian of Safe Working

Date: 1st October 2022

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	6 December 2022	
Director Lead	Simon Parkes, NED / Chair of Audit, Risk & Governance Committee	
Contact Officer/Author	Lee Bond, Chair Financial Officer	
Title of the Report	**Audit, Risk and Governance Committee Minutes of meeting held on 27 July 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Audit, Risk & Governance Committee held on 27 July and approved at its meeting on 24 November 2022.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: ARG Committee
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Oversight of entire BAF process, completion and achievement.
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: Click here to enter text.

***Board Assurance Framework (BAF) Descriptions:**

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

MINUTES

MEETING:	Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**	
DATE:	**27 July 2022** via MS Teams	
PRESENT:	Simon Parkes	Chair of ARG Committee / Non-Executive Director
	Gill Ponder	Non-Executive Director
	Michael Whitworth	Non-Executive Director
IN ATTENDANCE:	Helen Harris	Director of Corporate Governance
	Mike Norman	External Audit – Auditor (Mazars)
	Mark Surridge	External Audit – Director (Mazars)
	Helen Higgs	Managing Director / Head of Internal Audit (Audit Yorkshire)
	Danielle Hodson	Assistant Internal Audit Manager (Audit Yorkshire)
	Sally Stevenson	Assistant Director of Finance – Compliance & Counter Fraud
	Nicki Foley	Local Counter Fraud Specialist
	Matt Overton	Emergency Planning Manager (For item 9.1)
	Bill Parkinson	Associate Director of Safety & Statutory Compliance (For items 9.2 & 9.3)
	Ivan Pannell	Head of Procurement (For items 9.4 & 10.4)
	Mick Chomyn	Director of Pathology (For item 10.1)
	Angie Legge	Associate Director of Quality Governance (For item 10.2)
	Sue Meakin	Data Protection Officer (For item 10.3)
	Steve Mattern	Associate Director of IM&T (For private item 12.1)
	Tonya Fredrickson	IT Security Manager (For private item 12.1)
	Christine Brereton	Director of People (For item 6.1 and 6.2)
	Anne Sprason	Directorate Admin Manager / PA to CFO (Minutes)
	Lauren Short	Directorate Admin Assistant (Observer for Minutes)

Item 1 07/22 **Apologies for Absence:**

Apologies received from Lee Bond and Chris Boyne.

Item 2 07/22 **Declarations of Interests**

Simon Parkes asked if there were any additional declarations of interest not otherwise disclosed on the Trust Declaration system. None were advised.

Item 3 07/22 **Minutes of Previous Meetings**

3.1 The minutes from the meeting held on 10 June 2022 were agreed as an accurate record.

3.2 The Highlight Report from 10 June 2022 had been provided and noted.

Item 4 07/22 **Matters Arising/Review of Action Log**

There were no matters arising that were not included on the agenda.

Item 5 07/22 **External Audit (Mazars)**

5.1 Auditor's Annual Report Year Ended 31 March 2022

Mark Surridge presented the Auditor's Annual Report 2021/22 which summarised the external auditor's work for the year and followed a specified format to include financial statements; commentary on VFM arrangements and other reporting responsibilities in line with their Code of Practice. Mark Surridge explained that the report would be presented to the Council of Governors (CoG) as independent assurance of the work performed and was a positive report despite some pre-existing significant weaknesses of a complex nature that would take time to resolve. There were no new issues to raise from those discussed at the last meeting.

Gill Ponder stated it is what it is and that whilst the Trust would like to be out of financial special measures, which could happen following the recent CQC inspection, she acknowledged there were some things that did not reflect favourably on the Trust that needed to be included within the Annual Report.

Simon Parkes noted that this was the last meeting for Mazars and thanked both Mark Surridge and Mike Norman for their honesty and transparency about their inability to continue as the Trust's External Auditor and thanked them for the work undertaken. Mark Surridge added that the CoG meeting would be their last act of business for the Trust, and thanked the ARG Committee, Sally Stevenson and Nicola Parker.

5.2 Progress Report

There was no progress report.

5.3 Annual Review of External Auditor Performance

Simon Parkes queried whether the Auditors should be present for this item and Sally Stevenson confirmed that it had been agreed the previous year that Auditors should remain in the meeting for this item as any issues during the year would have already been escalated/raised with them. The performance report was presented with no issues to raise.

The report was noted, and Mark Surridge and Mike Norman left the meeting.

Gill Ponder queried the position with the External Audit tender. Sally Stevenson explained that the tender for the appointment of new External Auditor would close on 5 August 2022 and was hoping for at least one bid, although noted that other Trusts had experienced difficulties in appointing one. Gill Ponder suggested the timing was not ideal and Sally Stevenson explained that it had been discussed with Mark Surridge who had suggested waiting until the end of June before advertising due to end of year work pressures for potential bidders. Simon Parkes acknowledged that it was a difficult market, but just needed one tender submission.

Item 6 07/22 **Internal Audit (Audit Yorkshire)**

6.1 Internal Audit Progress Report

Danielle Hodson presented the Internal Audit Progress Report on the 2022/23 plan and highlighted that three reports had been finalised since the last report i.e. Waiting List Management including Clinical Harm (Significant assurance); Use of Agency Staff (Significant assurance); and Data Security & Protection Toolkit (Significant / Moderate assurance).

Gill Ponder queried the Data Quality audits, discussed at a previous meeting in terms of data integrity and Danielle Hodson explained that a discussion had been arranged with Lee Bond but this was not until September and would then be brought to the following ARG Committee. Sally Stevenson noted that it was included on the action log to be brought forward for the November meeting.

Christine Brereton had joined the meeting to observe.

Simon Parkes referred to the Clinical Harm review and was slightly concerned of management responses and was not confident that relevant reviews had been completed. It was proposed to be deferred to the end of the year, noting that it was not classed as a major risk. Gill Ponder commented that the Trust gets a high level of assurance from Internal Audit reviews, providing the recommendations did not go overdue and create a backlog again.

Christine Brereton highlighted that Agency guidance had been received from NHSI that she would discuss with Shaun Stacey and Brian Shipley regarding the reduction and direction of agency spend that would need to be implemented.

Gill Ponder noted that agency spend was discussed at the Finance and Performance Committee as part of the review on overall agency spend and compliance with guidance. The Finance and Performance Committee gave significant focus to the subject which resulted in microscopic analysis of data. Workforce plans were also to be considered and a separate session may be needed to agree on the governance to gain assurance that everything possible was considered. Christine Brereton stated that it would be a challenge.

Following the discussion, the report was noted.

6.2 IA Recommendations Follow-up – Status Report

Danielle Hodson presented the report and highlighted there were currently six overdue recommendations i.e. three moderate and three minor, with one moderate now closed down. Since the last meeting a monthly report to Executives had been introduced by Audit Yorkshire, which was over and above the automatic system updates already in place, which was designed to give the Executives easier oversight of recommendations within their areas.

Helen Higgs referred to the Job Planning recommendation (Ref 21798) and noted that there were no links back to declarations interests and links to job plans which was an area still to be picked up. Simon Parkes stated it would be helpful to attach declarations to job plans to close that loop. Helen Harris explained that declarations were now completed on-line and an internal audit review was due in Q3. Danielle Hodson confirmed that the audit was due to be undertaken in November 2022 and she would link in with Helen Harris at that point. Simon Parkes acknowledge that job planning had improved since the audit was undertaken in November 2021 and was heading in the right direction.

6.3 Insight Technical Updates Report

The Insight Technical Updates Report had been provided for information and Danielle Hodson highlighted specifically items on ICS, and the HFMA sustainable review.

6.4 Briefing Paper on NHSE Requirement to Commission Internal Audit to report on the HFMA publication – *Improving NHS financial sustainability: are you getting the basics right?*

Sally Stevenson explained that compliance was required to comply with receipt of additional funding by ensuring the Trust completed a quite lengthy HFMA financial sustainability checklist. There were two sections i.e. a self-assessment and a detailed list of questions, which required to be signed-off by the Chief Financial Officer and Chief Executive by the end of September 2022 before submission to Internal Audit for review and assessment. Helen Higgs had just received further information that completion of the audit work was required by the end of November 2022 and reporting to the ARG Committee, with any improvements to be implemented by the Trust by January 2023. A piece of work would be commenced with the terms of reference currently being developed. The work would need full cooperation to meet the tight deadlines.

Gill Ponder queried whether it was in respect of existing or additional funding and it was confirmed that it was additional funding. There was an expectation that the submission would be done, and results shared with system partners for benchmarking purposes and to ensure transparency. Gill Ponder commented that it was quite an onerous self-assessment process not dissimilar to the CQC process but with a focus on financial evidence and suggested significant resource would be required.

Sally Stevenson stated that the checklist and Internal Audit report would be brought back to the 24 November ARG Committee meeting. Gill Ponder queried whether a meeting in its own right was necessary to discuss the checklist before the November ARG meeting. It was agreed that Simon Parkes would discuss further with Lee Bond, noting that the three Committee members were content to have a separate meeting if required.

Action: Simon Parkes

Item 7 07/22 **Counter Fraud**

7.1 LCFS Progress Report

Nicki Foley presented the progress report and highlighted key points to note as follows:

- Counter Fraud Functional Standard Return submitted by the deadline with a rating of Green.
- The Annual Staff Fraud Awareness Survey had received 415 responses. The results, including benchmarking of the Trusts within the counter fraud collaborative, were included within the report at Appendix 2.
- Two Fraud Prevention Notices (FPN) had been issued since the last meeting i.e. Payment Fraud/Payment Terminal; and Cyber enabled Mandate fraud. This FPN had also been shared with IT and was on their radar. Two factor authentication was discussed.
- Refreshed Trust Corporate Induction – Fraud Awareness – Nicki Foley had attended several sessions to contribute to the development of a refreshed Induction Programme. Currently it is planned that all new starters will complete the national eLearning package as part of their induction and will also have an induction booklet available to them which features a fraud awareness page.
- Nicki Foley is also attending the inaugural meeting in September 2022 of the newly formed Portfolio Governance Board, to present to the meeting a request for the Fraud Awareness national eLearning package to become part of the Trusts mandatory training. Nicki Foley will provide update at the next meeting.
- There had been 2 new referrals since the last meeting, 4 cases closed and 3 cases remained on-going.

Gill Ponder commented on the lack of training take up compared to other Trusts in the collaborative and that a real focus on raising awareness would help to get to the position where people would not be able to deny they had received training. She suggested consideration of raising with the Board.

Christine Brereton agreed that the fraud awareness training was worthwhile, and explained that they get a lot of requests to the Portfolio Governance Board (PGB) but would ensure a wider debate and discussion, noting that new starters were encouraged to undertake as much training as they could before commencement in post. Christine Brereton stated that she was sure that Nicki Foley would make a very strong argument at the PGB for making fraud awareness training mandatory every three years, adding that although she would not be at the meeting it would be considered. Simon Parkes stated that Nicki Foley could reflect the ARG Committee's support for mandatory training at the PGB, but also acknowledged Christine Brereton's point about the number of requests received.

Christine Brereton left the meeting.

7.2 LCFS Annual Report 2021/22

Nicki Foley presented the annual report which was a summary of quarterly reports previously received by the Committee and highlighted that included within the annual report was an analysis of time spent and the new outcome based metrics.

The Annual Report was noted, and Simon Parkes thanked Nicki Foley for both reports.

Item 8 07/22 **Board Assurance Framework and Strategic Risk Register – Q1**

Helen Harris presented the report and explained that all reports had recently been reviewed by the individual sub-committees apart from the Strategic Development Committee as their meeting had been cancelled. The target for SO3.1 had been met but for 2022/23 was expected to become a significant risk of 20, with oversight from the Finance and Performance Committee.

The report still required updating with several recommendations which would be actioned by Q2 including planned actions and risk appetite scores. Helen Harris also highlighted that links to the high-level risk register was being worked through and would be developed over the course of the year.

Gill Ponder referred to the table on page 4 of the report which explained the progress from year to year, and which Gill Ponder felt was a very good summary set out well, and noted that SO3.1 and 3.2 target risk scores were increasing. Helen Harris agreed and explained that she had been unable to meet with Lee Bond due to annual leave and would be reviewing the score with him and would update either at the next Finance and Performance Committee or quarterly BAF cycle.

Action: Helen Harris

Simon Parkes referred to the risk related to SO1.5 the "*digital infrastructure may affect the quality, efficacy, or efficiency of patient care".* Helen Harris noted that the score was down from 12 to 9 which was positive. Simon Parkes proposed that he would not raise at the Trust Board but would write to Shauna McMahon to ask for the cyber element (specifically two factor authentication) to be reflected within the BAF. He noted that the Committee did not have a full discussion but if it was felt necessary Shauna McMahon could be invited to a future meeting.

Action: Simon Parkes

Item 9 07/22 **Management Reports for Assurance - Items for Approval**

9.1 Annual Emergency Preparedness, Resilience and Business Continuity Report 2021/22

Matt Overton attended the meeting to present the annual report and noted key points:

- The Trust had been substantially compliant with the required core standards reaching and maintaining 89%-90%. There were two standards that the Trust reported partial compliance i.e. Standard 57 – HAZMAT/CBRNe Planning arrangements: and Standard 59 – Decontamination capability and availability. EMAS conducted a HAZMAT / CBRNe audit at DPOW and SGH during February 2022 and no issues were raised.
- The training programme had been greatly reduced due to the Covid-19 pandemic and more training was now planned.
- Incidents – The Covid-19 pandemic was the one live incident (although now down to level 3) and continuity plans had been well tested. As the Trust was transitioning out of Covid the responses were now built into business as usual.
- Training – new national guidance related to a mandate for commander training following lessons learned after Grenfell and the Manchester bombing. All strategic command training would be completed by the end of September 2022.
- Winter planning was ongoing.
- New ICS escalation processes incorporated into NLAG documents as necessary.

Gill Ponder referred to page 10 and the Fuel Plan and reference that the national plan was utilised and suggested that given the risk was escalating it may warrant more than the 2017 national plan and asked how the Trust would address that. Matt Overton agreed this was a good question and explained that the national fuel plan dictated how category 1 and 2 workers were prioritised for fuel. Matt Overton explained that the Trust has local arrangements in place for fuel cards for community and key workers to emergency fuel stocks. It is very complex in terms of management to ensure that the system is not abused. Matt Overton further explained that fuel was included on the regional risk register and regularly reviewed how the plans would work.

Gill Ponder noted that it was not just fuel, but also heat and light, and Matt Overton stated that discussion had taken place at a Power Outage workshop if national power was unavailable for a week. There were several areas covered in those plans including resilience of generators and how to get fuel for those. A tabletop exercise for this area would be undertaken to ensure the Trust was as resilient as possible in the event of a full power outage.

Danielle Hodson stated that Internal Audit were in the process of scoping an audit in this area.

Simon Parkes commented that there was a strong level of assurance over EPRR in the report, acknowledging issues with CBRNe. Matt Overton was thanked for the update and he left the meeting.

9.2 Annual Fire Report 2021/22

Bill Parkinson attended the meeting to present the Annual Fire Report and highlighted key points to note as follows:

- The highest risk was the potential failure of the fire detection system. DPOW had recently had a new system installed and was now up and running. The age of the system at SGH resulted in an increase in the number of false alarms and remedial work was being undertaken in the interim.

- A peer review had been undertaken by safety officers at HUTH who reviewed policies and procedures and made recommendations to improve fire safety within NLAG which were now being taken forward.
- Fire warden training is being revamped and would be relaunched in August 2022.
- Changes to legislation following the Grenfell fire are expected in 2023, which would include high risk residential buildings and high-risk buildings, including hospitals. Interim changes to Trust policies would be made with a full review once the changes in legislation were known.
- A fire door inspection had been undertaken and training of Estates staff to undertake authorised repairs to damaged doors where possible.

Simon Parkes noted the key issue being the inadequacy of the fire alarm system at SGH and Goole, which had been escalated to Trust Board following the recent Finance and Performance Committee. Simon Parkes also noted the fire door issues which in some cases were not being reported and acknowledged the training to be undertaken for authorised repairs to be completed, adding that training was important so that everyone was aware of their responsibilities.

2.20pm Mick Chomyn and Ivan Pannell joined the meeting

9.3 LSMS Annual Report 2021/22

Bill Parkinson presented the Annual Report and highlighted that a lot of work was being done/planned and the positive steps taken in terms of linking in with Humberside Police and Local Authorities was improving co-operation and several initiatives working collaboratively were being taken forward. Bill Parkinson advised of an increase in violence and aggressive behaviour across the three hospital sites but with support from the police more action was now being taken and had seen a decrease in anti-social behaviour following intervention by the police.

The lone working devices had been upgraded for community workers which gave a better signal and were more reliable.

The new CCTV surveillance systems across the three sites were now in place noting some small adjustments were still to be made in the next couple of weeks.

2.33pm The report was noted, and Bill Parkinson was thanked for attending and he left the meeting.

9.4 Sales Representatives Policy

Ivan Pannell attended the meeting to present the report and highlighted that following a three-yearly review only minor amendments had been necessary, including a strengthened section on consignment stock which ensured operating teams were working within SFIs; and an updated Pharmacy formulary.

Simon Parkes asked if there was a process to keep the policy up to date before the three-yearly review, even just for contact details which had named individuals included. Ivan Pannell agreed that it had been an opportunity to update details in other policies and would not wait for three years to review in terms of staff contact details being updated as changes occurred.

The Sales Representatives Policy amendments were noted and approved.

Item 10 07/22 **Management Reports for Assurance**

10.1 Mortuary and Body Store Assurance – Action Plan Update

Mick Chomyn attended the meeting to present the latest position with this report and highlighted that NHSE/I published a letter in October 2021 with additional guidance for mortuaries and body stores. This had been presented to Trust Board in December 2021 with the outcome for the ARG Committee to have oversight of ongoing compliance and provide Trust Board assurance. This was the latest report to the Committee, and Mick Chomyn was pleased to report that actions were nearly complete.

Part of the requirement was to audit access to the mortuary and body stores and the data linked with CCTV. It had proved problematic in Goole and the decision had been made to change the arrangements, in agreement with Clinical Divisions, to secure the services of a local funeral director to collect bodies direct from the wards and not use the body store. It was anticipated that this arrangement would be in place by August 2022, similar to other Hospitals, and there would no longer be a body store in Goole.

Mick Chomyn referred to the Human Tissue Authority (HTA) guidance which related to mortuaries, noting that the NHSE/I additional guidance also included body stores, which had been resolved at Goole by removing that service.

Simon Parkes queried if it would remain an issue at Goole until August 2022 and Mick Chomyn explained that to put it into context there were only approximately 8-10 deaths in Goole per year so was not expected to be a significant issue. Mick Chomyn also highlighted the four major findings following the HTA inspection in May which included inadequate capacity of body storage at DPOW and SGH which was being addressed through capital equipment scheme due to lack of available funds. £400k had been secured to fund additional fixed storage to increase capacity for both sites, which would enable the removal of the temporary storage in place longer term.

Mick Chomyn highlighted ventilation issues in post-mortem rooms, and the requirement to change air ten times a day, and advised that the decision had been made to cease mortuary activity at Grimsby and transfer to Lincoln (with no loss of income); this would come into effect in September 2022. This would remove this issue identified by the HTA.

Following the review of the report the ARG Committee was content to report back to the Trust Board on assurance of the body store access, noting other actions would be dealt with by Quality and Safety Committee. Mick Chomyn was asked for a further update at the next meeting,

2.46pm Mick Chomyn was thanked for the update and he left the meeting.

10.2 Clinical Audit Annual Workplan 2022/23

Angie Legge attended the meeting to present the workplan for 2022/23 which had been provided for information. Angie Legge highlighted that given the finite number of staff available to undertake the clinical audits a prioritisation process was in place and was monitored throughout the year by the Quality Governance Group.

2.48pm The ARG Committee noted the workplan and Angie Legge left the meeting.

10.3 IG Steering Group Highlight Report including Annual IG Toolkit Return

Sue Meakin attended the meeting to present the report, which she commented was getting bigger as IG diversifies, and advised that the Trust submitted the final DSP toolkit on 30June 2022 with a rating of 'Approaching Standards'. Sue Meakin highlighted the changes to the process from previous years, which included review of the plan before submission by the Regional IG Lead to ensure that there was a consistent approach across the Region on how they were doing things.. The improvement plan now also includes the option of' partial' in terms of the actions where organisations could evidence working towards or have a solution in place but improving that solution to provide greater assurance.

Sue Meakin highlighted that 91% of staff had undertaken IG Training, noting the additional measures put in place to try and reach the required 95% target in the run up to the deadline. Sue Meakin was disappointed with not achieving the 95% target given all the hard work that had gone in to trying to get there.

The procurement of IT services for a backup storage solution was ongoing with the Procurement Department with the Digital Delivery Group involved in that process.

Simon Parkes acknowledged that 95% compliance was a tough ask but did not think it required escalating to the Trust Board as actions were well in hand and were being pursued as vigorously as possible, and he urged Sue Meakin to keep pushing.

Gill Ponder differed from that view noting there were several standards not met by the Trust but felt that reaching 95% compliance for IG training was within the organisation's gift as it was a mandatory requirement, only took an hour and was part of the toolkit and suggested the need for additional focus on it.

Helen Harris referred to IG incidents and asked if it would be worthwhile to include within the report if they had increased or decreased. Sue Meakin stated that an overview was available, and the Divisions also received a report and she was currently looking to develop that information using the data on Ulysees, noting that it was a manual process.

Simon Parkes proposed including in the highlight report the 91% IG training level.

10.4 Waiving of Standing Orders Report

Ivan Pannell presented the report and highlighted that it had been relatively quiet which was usual for the time of year and there was nothing specific to highlight to the Committee.

The report was noted, and Ivan Pannell left the meeting.

10.5 Salary Overpayment Report

Sally Stevenson presented the report and noted that it was the lowest quarterly overpayment figure since Q1 of 2017/18 which was pleasing to see and good for the Payroll team.

Simon Parkes referred to a £17k payroll processing error and asked for clarification of the reason for the error as it was a significant amount for a salary. Sally Stevenson confirmed that checks were made when salaries exceeded a threshold value. The error related to additional PAs being entered incorrectly into the system. Sally Stevenson advised that it had been picked up and the amount fully recovered.

The Committee was pleased to note the significant reduction for the quarter but decided not to report this to the Board until there was sustained reduction.

Following the review of the report and the subsequent clarification, the report was noted.

Item 11 07/22 **Action Logs and Highlight Reports from other Sub-committees.**

The following action logs and Highlight reports were provided and noted:

11.1 Finance & Performance Committee
11.2 Quality & Safety Committee
11.3 Workforce Committee
11.4 Health Tree Foundation Committee
11.5 RATs Committee - not received and a reason given that it contained confidential information. A proposal had been put forward which Simon Parkes did not agree with. He understood the concern and would report back at the next meeting with a proposal for a way forward.

Action: Simon Parkes

11.6 Strategic Development Committee – no meeting had taken place.

Item 12 07/22 **Private Agenda Items**

12.1 This item was discussed and minuted under a private item.

Item 13 07/22 **Any Other Business**

13.1 Schedule of ARG Committee Meetings 2023

Simon Parkes asked for any clashes or challenges for 2023 to be advised accordingly.

13.2 Any Other Urgent Business

There was no other urgent business raised.

Item 14 07/22 **Matters for Escalation to the Trust Board**

All issues for escalation were agreed throughout the meeting. Sally Stevenson would draft the highlight reports for both public and private agenda items.

Action: Sally Stevenson

Item 15 07/22 **Matters to Highlight to other Trust Board Assurance Committees**

There were no issues to highlight to other Trust Board Assurance Committees

Item 16 07/22 **Review of ARG Committee Workplan**

The ARG Committee workplan was noted.

Item 17 07/22 **Review of the Meeting.**

Michael Whitworth commented that the meeting had gone very well, adding that it was informative, the level of detail was good and they had received reassurance.

Item 18 07/22 **Date and Time of the next full meeting**

The next meeting was scheduled as follows: 24 November 2022 – 1.00pm – 4.00pm. via Microsoft Teams. It was noted that an additional meeting may be required as discussed during the meeting regarding the HFMA self-assessment and check list.

Simon Parkes advised that it was Anne Sprason's last meeting before retirement and thanked her for all she had done for the Committee and wished her well for the future.

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	6 December 2022	
Director Lead	Neil Gammon, Chair of Health Tree Foundation Trustees' Committee	
Contact Officer/Author	Lee Bond, Chair Financial Officer	
Title of the Report	**Health Tree Foundation Trustees' Committee Minutes of meeting held on 8 September 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Health Tree Foundation Trustees' Committee held on 8 September 2022 and approved at its meeting on 3 November 2022.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: HTF Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
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1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **8 September 2022 – Via Teams Meeting**

Present:	Neil Gammon	Independent Chair of HTF Trustees
	Gill Ponder	Non-Executive Director
	Peter Reading	Chief Executive
	Kate Wood	Medical Director
	Jug Johal	Director of Facilities
	Melanie Sharp	Deputy Chief Nurse
	Paul Marchant	Chief Financial Accountant
	Clare Woodard	HTF Charity Manager
In attendance:	Simon Leonard	Communications Assistant
	Lauren Short	Finance Admin (For the Minutes)
	Jackie Fenwick	Senior Nurse Vulnerabilities Safeguarding Team (Item 6.1)
	Kate Scott	Clinical Nurse Specialist – Dementia Safeguarding Team (Item 6.1)

Item 1 09/22 **Apologies for Absence**

Apologies for absence were received from: Mike Proctor, Ellie Monkhouse, Lee Bond, Christine Brereton and Victoria Winterton.

Item 2 09/22 **Declaration of Interests**

The Chairman asked the members of the Health Tree Foundation Trustees' Committee for their "Declarations of Interests". None were raised.

Item 3 09/22 **Minutes of meeting held on 14 July 2022**

The minutes of the meeting held on 14 July 2022 were reviewed for accuracy and approved.

Item 4 09/22 **Matters Arising**

All matters arising were covered within the action log.

Item 5 09/22 **Review of Action Log**

- Trustee Development Opportunity – Neil Gammon advised that Trustees had received this notification in their diaries but will write to remind all, to maximise attendance at 10:00amon Thursday 3 November.
- Fairchild Legacy – This action was covered on the agenda (item 6.1)
- KPIs – This item featured in the HTF Manager Update Report (item 7.1)

- Evaluation of Wishes – Clare Woodard confirmed that the HTF team had reviewed this and that big-ticket items require the most time, with the smaller items easily completed via a quick phone call. The 10% trial will run until the end of the year, with a feedback report scheduled to feature on this agenda in March 2023.

- Revenue Costs – Circle of Wishes form updated to reflect the revenue costs for each request. Action to be closed.

- HTF Sparkle Position – This action is on-going with the correct process being followed to ensure this post becomes permanent from September 2023.

Item 6 09/22 **Items for Discussion / Approval**

6.1 Dementia Friendly Facilities / Fairchild Legacy - SGH

Jackie Fenwick and Kate Scott from the Vulnerabilities Team joined the meeting and Neil Gammon asked members of the committee to introduce themselves.

Jackie Fenwick explained that improving dementia facilities to make them more consistent across SGH would make a considerable difference to all patients, not only those with dementia, but those with learning disabilities and other issues which make them more vulnerable when in hospital. Dementia is rising and affecting more and more patients each year. By creating a hospital environment which is more suited to the needs of those vulnerable patients, the Trust could provide improved care and support to make their hospital stay as comfortable and stress free as possible. Being dementia friendly would help reduce panic, accidents and make individuals feel a lot calmer.

In terms of a dementia friendly coordinator, Jackie confirmed the main duties of the role would be to visit the wards, identify those patients who seem to be struggling and help the carers. This would benefit the patient which in turn would help the ward staff and carers. The proposal was for the post to be funded by HTF for one year.

Kate Scott expressed the huge benefit this request would have on both patients and staff within the Trust and gave examples of patient experiences which have happened during her time working at the Trust.

Kate Wood was in favour of this proposal adding that a significant amount of people come through our hospital doors with 1% of the population suffering from dementia.

Jug Johal questioned whether going forward, the Estates and Facilities team need to ensure all new wards and signage are required to be dementia friendly as standard, with the correct clinical representation required to achieve this. Whilst the view was that this would be highly desirable, it was not for HTF Trustees to rule on this.

The cost of a dementia friendly ward refurbishment is £30k per ward and the cost of a dementia friendly co-ordinator for one year is £22k. The total cost to refurbish 6 wards & fund a Dementia friendly co-ordinator is £202k. This would be funded from the Elizabeth Fairchild Legacy which was for a total of £326k.

Neil Gammon confirmed that all those present were in favour of approving this wish. The aim is to complete the refurbishment of one ward by Christmas 2022 for Trustees to review this. A decision can then be taken regarding the request for the five further wards.

Neil Gammon asked for the HTF to assess the wish as the work is carried out and provide an update to this committee in March 2023.

Action: Clare Woodard

6.2 Review of HTF Risk Register

Clare Woodard presented the risk register which provided an update of the risks associated with the Health Tree Foundation and the impact they may have on the charity. Clare also wished to determine if other risks needed to be added.

Kate Wood suggested this needed to be in the same format as the Trust's risk register and to ask the Trust's risk team to review this to add assurance to the report.

Gill Ponder suggested a risk be added to the register regarding rising inflation and the increased cost of Wishes.

Kate Wood wanted it noting that neither Ellie Monkhouse nor Kate Wood are Director leads of the HTF, they are clinical champions only, with Lee Bond being the Director lead.

Neil Gammon opened the discussion regarding how frequently this item should feature on the agenda.

Gill Ponder commented that the risks do not tend to drastically change and that every other month should suffice.

Kate Wood acknowledged that the risks may not drastically change, however she would prefer for the risk register to be a standing item on the agenda to ensure regular monitoring.

After listening to the trustee's thoughts, Neil Gammon agreed to add the risk register as a standing agenda item and for the register to remain a 'living and thus amendable document'.

6.3 NHS CT Development Grant

This is an opportunity for the Health Tree Foundation to bid for £30k from NHS Charities for the grant to be spent on HTF development needs.

A self-assessment tool needs to be completed by Health Tree Foundation representatives to identify areas where further development and/or training may be required to support the improvement of the charity.

Neil Gammon asked for two volunteers to help himself and Clare Woodard to complete the tool.

As the only NED in attendance at this meeting, Gill Ponder expressed how this put her in a difficult situation. Gill Ponder added that this is something she would like to be involved in, however face to face meetings are a barrier at the moment due to other competing demands of the Trust.

Kate Wood questioned why four trustees required involvement and suggested that Neil Gammon and Clare Woodard complete the tool and send to trustee's virtually for comments. This comes at a time when the Trust is likely to receive their CQC report.

Neil Gammon was not in favour of Kate Wood's suggestion due to the timescale, however Gill Ponder offered a compromise by agreeing to support the completion of the tool via an MS Teams call. The Trustees agreed that the Chair should decide the optimum way forward.

Action: Neil Gammon

Item 7 09/22 **Updates from Health Tree Foundation**

7.1 HTF Manager Update Report

Clare Woodard highlighted the key points within the report.

Clare Woodard commented that several wishes had been received over the past few months for improvements to services for Women & Children's areas. It was felt that these wishes could be amalgamated and used as the basis of a fund raising appeal under the 'Little Lives' banner.

Jug Johal raised a point around the bigger requests, for example the re-modelling of bathrooms and suggested that Clare Woodard contact Kerry Carol or Clare Hansen to avoid any overlap with HASR plans.

Kate Wood queried how much was in the Little Lives fund. Paul Marchant confirmed that this is a very active fund in terms of income and expenditure and is currently over committed by £6k.

Kate Wood urged Trustees to be mindful of raising money for one specific area of the Trust who may be more familiar with fundraising, compared with other departments. She was keen to avoid such areas benefitting more than others and urged equity as far as possible.

Trustees agreed to have a Little Lives appeal ensuring that Kate Wood's advice was heeded.

Clare Woodard updated the meeting regarding recent requests for charity to fund chairs to a total value of £92k.

Neil Gammon was bemused as to why the Trust do not seem to have a rolling programme to replace the usual plastic chairs as this should be standard.

Melanie Sharp commented that the wards probably see the HTF as an easy route to secure funding for these types of items, however Melanie agreed to send a message to all wards to educate them on how to order the standard chairs.

Gill Ponder voiced her concern around why we still order the same plastic chairs if they do not have a very good life expectancy and that this is something the Trust should rectify.

Following a discussion, it was agreed to fund chairs which have an enhanced element and improve the patient and visitor experience. However, the charity would not fund the basic plastic bedside chairs.

Clare Woodard informed the trustees of a legacy which had been gifted after this report was completed. The legacy was for £33k and is for DPOW General funds.

Clare Woodard hoped that the fund raising will increase in September, with plans around fund raising over Christmas starting to take shape. With this said, the cost-of-living crisis may affect the current projected fund raising targets as people will have less disposable income.

Gill Ponder highlighted that it would be a good time to advertise that people can use the Amazon smile account, specifying HTF, when purchasing items from Amazon. This generates income for HTF but does not cost the buyer any more money.

Trustees agreed that this needed publicity.

Action: Clare Woodard

From mid-October Clare Woodard will be taking up a 13 month temporary role within Smile, therefore a recruitment process is being undertaken to fill the Charity Manager position. Clare Woodard expressed her disappointment with regards to the limited number of applicants received, however short listing had taken place and Trustees were welcome to join the interview panel on 19th September.

It was agreed for Neil Gammon to send an email to trustees to gain a volunteer to join the interview panel.

Action: Neil Gammon

Clare Woodard confirmed that the survey for NHS Charities Together, which gave feedback on the Stage 1 Covid-19 emergency response grants, had been completed from a governance point of view.

Neil Gammon referred to the new KPIs and requested that Trustees review them and feedback. It was agreed that in future a summary of KPIs would be included in the HTF Update report.

Action: Trustees

Item 8 09/22 **Sparkle Programme**

8.1 Sparkle Update

The report was taken as read with no discussion required.

Item 9 09/22 **Finance Update**

9.1 Finance Report – July 2022

Paul Marchant presented the Finance report and highlighted the key points, including;

- Income for the 4 months to July 2022 was £439k which included £233k of NHSCT grant income, this was not in the plan but has now been included in the full year forecast. When NHSCT grant income was excluded, income was £206k, which was £77 less than budget.

- Expenditure for the 4 months to July 2022 was £485k which included £233k of NHSCT grant payments, when these were excluded expenditure was £252k, which was £87k less than budget.

- Equipment purchased in the 4 months to July included; Feature Ceiling for DPOW A&E £29k, ChargeBox for DPOW A&E £8k, MotoMed Exerciser £7k and ECG & trolley £7k.

- The CCLA investment fund was revalued on 30th June resulting in a loss of £121k. Investments will be revalued again on 30th September.

Item 10 09/22 **Any Other Business**

Peter Reading explained that recent work had taken place to improve the fishponds and flower beds in some of the DPOW courtyards which has had a big impact and of huge therapeutic benefit for patients, visitors, and staff.

Peter Reading asked whether HTF would consider funding improvements to communal areas including courtyards and gardens around the Trust. Peter proposed for the Estates and Facilities to help with a walk around to identify where potential improvements could be made.

Gill Ponder agreed that this would be a good use of charitable funds as this is over and above what the Trust can provide and agreed that it is of huge benefit to all who use our hospitals.

Clare Woodard confirmed that she had previously met with Sally Yates, with the outcome of that meeting being teams could adopt a communal area around the Trust to maintain.

Peter Reading was favourable of staff adopting areas as these areas do not maintain themselves.

Clare Woodard agreed to monitor the wishes of a similar nature and advertise for teams to be able to adopt an area.

Action: Clare Woodard

Item 11 09/22 **Matters for Escalation to the Trust Board**

It was agreed that Neil Gammon would highlight the following to the Trust Board:

- Dementia Wards/Fairchild Legacy
- Courtyard proposal

Action: Neil Gammon

Item 12 09/22 **Date and Time of the next meeting:**

Thursday 3 November 2022
1:00pm – 3.30pm
Via MS Teams

Attendance Record:

Name	Nov 2021	Jan 2022	March 2022	May 2022	July 2022	Sept 2022
Neil Gammon	✓	Cancelled	✓	✓	✓	✓
Peter Reading	✓		✓	✓	✓	✓
Terry Moran						
Linda Jackson	Apols					
Gill Ponder	✓		✓	✓	✓	✓
Mike Proctor	✓		✓	Apols	Apols	Apols
Maneesh Singh	✓		✓	✓	✓	
Lee Bond	✓		✓	✓	✓	Apols
Jug Johal	Apols (Rep)		Apols	-	✓	✓
Kate Wood	✓		✓	✓	Apols	✓
Ellie Monkhouse	Apols (Rep)		✓	Apols (Rep)	Apols	Apols (Rep)
Christine Brereton	Apols (Rep)		-	✓	-	-
Paul Marchant	✓		✓	✓	✓	✓
Andy Barber	-		-	-	-	-
Victoria Winterton	✓		Apols	✓	✓	-
Clare Woodard	✓		✓	✓	✓	✓
Adrian Beddow	Apols (Rep)		-	-	-	-
Ian Reekie (Governor)	-					
Tony Burndred			✓	-	-	-
Total	**10**		**10**	**10**	**9**	**7**

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	6/12/2022	
Director Lead	Adrian Beddow, Associate Director of Communications	
Contact Officer/Author	Charlie Grinhaff, Communications Manager	
Title of the Report	**Communications Round up – December 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights some of the key projects the Communications team are working on to improve staff morale and engagement and reputation through external communications. It covers September and October 2022 and includes an overview of team plans and progress.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Pandemic Response ✓ Quality and Safety ✓ Estates, Equipment and Capital Investment ☐ Finance ✓ Partnership and System Working	✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

December 2022

Kindness • Courage • Respect

December update 2022 – September and October

Contents

Headlines

3800+ Members of the staff Facebook group

238 Ask Peter questions asked

126 General enquiries dealt with

384 Staff attended Team Brief Live

94% Of media enquiries dealt with on deadline

This report covers Sept and Oct 2022

Progress and plans

Improve Trust reputation through external communications and patient experience	Improve staff morale and engagement
What we've already done • Launched a new website in line with accessibility requirements • Consistently achieved goals around responsiveness to media enquiries • Responded to 95%+ FOIs within statutory time limits. • Taken over the remit of 'Membership communications' and started a new quarterly newsletter	**What we've already done** • Created a regular drumbeat for internal communications – Monday Message, Weekly Wednesday News, Building our Future on Thursdays and #ThumbsUpFriday • Put in place a new Thank You System for staff to easily share compliments boosting morale • Created a safe space for staff to raise concerns via the Ask Peter forum • Set up a staff Facebook group (c3.8k members) and have recently carried out a review of this to make improvements • Introduced Team Brief Live • Re-invigorated the way we share compliments on social media – swapping #ThankYouTuesday for #ThankYouNHS
What we're working on • How we can work more closely with our local media, providing positive news stories • Introduce more video content where relevant • Reviewing our social media channels	**What we're working on** • Targeted line management communication • Working with senior leaders on their approach to engagement and communication • Supporting the People division with the Health and Wellbeing and Culture Transformation work.

Supporting the Trust's priorities

Trust Priority 1 – Our People
Staff survey
A huge amount of Communications resource during September, October and beyond was dedicated to planning and preparing for the Staff Survey which went ran from 3 October to 25 November. Communications activities during this time included, but was not limited to; a Monday Message, regular bulletin articles, Hub and staff Facebook group posts, screensavers, visual graphics, posters, staff app notifications, leaderboards and visits to site to spread the word and encourage people to tell us what they think.

Speaking up
October is Speak Up month and we supported our Freedom to Speak Up Guardian, Liz, with the campaign internally. This included supporting her with a Monday Message, staff case studies, manager guidance, virtual and on-site drop in sessions and informative manager sessions to support them with concerns from their team.

Trust Priority 4 – Reducing health inequalities
The staff stop smoking offer is now in place at our three hospital sites. We continue to promote this service to colleagues and aim to share positive stories of people who have successfully quit using the staff and/or patient service.

Trust Priority 5 – Collaborative and System working

Group structure A key piece of work during this period was around the proposed group structure with Hull University Teaching Hospitals (HUTH). Working jointly with the HUTH Communications Team we drafted all staff emails and FAQs, held all staff and Senior Leadership Community briefings, gave staff and stakeholders opportunities to share their feedback and helped collate it all for a report which went to both Trust Boards.

Supporting the Trust's priorities

Trust Priority 8 – Capital Investment
Unsurprisingly, the opening of Grimsby's new Emergency Department saw a huge spike in levels of external engagement with our Capital Programme.
There was coverage across all local print and broadcast media (with an estimated potential total audience of more than 2,300,000), while the reach of our own external channels in October rose by 293% compared to the previous month, with a 574% increase in levels of positive reactions (likes etc) and a **4572%** increase in views of associated photographs, graphics and video content. The video of ED Matron Natalie Till giving a tour of the ED has now been viewed in excess of 7,370 times through our channels alone.

Trust Priority 10 – The NHS Green agenda
We continue to support and raise awareness of the Green agenda with regular campaigns and stories, including promoting Recycle Week and celebrating the Trust achieving four stars in the Zero Waste Awards.

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Key Campaigns

Campaigns and awareness weeks

In this period we supported and promoted Recycle Week, Breast Cancer Awareness Month, AHP Day and Organ Donation Week.

During **Black History Month** we shared staff member stories on the closed Facebook group and invited one of our staff governors to write a thought-provoking piece on the experience of staff from Black and minority ethnic backgrounds at the Trust.

We ran a campaign promoting the new **maternity triage service** telephone number. Ahead of the number launching on 31 October, we used a Halloween graphic to raise awareness. The story featured in the Goole Times and on the GI Media social media pages. It also had lots of engagement on our social media pages, reaching more than 1,000 people, and the NLaG Maternity Facebook page. The news release was shared 76 times from our Facebook page.

Improving staff morale and engagement

Team Brief Live

Team Brief Live is a relatively new format held on Teams. For those who can't make it we share a recording of the session. Feedback has been positive so far.

September was an estates and digital special with 266 staff dialling in October covered central ops update on activity, 118 attended.

Senior Leadership Briefing

97 senior leaders attended the SLC briefing in September and 91 joined in October. An additional session was held to brief staff on the group structure proposal – 164 attended this, by far the highest attendance at any this year.

164
Senior leaders attended the last SLC briefing

Improving staff morale and engagement

All staff emails

Each week we send to all staff the Monday Message (a blog from a senior leader on a key topic), Wednesday Weekly News (an e-news round-up of news and updated) and on Thursdays we have a dedicated 'Building Our Future' update covering updates on the capital programmes in both estates and digital. In addition to this there are times when we need to issue a separate all staff email, such as inviting staff to book on for their Covid booster vaccine, details on the agenda for change pay award, Trust on OPEL 4, COVID-19 inquiry, changes to infection control arrangements, advertising Team Brief Live and updating staff on the group structure proposal with HUTH.

Staff Facebook group

Our closed staff Facebook group continues to grow and is one of our most used communication channels. It's a useful way of reaching staff who do not work in front of a computer all day so have limited access to the Hub, emails etc. We have more than 3,800 staff members on there and engagement levels are increasing.

We are currently reviewing the group and will be implementing a number of improvements including new group rules, regular reminders of the group etiquette, inviting additional staff to become administrators of the group and much more. A fuller update on this review will be shared in the group soon.

Facebook group stats

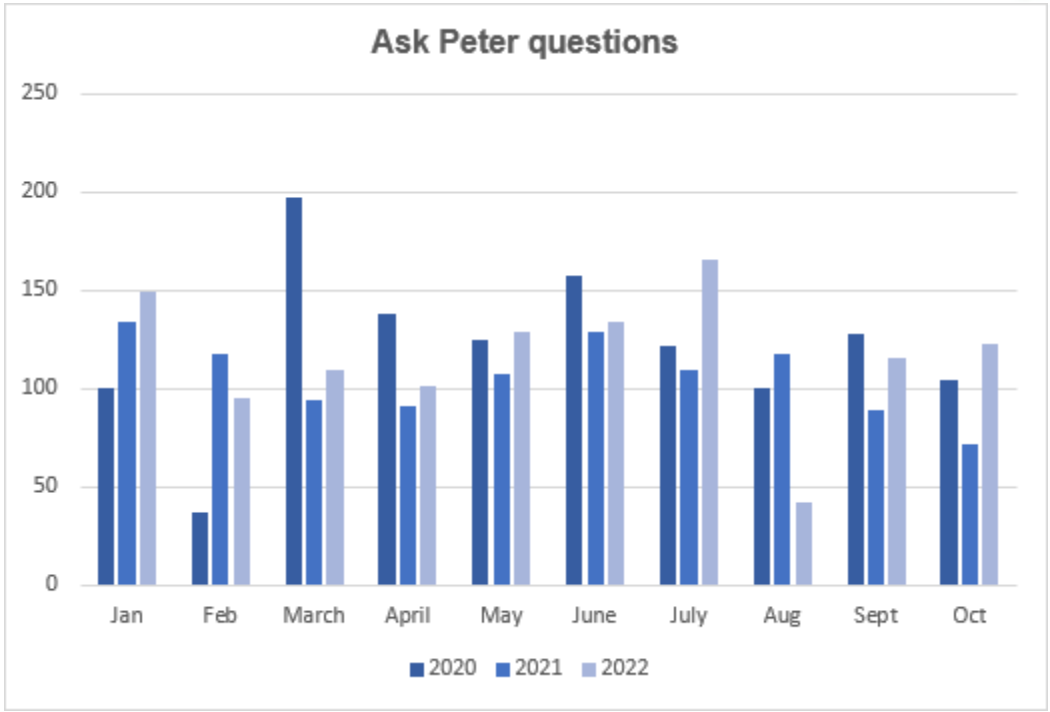
3832 members
814 posts in this period
4,783 comments
15,963 reactions

Improving staff morale and engagement

Ask Peter

This continues to be an extremely popular forum for staff to raise concerns and ask questions about absolutely anything. We saw a slight increase in the number of questions in October (123), compared to previous month when we received 115. Hot topics have included: incentives, back pay, our estates including car parking and signage, masks, smoking, intentional rounding, and pool cars parking in disabled bays.

The chart shows the total number of Ask Peter questions between January 2020 and October 2022:



Improving staff morale and engagement

Monday Message

Topics have included:

- An update of what happens next after the Big Conversation - Be the Change
- Improvement in our inpatient survey
- Freedom to Speak Up Month
- Black History Month
- Launch of the national staff survey
- Launch of the Perfect Fortnight

"Just wanted to say thank you for the way that you have kept going under all the pressure and difficult circumstances of recent weeks. I think that I speak for all of us in Audiology when I say that we really appreciate the work that you do for us and our patients."

Staff Thank Yous

Since the 'Thank you' system launched in January staff have sent more than 900 compliments to their colleagues to date. These are emailed directly to the staff member and can also be shared with their manager and/or the Communications Team. Many of these are shared in the Wednesday Weekly News. We are looking at what else we can do with these.

Improving reputation through external communications

Media

Media coverage

There were 76 stories about the Trust in the media during this period. 84% of media coverage was positive or neutral in tone. The majority, 83% of coverage was in print or online media.

We categorise the media coverage into themes – in this period '**pressures'** was the top theme reflecting the busy operational period the Trust has had. **'**Care issues and 'service development' were the next most categorised themes due to the new ED opening at DPOW.

We issued 11 proactive news releases and the most covered was a story was on the new ED dept. Staff have also been interviewed on hospital cancellations (Shaun Stacey) and Jennifer Hinchliffe spoke to Lincs FM about our recruitment plans.

83%
Of media coverage was positive or neutral

National media coverage of note: The Mirror – hospital; cancels appointments and surgery and BBC News 91 year old woman had four hour wait outside hospital

Medicine have had the most positive media coverage, again due to the new ED opening.

Media enquiries

50 media enquiries were handled in this time, 94% were dealt with within the requested timescale.

The majority of requests came from radio outlets. The top theme for media enquiries was 'other' with many of these relating to the bank holiday arrangements for Her Majesty Queen Elizabeth II's funeral and queries about the cost-of-living crisis. 8 came in on the back of proactive news releases. The main reason journalists got in touch was to request information. 8 reactive statements were issued in this period.

94%
Of media enquiries dealt with on deadline

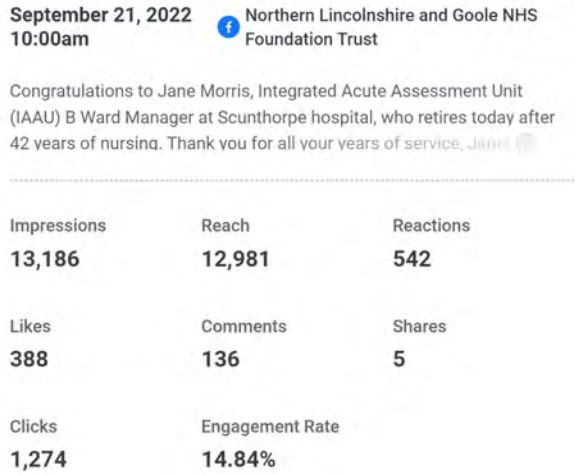
Improving reputation through external communications

Social media

Followers update for the Trust's corporate accounts:

- 13,685 on the Trust's Facebook page
- 5,350 followers on Twitter
- 4,603 followers on LinkedIn
- 560 subscribers on YouTube

We shared 12 #ThankYouNHS posts and 14 #ThumbsUpFriday posts in this period. Medicine and Family services had the most posts. Since we switched to #ThankYouNHS we've generated 162,834 post impressions. As the posts tend to generate lots of compliments for staff we are now sharing these into the closed staff Facebook group. Top posts included staff retiring and praise from new parents:



Improving reputation through external communications

Twitter

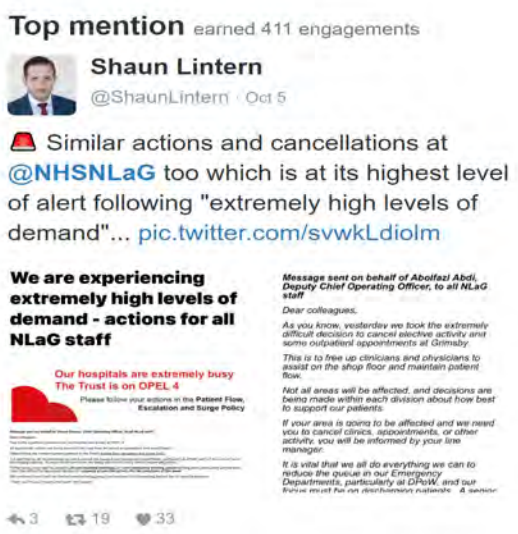
Our top tweet (by impressions) and our top mention were both about hospital cancellations due to operational pressures, which highlights the usefulness of social media of spreading messages to the public when needed.

Top tweet Sept

Top tweet Oct

Top mention Sept

Top mention Oct



This report covers Sept and Oct 2022

Improving reputation through external communications

Facebook page

The Facebook post with the highest engagement was a heart-warming post about the compassionate care given by Lynn, Mortuary Assistant. The family of one of her patients said: “As a parent, losing our teenage son was and continues to be a living nightmare. Lynn in the mortuary was able to do all of the things we weren’t; hold our son’s hand, tell him how much we love and miss him and she even played him his favourite music. We knew our son was in safe hands with her. In the most painful moments of our lives, Lynn provided some comfort, and we can never thank her enough.”

As well as more than 4,800 clicks, it had 162 comments and 42 shares. Meanwhile a post about cancelling operations reached more than 23,000 people and an insight into our new ED at Grimsby had 289 reactions.

September 26, 2022 05:09pm

Due to extremely high levels of demand, we have taken the difficult decision to cancel outpatient appointments and elective surgical procedures due to take place at our Grimsby hospital for the remainder of this week. Cancer treatments will continue as normal and

Post Clicks	Reactions	Impressions	Reach	Eng. Rate
4,539	35	24,490	23,222	19.83%

September 1, 2022 10:00am

“As a parent, losing our teenage son was and continues to be a living nightmare. Lynn in the mortuary was able to do all of the things we weren’t; hold our son’s hand, tell him how much we love and miss him and she even played him his favourite music. We knew our

Post Clicks	Reactions	Impressions	Reach	Eng. Rate
4,882	1,247	23,251	21,960	27.24%

October 5, 2022 01:00pm

With a new Emergency Department in Grimsby that's twice the size of our old one, and another being built in Scunthorpe, we also needed more staff. We've had a really successful recruitment campaign. Many of the staff we need are here and ready to go and we have

Post Clicks	Reactions	Impressions	Reach	Eng. Rate
3,690	289	12,485	12,410	32.11%

Improving reputation through external communications

LinkedIn

Stats

1,986 page views
752 unique visitors
401 reactions
20 comments
57 reposts

Job opportunities and Trust award nominations provided the top content.

You Tube

Our top video was the 'Take a tour of the new ED' video which had 652 views

September stats	October stats
25	**16**
NEW SUBSCRIBERS	NEW SUBSCRIBERS
4,318	**3,171**
TOTAL VIEWS	TOTAL VIEWS
8,551	**5,814**
MINUTES WATCHED	MINUTES WATCHED

This report covers Sept and Oct 2022

Improving reputation through external communications

External website – www.nlg.nhs.uk

We are currently rated ‘great’ on the Silktide accessibility NHS rankings, with a score of 87/100, putting us just outside their top 30 NHS Trusts.

Key stats:

50,078 users, 81,817 visits and 204,271 page views – these figures are up between 5 and 7% on the last report

76% of visitors were new users

71% of users accessed the site via their mobile, 26% via a desktop and just 3% via a tablet.

Safari was the top browser used to access the site followed by Chrome. IOS was the top operating system

81% of people came to the website via a search, 15% direct, 3% from social media (mainly Facebook) and 1% from other websites

Most visited page: staff page followed by the Grimsby hospital home page. This is consistent with previous reports.

The top three news releases viewed on the website were ‘healthcare assistant open days (575 views), new triage number for concerns in pregnancy (539 views) and new emergency department opens in Grimsby (521 views)

204k
Page views on our website

126
General enquiries dealt with

114
FOIs received

General enquiries

The team receives general enquiries via a form on the Trust website. In this period 126 were received and dealt with. These can be anything from chasing appointments and results to providing feedback on services. For many of these the team act as a conduit for the Trust and filter them to other teams to deal with, but some are more complex and take more time.

Freedom of Information requests (FOIs)

Complex FOIs are continuing to require more time than in the past to pull together an appropriate response which meets the statutory requirements. There were 114 submitted in this period – of these 106 are closed, 8 are still in progress and 2 are awaiting a response from the requester.

Other work

Membership Communications

The team have taken over the remit of Membership Communications. We currently have 6,388 public members who have received little from the Trust over recent years. We issued a new quarterly e-newsletter for members in September and are also part of a governor workgroup set up to look at refreshing member engagement.

THE HEALTH TREE FOUNDATION
Your hospital charity

Health Tree Foundation:

The charity has now reached its target of £70,000 (£35,000 at Scunthorpe and £35,000 at Grimsby) for the ED fundraising appeal, to buy and install additional features to enhance patient experience. We are very pleased to have supported and promoted this in the media and to the wider public and staff.

We sent out news releases in this period about the new CDC sensory room and a new fusion biopsy machine, both funded by HTF. The sensory room received lots of local media coverage. Internally, we have promoted special inpatient blankets for Christmas the charity is providing We're also raising awareness of how you can donate to HTF when you make a purchase on Amazon.

NLG(22)243

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	6 December 2022	
Director Lead	Dr Peter Reading, Chief Executive	
Contact Officer/Author	As Above	
Title of the Report	**Documents Signed Under Seal**	
Purpose of the Report and Executive Summary (to include recommendations)	The report below provides details of documents signed under Seal since the date of the last report (August 2022 – NLG(22)150).	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
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: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
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2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
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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 has been used on the following occasions:

Seal Register Ref No.	**Description of Document Sealed**	**Date of Sealing**
273	Licence for Alterations, Ground & First Floor, Scunthorpe Integrated Health & Social Care Centre	07.09.2022
274	Lardswood Lease	10.10.2022

Action Required

The Trust Board is asked to note the report.

Name of the Meeting	**Trust Board - Public**
Date of the Meeting	6 December 2022
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Statutory COVID-19 Inquiry Preparation and Update**
Purpose of the Report and Executive Summary (to include recommendations)	To provide an update as the progress of the UK COVID-19 Inquiry and how this will impact the Trust. Trust Board is asked to note: **1.1.** the Trust must avoid comment in the media on issues the Inquiry will be covering, but must continue to deal with investigations and duty of candour to patients / families as usual. **1.2.** if the Trust receives a Freedom of Information (FOI) request for information that has been prepared for the Inquiry, then it is the Inquiries document and cannot be shared at that time. Each FOI request should be reviewed on an individual basis by Trust Management. **1.3.** should the Trust be requested to engage with the Inquiry Team, it will receive a 'Rule 9'. (Refer to Section 5.1 for an explanation of a Rule 9). **1.4.** there will be sometimes short periods to respond to the Inquiry and appropriate resourcing will need to be upscaled. **1.5.** that providing data to national bodies will be subject to their powers under legislation ie. NHS Act 2006, Inquiries Act 2005, Inquiry Rules 2006 and UK General Data Protection Regulations (GDPR) / Data Protection Act 2018; and FOI Act 2000. **1.6.** the Trust should consider the possibility that the Inquiry Team may request details from the Medical Gas Pipeline major incident, particularly due to national media at the time. It is highly recommended for the Directorate of Estates and Facilities to consider pulling together a narrative document, as well as document collation, as the time to respond to the Inquiry Team will be fairly short. **1.7.** the risks and issues, particularly: i. not properly resourcing the team could risk the Trust not being responsive to the Inquiry, leading to reputational damage ii. potential civil claims or criminal investigations iii. serious action taken either by an organisation or a professional regulator

	iv. individual cases of care could be referred to a regulator v. destroying records when the Trust has been instructed not to vi. local decisions not aligning with national decisions.	
Background Information and/or Supporting Document(s) (if applicable)	COVID-19 Inquiry Terms of Reference UK Covid-19 Inquiry (covid19.public-inquiry.uk)	
Prior Approval Process	✓ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Statutory Covid-19 Inquiry Preparation and Update

Helen Harris, Director of Corporate Governance

October 2022

Contents

1. Executive Summary

1.1. System Leaders were required to prepare for the possibility of a statutory inquiry into the Covid-19 pandemic and undertake a number of key actions. An initial briefing was presented to Trust Management Board (TMB) in July 2021.

1.2. Baroness Heather Hallett officially launched the Inquiry on 21 July 2022 and opened its first investigation into how well the UK was prepared for a pandemic, examine the UK's response to and impact of the Covid-19 pandemic; and learn lessons for the future. The Covid-19 Inquiry has not released a timeframe to undertake the investigation into the impact of Covid, and governmental and societal responses to it, on healthcare system, including patients, hospital and other healthcare workers, and staff.

1.3. Interim reports with analysis, findings and recommendations will be delivered whilst the Inquiry's investigations are ongoing, so that key lessons from the pandemic are learned quickly and implemented promptly by all organisations.

1.4. The Trust must avoid comment in the media on issues the Inquiry will be covering, but must continue to deal with investigations and duty of candour to patients / families as usual.

1.5. If the Trust receives a Freedom of Information (FOI) request for information that has been prepared for the Inquiry, then it is the Inquiries document and cannot be shared at that time. Each FOI request should be reviewed on an individual basis by Trust Management.

1.6. If the Trust is requested to engage with the Inquiry Team, it will receive a 'Rule 9'. (Refer to Section 5.1 for an explanation of a Rule 9).

1.7. The Trust will sometimes have short time periods to respond to the Inquiry and appropriate resourcing will need to be made available. When providing a statement and collating evidence, as to whose document and whose decision it was, if the documentation was produced by Department of Health and Social Care (DHSC), NHS England (NHSE) etc, then it won't be relevant to the Inquiry.

1.8. Providing data to national bodies will be subject to their powers under legislation ie. NHS Act 2006, Inquiries Act 2005, Inquiry Rules 2006 and UK General Data Protection Regulations (GDPR) / Data Protection Act (DPA) 2018; and FOI Act 2000.

1.9. The Trust should consider the possibility that the Inquiry Team may request details from the Medical Gas Pipeline major incident, particularly due to national media interest at the time. It is highly recommended for the Directorate of Estates and Facilities to consider pulling together a narrative document, as well as document collation, as the time to respond to the Inquiry Team will be fairly short.

2. Strategic Objectives

The report does not directly link to the Trust's Strategic Objectives.

3. Introduction and Background

3.1. Following the Healthcare Leaders update by Amanda Pritchard on 8 June 2021, System Leaders were required to prepare for the possibility of a statutory inquiry into the Covid-19 pandemic and undertake a number of key actions. An initial briefing was presented to TMB in July 2021.

3.2. Baroness Heather Hallett officially launched the Inquiry on 21 July 2022 and opened its first investigation into how well the UK was prepared for a pandemic, examine the UK's response to and impact of the Covid-19 pandemic; and learn lessons for the future. The Inquiry's work is guided by Terms of Reference (see Appendix 1).

3.3. The Inquiry will be undertaken in modules:

Module	Topic	Investigation Opened	Procedural Hearing
1	Will examine the resilience and preparedness of the UK for the coronavirus pandemic	21 July 2022	September 2022
2	Will examine core political and administrative governance and decision-making by the UK Government	31 August 2022	October 2022
3	Investigate the impact of Covid, and governmental and societal responses to it, on healthcare system, including patients, hospital and other healthcare workers, and staff.	Not yet available	Not yet available

3.4. Further modules will be agreed for 2023 and are expected to cover both 'system' and 'impact' issues including: vaccines, therapeutics and anti-viral treatment; the care sector; Government procurement and Personal Protective Equipment (PPE); testing and tracing; Government business and financial responses; health inequalities and the impact of Covid-19; education, children and young persons; and the impact of Covid-19 on public services and on other sectors.

3.5. Interim reports with analysis, findings and recommendations will be delivered whilst the Inquiry's investigations are ongoing, so that key lessons from the pandemic are learned quickly. A final report will be published once the Inquiry has concluded.

3.6. The Inquiry was due to hold its first preliminary hearing on 20 September, which was an update on Core Participant applications, procedural matters and the plans for Module 1, however this was postponed to 4 October. The preliminary hearing was open to the public. Public hearings will commence in Spring 2023.

3.7. The Inquiry will listen to and consider the experiences of bereaved families and others who have suffered hardship or loss. The experiences shared will be analysed and reports produced highlighting key themes that emerge. Existing research about the pandemic will be reviewed from around the world. Scientific experts and other experts will be commissioned to undertake research and provide expert advice.

4. Current Progress to Date

4.1. The Trust appointed Helen Harris, Director of Corporate Governance as the Board level director to have an overview and support the organisational lead.

4.2. The organisational lead is Matt Overton, Associate Director of Operations.

4.3. A Covid-19 Inquiry support team has been established as follows:

Helen Harris, Director of Corporate Governance (Executive Lead)
Matt Overton, Associate Director of Operations (Organisational Lead)
Gerard Curran, Head of Legal (Claims)
Alison Hurley, Assistant Trust Secretary
Jennifer Grainger, Interim Associate Director of Quality
Sue Meakin, Data Protection and Head of Information Governance
Ashley Leggott, Emergency Planning Manager

4.4. The meeting action log can be reviewed in Appendix 2 to illustrate progress.

4.5. A mechanism for document management and recording engagement on Inquiry related matters has been established.

4.6. The Hub now includes a section on the Covid-19 Inquiry, which will continue to be populated with key information.

4.7. Communications have been issued around the Trust, as follows:

- Report to Trust Management Board (TMB) on 16 July 2021, including 'Stop Notice'
- 'Stop Notice' issued to advise staff to retain documentation for the COVID Inquiry in Wednesday Weekly News in November 2021
- All Staff daily e-mails were issued in 2021 which were then followed by weekly all Staff Covid-19 updates
- Various Covid updates in the internal Wednesday Weekly News.

4.8. The team has regularly attended Covid-19 Inquiry webinars, run by NHS Providers, in conjunction with law firms which include: Hempsons, Capsticks and BrowneJacobson.

4.9. Training for key staff is being arranged, such as: Public Inquiries with a focus on strategic command – looking at responsibilities and failures, how courts and inquiries analyse decision making in incident response, the importance of log keeping and contemporaneous notes and how to write an effective witness statement for a public inquiry.

5. Issues

5.1. Engaging with the Inquiry Team

5.1.1. The Trust has a duty of candour, to be open and transparent, reflective and demonstrate learning.

5.1.2. If the Trust is requested to engage with the Inquiry Team, it will receive a 'Rule 9'.

[As per the Inquiries Act 2005, Chapter 7, Inquiry Procedure, Rule 9: Written Statements:

255. Rule 9 provides that the inquiry panel must send a written request for a written statement to any person from whom the inquiry proposes to take evidence. It does not allow the inquiry itself to take statements from witnesses.

5.1.3. It is considered to be highly unlikely that the frontline staff will be directly involved in the inquiry, although the Inquiry Team could seek shared experiences from staff of the pandemic.

5.1.4. The level of involvement by individual Trusts is unlikely to happen. It is expected that if a Trust is an outlier, they may be asked to participate or asked for evidence on a particular matter. The Inquiry team will direct the scope of disclosure that is required, however, the Trust can ask more specifics if unsure of the request.

5.1.5. The Trust should consider that due to the major incident related to the medical gas pipeline and the attention it drew from the national media, the Inquiry Team may ask for a request for documents. On this basis, it would be prudent for the Directorate of Estates and Facilities to consider pulling together a narrative document, as well as document collation, as the time to respond to the Inquiry Team will be fairly short.

5.2. Responding to a Request and Searching

5.2.1. The Trust will sometimes have short time periods to respond to the Inquiry and appropriate resourcing will need to be made available. Comprehensive and rigorous searches in response to a request for documents must be undertaken, with a requirement to be creative with "keyword searches". During the search process, the Trust will need to consider where information is stored to enable the search, eg. WhatsApp, Twitter, Facebook, the Hub, Internet, WebV, PAS, etc.

5.2.2. Importantly, WhatsApp used on a work phone will be covered under the Inquiry and will be considered relevant. The Trust will need to consider how it undertakes searches on dedicated work phone devices. A personal phone requires the individual's permission to access that information and therefore you are not able to force an individual to give the Trust access.

5.2.3. Documents (paper and electronic) must be provided to the Inquiry team within the time limits that they specify, or the Trust is to give early notification should there be a delay.

5.2.4. An alternative approach is to provide a narrative document, as well as document collation, which would provide a focus on the challenges that the Trust faced, key decisions and referencing key documents. This would enable the Trust to review gaps in evidence and learn lessons. Clinical input is highly recommended with this approach, and it would enable the Trust to commence its learning sooner, rather than waiting for the interim and final reports from the Inquiry.

5.2.5. If a suite of documents that is to be sent to the Inquiry Team contains sensitive information, the Trust can request a Section 21 under the FOI Act 2000 eg. Redact. It is vitally important not to send information to the Inquiry that is not relevant.

5.2.6. It will be important to remember when providing a statement and collating evidence, as to whose document and whose decision it was eg. DHSC, NHSE etc. If the Trust implemented a recommendation or undertook an action, that is the evidence that is required.

5.3. Writing a Statement

5.3.1. If a statement is requested by the Inquiry Team, support and guidance will be provided throughout by the team and through the Trust's legal services team. An effective statement will ask you to identity why you took that action, who was the accountable person making that decision, cross reference documents clearly and concisely, write in good plain English, be transparent and ensure the statement is articulate, and has paragraph and page numbers.

5.3.2. If a statement is required from the Trust, it will more than likely come from the Chief Executive as the Accountable Officer. If anyone is requested to make a statement to the Inquiry Team, they should contact Matt Overton, Associate Director of Operations.

5.4. Corporate Knowledge and Board Oversight

5.4.1. The Trust will have corporate knowledge of its approach to the pandemic through a single organisational lead. There needs to be clear oversight to assure the Board and others that proper processes are in place to deal with the Inquiry.

5.5. Providing Data to National Bodies and Regulators

5.5.1. Providing data to national bodies will be subject to their powers under legislation ie. NHS Act 2006, Inquiries Act 2005, Inquiry Rules 2006 and UK GDPR / DPA 2018; and FOI Act 2000.

5.5.2. A clear short policy is to be developed between the organisational lead, lead director overseeing, Caldicott Guardian, Senior Information Risk Owner, Data Protection Officer and Head of Legal.

5.6. Collaborating with Related Activities

5.6.1. The Trust may wish to consider collaborating with key stakeholders in relation to the collation of datasets, searching known databases, sorting key documents into themes and categories.

5.7. Communications and Duty of Candour

5.7.1. The Trust must avoid comment in the media on issues the Inquiry will be covering but must continue to deal with investigations and duty of candour to patients / families as usual.

5.7.2. If the Trust receives a Freedom of Information request for information that has been prepared for the Inquiry, then it is the Inquiries document and cannot be shared at that time. An exemption must be applied stating that material is intended for future publication. If this information were to be disclosed it would prejudice the Inquiry. Each FOI request should be reviewed on an individual basis by Trust Management.

5.8. Lessons Learned from Previous Inquiries

- The need to properly resource the response team
- Ensure clear Board oversight
- Consider the reputational aspects – be open in a response
- Be prepared for civil claims or criminal investigations
- Consider the human impact on patients, staff and the public
- Keep clear corporate logs on engagement and evidence.

5.9. Interim Reports, Final Reports and Learning

5.9.1. The Inquiry will produce recommendations within the Interim Reports and the Trust must implement these quickly where relevant and not wait for the final report.

5.9.2. It has been recommended that all Trusts should continue to investigate and undertake lookback exercises to identify any learning.

6. Implications / Impact

6.1. Risks / Issues

i. Not properly resourcing the team could risk the Trust not being responsive to the Inquiry, leading to reputational damage
ii. Potential civil claims or criminal investigations
iii. Serious action taken either by organisation or a professional regulator resulting in increased scrutiny which could arise if an individual makes a referral because a family member came to harm
iv. Individual cases of care could be referred to a regulator
v. Destroying records when the Trust has been instructed not to
vi. Staff shortages due to sickness / holiday
vii. Covid-19 future wave
viii. Not understanding the requests and preparing poorly written statements resulting in criticisms
ix. Local decisions not aligning with national decisions
x. Media enquiries and increase in freedom of information requests.

7. Recommendations

Trust Management Board is asked to:

7.1. Note the Trust must avoid comment in the media on issues the Inquiry will be covering but must continue to deal with investigations and duty of candour to patients / families as usual.

7.2. Note, if the Trust receives a FOI request for information that has been prepared for the Inquiry, then it is the Inquiries document and cannot be shared at that time. Each FOI request should be reviewed on an individual basis by Trust Management.

7.3. Note, should the Trust be requested to engage with the Inquiry Team, it will receive a 'Rule 9'. (Refer to Section 5.1 for an explanation of a Rule 9).

7.4. Note, there will be sometimes short periods to respond to the Inquiry and appropriate resourcing will need to be upscaled.

7.5. Note, that providing data to national bodies will be subject to their powers under legislation ie. NHS Act 2006, Inquiries Act 2005, Inquiry Rules 2006 and UK GDPR / DPA 2018; and FOI Act 2000.

7.6. Note the Trust should consider the possibility that the Inquiry Team may request details from the Medical Gas Pipeline major incident, particularly due to the interest of the national news. It is highly recommended for the Directorate of Estates and Facilities to consider pulling together a narrative document, as well as document collation, as the time to respond to the Inquiry Team will be fairly short.

7.7. Note the risks and issues, particularly:

i. not properly resourcing the team could risk the Trust not being responsive to the Inquiry, leading to reputational damage
ii. potential civil claims or criminal investigations
iii. serious action taken either by an organisation or a professional regulator
iv. individual cases of care could be referred to a regulator
v. destroying records when the Trust has been instructed not to
vi. local decisions not aligning with national decisions.

7.8. Recommend the Statutory Inquiry Report be presented to Trust Board to provide oversight and assurance.

Compiled By: Helen Harris, Director of Corporate Governance
Date: 17 October 2022
Version: Final

Appendix 1

UK Covid-19 Inquiry Terms of Reference

The Inquiry will examine, consider and report on preparations and the response to the pandemic in England, Wales, Scotland and Northern Ireland, up to and including the Inquiry's formal setting-up date, 28 June 2022.

In carrying out its work, the Inquiry will consider reserved and devolved matters across the United Kingdom, as necessary, but will seek to minimise duplication of investigation, evidence gathering and reporting with any other public inquiry established by the devolved governments. To achieve this, the Inquiry will set out publicly how it intends to minimise duplication, and will liaise with any such inquiry before it investigates any matter which is also within that inquiry's scope.

In meeting its aims, the Inquiry will:

a) consider any disparities evident in the impact of the pandemic on different categories of people, including, but not limited to, those relating to protected characteristics under the Equality Act 2010 and equality categories under the Northern Ireland Act 1998;
b) listen to and consider carefully the experiences of bereaved families and others who have suffered hardship or loss as a result of the pandemic. Although the Inquiry will not consider in detail individual cases of harm or death, listening to these accounts will inform its understanding of the impact of the pandemic and the response, and of the lessons to be learned;
c) highlight where lessons identified from preparedness and the response to the pandemic may be applicable to other civil emergencies;
d) have reasonable regard to relevant international comparisons; and
e) produce its reports (including interim reports) and any recommendations in a timely manner.

The aims of the Inquiry are to:

1. Examine the COVID-19 response and the impact of the pandemic in England, Wales, Scotland and Northern Ireland, and produce a factual narrative account, including:

a) The public health response across the whole of the UK, including:
   i) preparedness and resilience;
   ii) how decisions were made, communicated, recorded, and implemented;
   iii) decision-making between the governments of the UK;
   iv) the roles of, and collaboration between, central government, devolved administrations, regional and local authorities, and the voluntary and community sector;
   v) the availability and use of data, research and expert evidence;
   vi) legislative and regulatory control and enforcement;
   vii) shielding and the protection of the clinically vulnerable;
   viii) the use of lockdowns and other 'non-pharmaceutical' interventions such as social distancing and the use of face coverings;
   ix) testing and contact tracing, and isolation;
   x) the impact on the mental health and wellbeing of the population, including but not limited to those who were harmed significantly by the pandemic;
   xi) the impact on the mental health and wellbeing of the bereaved, including post-bereavement support;
   xii) the impact on health and care sector workers and other key workers;

xiii) the impact on children and young people, including health, wellbeing and social care;
xiv) education and early years provision;
xv) the closure and reopening of the hospitality, retail, sport and leisure, and travel and tourism sectors, places of worship, and cultural institutions;
xvi) housing and homelessness;
xvii) safeguarding and support for victims of domestic abuse;
xviii) prisons and other places of detention;
xix) the justice system;
xx) immigration and asylum;
xxi) travel and borders; and
xxii) the safeguarding of public funds and management of financial risk.

b) The response of the health and care sector across the UK, including:
i) preparedness, initial capacity and the ability to increase capacity, and resilience;
ii) initial contact with official healthcare advice services such as 111 and 999;
iii) the role of primary care settings such as General Practice;
iv) the management of the pandemic in hospitals, including infection prevention and control, triage, critical care capacity, the discharge of patients, the use of 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions, the approach to palliative care, workforce testing, changes to inspections, and the impact on staff and staffing levels
v) the management of the pandemic in care homes and other care settings, including infection prevention and control, the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, workforce testing and changes to inspections;
vi) care in the home, including by unpaid carers;
vii) antenatal and postnatal care;
viii) the procurement and distribution of key equipment and supplies, including PPE and ventilators;
ix) the development, delivery and impact of therapeutics and vaccines;
x) the consequences of the pandemic on provision for non-COVID related conditions and needs; and
xi) provision for those experiencing long-COVID.

c) The economic response to the pandemic and its impact, including governmental interventions by way of:
i) support for businesses, jobs and the self-employed, including the Coronavirus Job Retention Scheme, the Self-Employment Income Support Scheme, loans schemes, business rates relief and grants;
ii) additional funding for relevant public services;
iii) additional funding for the voluntary and community sector; and
iv) benefits and sick pay, and support for vulnerable people.

2. Identify the lessons to be learned from the above, to inform preparations for future pandemics across the UK.

Appendix 2

COVID-19 INQUIRY SUPPORT GROUP – ACTION LOG AND TRACKER

ACTION LOG & TRACKER

NHS Northern Lincolnshire and Goole NHS Foundation Trust

COVID-19 Inquiry Group

Minute Ref	Meeting Date	Subject	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored
20/22	18/08/2022	Angie Legge's folders/evidence	Check and save all relevant folder/files held by Angie Legge before leaving the Trust	Sue Meakin	Sep-22				
19/22	18/08/2022	Clinical Reference Group	Medically led Clinical Reference Group - contact Laura Coo for information	Alison Hurley	Sep-22	E-mailed Laura Coo for access to the meeting details, copy of the decision log or minutes referring to C19 (9Sept22), sent follow-up e-mail as received no response to date			
18/22	18/08/2022	Exec Team Logs	E-mail Executive team requesting all records be sent to Covid inbox	Matt Overton	Sep-22	E-mail sent to Execs and saved in meeting folder		Email	yes
			Check response received from each Exec member	Matt Overton	Sep-22				
17/22	18/08/2022	Clinical Protocol	Clinical decision making protocol created by Colin Farquharson - locate file and save	Alison Hurley	Sep-22	Not accessible on hub, so checking with Document Control (9Sept22). Not a controlled document			
16/22	18/08/2022	Judicial Review	Save and hold confidential file for judicial review on death certificates conducted by Angie Legge - add note to evidence folder	Sue Meakin	Sep-22				
15/22	18/08/2022	High Risk Areas - Capture decisions made and evidence on:	Decisions on impacts on staff safety	Ashely Leggott	Sep-22				
			Decisions on impacts of patient safety	Ashely Leggott	Sep-22				
			Approach to Incident Response	Ashely Leggott	Sep-22				
			ICC records/logs	Ashely Leggott	Sep-22				
			Vulnerable staff C19 risk assessment - Contact Jackie France for information about being the first Trust to complete	Alison Hurley	Sep-22	AH saved assessment and guidance to evidence folder from hub			
			Vulnerable staff risk assessment - Contact Paul Bunyan about the number of assessments undertaken and any further details	Alison Hurley	Sep-22	Information and statistics requested from Paul			
14/22	18/08/2022	Capsticks COVID Inquiry Briefing	Confirm Trust staff invites and whether virtual session	Alison Hurley	Sep-22	All group members now invited to attend virtual training		Diary invite	
13/22	18/08/2022	E-mail account of ex-staff	Contact Jeremy Daws - is e-mail account still active?	Sue Meakin	Sep-22				
12/22	21/07/2022	Comms to Trust leavers	Decision making Trust leavers to be contacted advising they may need to provide evidence. Ensure correct contact details are held on	Ashley Leggott	Aug-22				
08/22	21/07/2022	Communications	Issue comms regarding retention of records - Hub and WWN	Sue Meakin / Ashley Leggott	Aug-22	Ashley to meet with Charlie Grinhaff regarding ongoing communications			
07/22	21/07/2022	Web Page	Discussion with Charlie Grinhaff to confirm who is responsible for updating the web page	Sue Meakin	Aug-22				
06/22			Create COVID Inquiry web page	Ashley Leggott	Aug-22				
			Sue to share examplar web page created by other Trusts	Sue Meakin	Aug-22	E-mailed to Ashley Leggott and Charlie Grinhaff			
05/22	21/07/2022	Create ToR	Create ToR for the search and clarify who provides authorisation (similar to SAR process)	Sue Meakin/All	Aug-22				
04/22	21/07/2022	E-mail accounts of ex-staff	Request copies of e-mail accounts for Graham Jaques, Maurice Madeo and Colin Farquharson from NHS Digital	Sue Meakin	Aug-22	Peter Reading to authorise copies of such decision making staff leaver mailboxes			
			Colin Farquharson and Maurice Madeo			SM sent request to NHS Digital to either save entire mailbox or keep accounts active			
			Graham Jaques e-mails	Sue Meakin	Aug-22	Sue to investigate option of saving Grahams e-mails received by/sent to someone as alternative approach			
02/22	21/07/2022	Decision Logs	Request Decision Logs from meeting groups and committees as below: ARGC Q&SC (from Mike Proctor/Laura Coo) Ethics Committee Medical Gas Committee - SI Oxygen incident details (from Kelly Bircham) Covid-19 ICC Log	 Ashley Leggott Alison Hurley Alison Hurley Ashley Leggott Ashley Leggott Ashley Leggott	Aug-22	 ARGC - collating into one document - O/S AH received from Laura Coo and saved to folder AH contacted Laura Coo - informed no EC decision log (AnL confirmed) AsL requested from Joanne - O/S AsL saved full report in folder AsL to complete full check and save to folder - O/S			
01/22	21/07/2022	Chronological List	Create chronological list of decision making and evidence sources and save evidence to C19 evidence folder	Ashley Leggott	Aug-22	Initial draft created from ICC but requires other decision making details to be added (from Committees etc)		Word Document	Yes

Long Term Actions

Minute Ref	Meeting Date	Subject	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored
11/22	21/07/2022	Deletion of copy email accounts	Delete copies of email accounts once inquiry concluded	Sue Meakin					

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