Northern Lincolnshire and Goole NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 4 April 2023
Ashbourne Hotel, Vicarage Lane, North Killingholme, DN40 3JL
Time – 9.00 am – 12.00 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
2.	**Business Items**			
2.1	**Declarations of Interest** Sean Lyons, Chair	Note	09:05 hrs	Verbal
2.1.1	**Register of Interests** Helen Harris, Director of Corporate Governance	Note		NLG(23)065 Attached
2.2	**To approve the minutes of the Public meeting held on Tuesday, 7 February 2023** Sean Lyons, Chair	Approve		NLG(23)045 Attached
2.3	**Urgent Matters Arising** Sean Lyons, Chair	Note		Verbal
2.4	**Trust Board Action Log – Public** Sean Lyons, Chair	Note		NLG(23)046 Attached
2.5	**Chief Executive's Briefing** Ellie Monkhouse, Chief Nurse & Acting Chief Executive	Note	09:15 hrs	NLG(23)047 Attached
2.5.1	**Trust Priorities 2023 / 24** Ellie Monkhouse, Chief Nurse & Acting Chief Executive	Approve		NLG(23)048 Attached
2.6	**Integrated Performance Report (IPR)**	Note		NLG(23)049 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Quality & Safety Report – Key Issues** Dr Kate Wood, Chief Medical Officer & Ellie Monkhouse, Chief Nurse	Note	09:20 hrs	NLG(23)049 Attached
3.2	**Quality & Safety Committee Highlight Report and Board Challenge** Fiona Osborne, Non-Executive Director & Chair of the Quality & Safety Committee	Note	09:35 hrs	NLG(23)050 Attached

3.3	**Maternity Oversight Report** Jane Warner, Associate Chief Nurse Midwifery	Note	09:40 hrs	NLG(23)051 Attached
3.4	**Performance Report – Key Issues** Shaun Stacey, Chief Operating Officer	Note	09:45 hrs	NLG(23)049 Attached
3.5	**Finance & Performance Committee Highlight Report and Board Challenge – Performance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	09:55 hrs	NLG(23)052 Attached
4.	**Strategic Objective 2 – To Be a Good Employer and Strategic Objective 5 – To Provide Good Leadership**			
4.1	**Workforce Report – Key Issues** Simon Nearney, Interim Director of People	Note	10:00 hrs	NLG(23)049 Attached
4.2	**Staff Survey** Simon Nearney, Interim Director of People	Note		NLG(23)053 Attached
4.3	**Workforce Committee Highlight Report and Board Challenge** Sue Liburd, Chair of the Workforce Committee and Non-Executive Director	Note	10:30 hrs	NLG(23)054 Attached
	BREAK – 10:35 hrs – 10:45 hrs			
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Finance – Month 11 – Key Issues** Lee Bond, Chief Financial Officer	Note	10:45 hrs	NLG(23)055 Attached
5.2	**Executive Report – Estates & Facilities** Jug Johal, Director of Estates & Facilities	Note	10:55 hrs	NLG(23)056 Attached
5.3	**Finance & Performance Committee Highlight Report & Board Challenge – Finance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:05 hrs	NLG(23)057 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Strategic & Transformation Report – Key Issues** Ivan McConnell, Director of Strategic Development	Note	11:10 hrs	NLG(23)058 Attached
6.2	**Strategic Development Committee Highlight Report and Board Challenge** Linda Jackson, Vice Chair and Chair of the Strategic Development Committee	Note	11:20 hrs	NLG(23)059 Attached
6.3	**Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – March 2023** Gill Ponder, Non-Executive Director	Note	11:25 hrs	NLG(23)060 Attached
7.	**Governance**			
7.1	**Audit, Risk & Governance Committee Highlight Report and Board Challenge** Simon Parkes, Non-Executive Director and Chair of the Audit, Risk & Governance Committee	Note	11:30 hrs	NLG(23)061 Attached
7.2	**CQC Statement of Purpose** Dr Kate Wood, Chief Medical Officer	Note	11:35 hrs	NLG(23)088 Attached
8.	**Approval (Other)**			
8.1	**Health Tree Foundation Trustees' Committee Terms of Reference** Gill Ponder, Non-Executive Director	Approve	11:40 hrs	NLG(23)062 Attached

8.2	**Audit, Risk & Governance Committee Terms of Reference** Simon Parker, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	Approve	11:45 hrs	NLG(23)063 Attached
8.3	**Division of Responsibilities between the Chair and Chief Executive** Helen Harris, Director of Corporate Governance	Approve	11:50 hrs	NLG(23)064 Attached
9.	**Items for Information / To Note (please refer to Appendix A)** Sean Lyons, Chair	Note	11:55 hrs	
10.	**Any Other Urgent Business** Sean Lyons, Chair	Note		Verbal
11.	**Questions from the Public**	Note		Verbal
12.	**Date and Time of Next meeting** **Board Development** Tuesday, 2 May 2023, 9.00 am **Public & Private Meeting** Tuesday, 6 June 2023, 9.00 am	Note		Verbal

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

- 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.
- In accordance with Standing Order 14.3 (2007), urgent business may be raised provided the Director wishing to raise such business has given notice to the Chief Executive not later than the day preceding the meeting or in exceptional circumstances not later than one hour before the meeting.
- Board members wishing to ask any questions relating to those reports listed under 'Items for Information' should raise them with the appropriate Director outside of the Board meeting. If, after speaking to that Director, it is felt that an issue needs to be raised in the Board setting, the appropriate Director should be given advance notice of this intention, in order to enable him/her to arrange for any necessary attendance at the meeting.
- **Members should contact the Chair** as soon as an actual or potential conflict is identified. **Definition of interests –** A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold." Source: NHSE – Managing Conflicts of Interest in the NHS.

NB: When staff attend Board meetings to make presentations (having been advised of the time to arrive by the Board Secretary), it is intended to take their item next after completion of the item then being considered. This will avoid keeping such people waiting for long periods.

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.

9.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
9.1	**Finance & Performance Committee Minutes – January 2023** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(23)066
9.2	**Health Tree Foundation Trustees' Committee Minutes – November 2022** Neil Gammon, Chair of the Health Tree Foundation Trustees' Committee	NLG(23)067 Attached
	Quality & Safety Committee	
9.3	**Quality & Safety Committee Minutes – January & 1 March 2023** Fiona Osborne, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(23)068 Attached
9.4	**Nursing & Midwifery Assurance Report** Ellie Monkhouse, Chief Nurse	NLG(23)069 Attached
	Workforce Committee	
9.5	**Workforce Committee Minutes – January 2023** Sue Liburd, Non-Executive Director & Chair of the Workforce Committee	NLG(23)070 Attached
9.6	**Freedom to Speak Up Guardian Report – Quarter Three** Liz Houchin, Freedom to Speak up Guardian	NLG(23)071 Attached
9.7	**Guardian of Safe Working Hours Report – Quarter Three** Dr Liz Evans, Guardian of Safe Working Hours	NLG(23)072 Attached
	Audit, Risk & Governance Committee	
9.8	**Audit, Risk & Governance Committee Minutes – November 2022** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(23)073 Attached
9.9	**Audit, Risk & Governance Committee Self-Assessment** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(23)074 Attached
	Other	
9.10	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(23)075 Attached
9.11	**Documents Signed Under Seal** Dr Peter Reading, Chief Executive	NLG(23)076 Attached
9.12	**Executive Director Statutory & Lead Roles** Helen Harris, Director of Corporate Governance	NLG(23)077 Attached
9.13	**Non-Executive Director Statutory Roles** Helen Harris, Director of Corporate Governance	NLG(23)078 Attached

9.14	**Trust Board Reporting Framework – 2023-24** Helen Harris, Director of Corporate Governance	NLG(23)087 Attached

NLG(23)045

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 7 February 2023 at 9.00 am
Main Boardroom, Diana, Princess of Wales Hospital

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
Shaun Stacey	Chief Operating Officer
Fiona Osborne	Non-Executive Director
Sue Liburd	Non-Executive Director
Gillian Ponder	Non-Executive Director
Simon Parkes	Non-Executive Director

In Attendance:

Debbie Bray	Associate Chief Nurse – Family Services (for item 3.4)
Liz Houchin	Freedom to Speak Up Guardian (for item 4.3)
Alison Hurley	Assistant Trust Secretary (representing Helen Harris)
Ed James	Director of Procurement, Humber and North Yorkshire Procurement Collaborative (for item 9.2)
Jug Johal	Director of Estates & Facilities
Jo Loughborough	Senior Nurse – Patient Experience (for item 1.3)
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Simon Nearney	Interim Director of People
Mr Kishore Sasapu	Deputy Medical Director (representing Dr Kate Wood)
Kate Truscott	Associate Non-Executive Director
Jane Warner	Associate Chief Nurse Midwifery (for item 3.3)
Lisa Webster	Communications Manager (representing Ade Beddow)
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.

It was noted Rachel Farmer, NHS Liaison, Neil Gammon and Ian Reekie were in attendance.

Sean Lyons advised Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) remained under increased pressures. Waiting lists were currently under scrutiny across the country and NLAG continued to support partners.

Sean Lyons welcomed Simon Nearney, Interim Director of People (and current Director of People at Hull University Hospitals NHS Trust (HUTH)) to the meeting.

1.2 Apologies for Absence

Apologies for absence were received by Dr Kate Wood, represented by Mr Kishore Sasapu, Deputy Medical Director, Ade Beddow, represented by Lisa Webster, Communications Manager, Helen Harris, represented by Alison Hurley, Assistant Trust Secretary and Stuart Hall.

1.3 Patients' Story and Reflection

Jo Loughborough shared Mary's story, a patient who had sought advice and help with mild pain via her GP, who then advised Mary to call 999. Mary decided to try NHS 111 initially but to no avail before finally attending the Emergency Department (ED).

Ellie Monkhouse felt the story described the desperation of what patients were experiencing before reaching ED with trying to access relevant care. Shaun Stacey agreed this was becoming a recurring issue, which unfortunately impacting on clinical staff at NLAG. This also impacted elective care due to the demand at the front door and flow out of the hospital. Dr Peter Reading added that the Trust were experiencing issues with patients being brought into ED by relatives with serious illnesses due to delayed ambulance issues. It was noted North East Lincolnshire was the second worst district in the country for General Practitioner (GPs) to patient ratio. A review was being undertaken collectively to attract GPs to the area which had been highlighted nationally. These issues were to be addressed by local Members of Parliament (MPs) and discussions had started to take place. It was agreed further updates would be provided once they became available.

2. Business Items

2.1 Declarations of Interest

No declarations of interests were received.

2.1.2 Fit & Proper Persons Annual Declaration – NLG(23)004

Alison Hurley shared the paper with the Board. Positive feedback from the Care Quality Commission (CQC) was noted from the recent inspection in respect of Fit & Proper Persons. The paper was noted.

2.2 To approve the minutes of the Public Meeting held on Tuesday, 6 December 2022 – NLG(23)005

The minutes of the meeting held on the 6 December 2022 were accepted as a true and accurate record and would be duly signed by the Chair once the amendment below had been actioned.

- Fiona Osborne referred to page five, item 3.2, Recommendations to the Trust Management Board for Trust Targets in line with Best Practice Time Pathways recommendation. The action should be amended to say this would be incorporated into the Integrated Performance Report (IPR). It was noted a discussion would take place outside the meeting as to how this would be incorporated into the IPR.

  Action: Dr Peter Reading

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(23)006

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

- Item 3.4, 4 October 2022 meeting – Bank Incentives. It was noted Dr Peter Reading had provided a briefing to the Board via email, board members were content with the update provided. Linda Jackson queried whether the incentives in place had been effective. Dr Peter Reading advised those that had undertaken additional shifts had been positive, however, there had not been evidence to show more shifts had been undertaken by staff. Specific areas had been deliberately targeted, in particular clinical and nursing staff. There had been some negative feedback received from staff not being offered incentives. Lee Bond advised it was disappointing as this had not made a positive difference with agency spend over this period. Simon Nearney explained additional shifts had been undertaken compared to the previous year, and although this had not reduced agency spend it had not increased as a result of the additional shifts. Ellie Monkhouse confirmed that in addition to the establishment review, additional posts had been added to counter balance the additional requirements. This also had not taken into account the number of vacancies which would show a more balanced position. Acuity of patients had increased and the skills mix of current staff had reduced due to recent changes in the workforce that now required additional support. It was noted the scheme had been extended

until the end of March 2023 when further discussion would be undertaken. It was agreed an update on this item would be provided at the next meeting. Fiona Osborne queried why it was considered to be unsuccessful. Lee Bond advised this would be reviewed.

Action: Simon Nearney and Lee Bond

- Item 4.3 – 6 December 2022 – Freedom to Speak Up (FTSU) Communications. It was noted Dr Peter Reading had provided a briefing to Board members via an email with details about the communications shared with staff on how to report any concerns. The Board were content with the update provided and it was agreed this item could be closed.

2.5 Chief Executive's Briefing – NLG(23)007

Dr Peter Reading referred to the report and drew the Board's attention to particular highlights. Congratulations were given to the Estates team due to the funds recently received for the Capital Investment Programme. The Our Stars Awards was noted in the report and due to take place on the 24 November 2023.

2.6 Integrated Performance Report (IPR) – NLG(23)008

Sean Lyons advised the IPR was for noting and discussion in the following Executive items on the agenda.

3. Strategic Objective 1 – To Give Great Care

3.1 Quality & Safety - Key Issues - NLG(23)008

Mr Kishore Sasapu referred to the report and highlighted the cancer and mortality performance. The Summary Hospital-Level Mortality Indicator (SHMI) remained in a good position. Assurance was provided to the Board following the review from NHS England (NHSE) on Out of Hospitality mortality details. Further to a discussion it was noted that although cancer numbers had not increased for the Trust the number of referrals which required testing had.

Ellie Monkhouse advised NLAG was close to the target of 19 in respect of Clostridium Difficile (C.Diff), however, the Trust remained in the top five performing Trusts and the top quartile for infection control generally. Complaint response times had improved and was currently at 78% within the 60-day timescale, Patient Advice Liaison Service concerns (PALS) were now at 69%, which had improved.

3.2 Quality & Safety Committee Highlight Report and Board Challenge – NLG(23)009

Fiona Osborne referred to the highlight report and noted key issues. It was noted the Never Event reported in December 2022 was currently being investigated. The committee had been assured actions already in place to prevent this happening again. Mr Kishore Sasapu highlighted that although this had been due to poor practice, it had arisen due to an object being left in a patient that was not included on the WHO surgical checklist.

3.3 Maternity / Ockenden Update – NLG(23)010

Jane Warner referred to the paper, provided an overview and confirmed this was going through the governance process. It was noted other reports were due to be completed nationally in March 2023 which would mean other actions being required by the Trust. Jane Warner thanked everyone for the support received during the submission of the Clinical Negligence Scheme for Trusts (CNST), which had been submitted in January 2023. The Board were advised changes were due to be made to the report which would include a more detailed matrix.

The team had completed an NHSE maternity self-assessment which had allowed the service to see where it sat against National Standards and Guidance.

Ellie Monkhouse explained reporting to the Board as a whole was being reviewed to ensure full oversight was provided. This would include a comprehensive maternity dashboard to provide greater assurance. Dr Peter Reading highlighted NLAG maternity services had in previous years been one of the worst but was now in a more improved place.

Sean Lyons thanked Jane Warner for the report received. Jug Johal wanted to highlight the Continuity of Carer work in deprived areas as NLAG was ahead in that area and had met the required target.

3.4 Neonates, Children & Young People's Strategy – NLG(23)011

Debbie Bray highlighted key areas of the report. Dr Peter Reading was pleased to see priority one was detailed within the strategy, Transition to Adulthood. A query was raised as to whether any additional support would be required to implement this priority. Debbie Bray advised support and engagement would be required from other specialty colleagues as it was noted the priority did not only relate to family services. Dr Peter Reading noted there was a complex multi-agency dimension that related to some young patients. Debbie Bray agreed there was some challenges as differing services reflect the age of adulthood at different points, for example some were at 16 years of age, however, others were 25 years of age.

Gill Ponder questioned whether any particular plans were in place to attract more people into paediatric nursing. Debbie Bray explained NLAG were working with Universities to identify whether there were issues as to why people were not attracted to this area of nursing. NLAG were now recruiting the first cohort of Nursing Associate Apprentices to support "grow our own", those staff would be the first to become registered nurses. Lincoln and Hull Universities were trying to develop a childrens' services apprenticeship route as there was not as many opportunities available in that area. Ellie Monkhouse advised the Trust held a Transformation Board for this Strategy which would review where the Strategy was delivered. However, the group would welcome the support of a Non-Executive Director (NED) or additional Executive support to implement the work required. In respect of working more closely with partners, as Simon Parkes worked with Lincoln University outside of the NED role support was offered as required. Sue Liburd recognised there was a national shortage of Health Visitors, and this role

was a key partner to deliver the strategy, a query was raised as to whether this may impact on the implementation of the work. Debbie Bray advised nothing within the Strategy was being newly introduced, and all work had been undertaken previously. It was noted the work to be undertaken would be achievable. It was agreed discussion would take place outside of the meeting to identify additional NED support.

The Trust Board approved the Neonates, Children & Young People's Strategy.

3.5 Executive Report – Digital – NLG(23)012

Shauna McMahon referred to the presentation and noted key highlights. Fiona Osborne felt the Board needed to consider how Digital Services interacted with other support services. The support function for Divisional Business Partners within Human Resources was embedded and it was felt this should be reflected for Digital Services.

Sue Liburd queried what the impact was on the less experienced digital staff when trying to deliver the transformational elements. Shauna McMahon explained it was not around the team being less professionally experienced, but a high number of staff within the service had only worked for NLAG so had not had sight of what developments could be implemented to achieve service improvements. With this in mind staff were being educated and trained in respect of different ways to work. Ivan McConnell suggested this should be introduced in an integrated way through the Strategic Capital Plan.

3.6 Performance - Key Issues (including Waiting Lists & Mutual Aid) – NLG(23)008

Shaun Stacey noted key highlights from the presentation. It was noted there was confidence the 78 week wait patients would all be treated by the end of March 2023. However, there remained some risks in respect of this due to the emergency care work, as demands on this service were putting the elective care programme at Grimsby at risk. Weekly discussions were being undertaken regarding mutual aid to identify the current position due to an extensive number of 78 week waits across the system. There was a risk that increased mutual aid would create further issues for NLAG if the numbers increased at the Trust. The high number of patients in the 66 week wait were at risk as of becoming longer waiters if not treated soon. The current number of vacancies were also impacting within surgery and anaesthetics, specifically in theatres. The refurbishment of theatres also created further impact.

The Trust was one of the few in the country that manually undertook validation of all pathways. Manually validating data did mean a significant risk and this had been highlighted to NHSE. It was hoped a formal directive would be received by NHSE later that day. As pathways had been stopped and started during COVID there was a potential risk that when the patient was added back onto the waiting list the cumulative wait could be over 78 weeks. A query had been raised with NHSE as in the past when similar events had occurred they had offered strategic direction, feedback was now awaited from the national team in respect of this.

The overall daily position was positive and daily reports were being shared with Dr Peter Reading and Sean Lyons to highlight the latest positions. Sean Lyons explained the reason for the extensive information being shared was due to Whitehall wanting to know the positions of Trusts and for those that were not where they should be, calls would be undertaken with Trust Chairs.

Shaun Stacey referred to the slide that detailed the number of mutual aid patients that had been treated by NLAG. Linda Jackson queried whether the process moving forward would be to treat patients in date order. Shaun Stacey confirmed this was how the process had always been undertaken, however, if there was a clinical priority the patient would be seen more quickly.

Sean Lyons queried whether NLAG was in a position to support further mutual aid to partners. Shaun Stacey advised NLAG were not able to offer further mutual aid at the moment, however, patients would be reviewed to see if this was possible on referral. Lee Bond felt mutual aid in terms of flow was very limited due to the number of patients on the NLAG waiting lists. Shaun Stacey confirmed capacity was reviewed on a daily basis against requests that were received for support, this would be put in place if NLAG was able to care for additional patients. Some requests received had not included all the relevant data and this had impacted on costs and time due to the additional work required. Dr Peter Reading highlighted the performance for 78 week waits would not be measured against individual Trusts, instead, this was measured against Integrated Care System (ICS) performance.

3.7 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(23)013

Gill Ponder referred to the report and provided key highlights. Linda Jackson queried whether the Magnetic Resonance Imaging (MRI) impact was due to not having sufficient appointment times to meet demand. Shaun Stacey confirmed this was the case along with the management of priority patients. An alternative approach would need to be reviewed to treat NLAG patients as an interim solution may be required. Shaun Stacey explained ambulance handover continued to be a major concern, although some improvements had been shown this month it was unsure whether this would be sustained. In addition to this the number of patients waiting more than 12 hours for a bed had increased due to patient flow issues.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Workforce - Key Issues - NLG(23)008

Simon Nearney took the report as read and shared key highlights on vacancy numbers. Deep Dive meetings within divisions were being held to try and address the issues for the medical vacancy rate as this remained a challenge. Sickness absence continued to be above average for the Trust.

Mr Kishore Sasapu advised that during COVID a number of staff members had not worked in certain areas due to being at high risk. Following the vaccination programme and the reduced risks the workforce had not yet returned to those areas. It was agreed this would need to be reviewed going forward. Simon

Nearney advised a meeting had been held the previous week with Clinical Leads where a number of issues had arisen, these would be addressed accordingly.

4.2 Gender Pay Gap Report – NLG(23)014

Simon Nearney referred to the report and noted that although the statistics were not positive, this did reduce significantly once medical staff were not included as this was the area with the highest male employees. It was recognised there was a need to try and attract more female consultants to NLAG but this had historically been difficult. More females were enrolling at medical school and it was hoped this would be reflected in the future. Other ways of working in respect of flexibility may be one of the ways in attracting individuals to the organisation. Dr Peter Reading would support NLAG being more flexible in the future to attract more female staff to the organisation. It was felt this should always be highlighted within the Trust priorities. The Board supported this approach in the future to attract more female staff.

Gill Ponder queried whether the Clinical Excellence Awards (CEAs) process could be reviewed by the Workforce Committee to ensure equality. Simon Nearney advised organisations were now awarding CEAs differently, NLAG had also awarded them differently on this occasion by sharing the award amongst permanent consultants. Linda Jackson felt the Remuneration and Terms of Service (RATS) Committee should be the one to review this as it had overall responsibility. Fiona Osborne queried what NLAG could put in place moving forward to attract female staff. Simon Nearney explained the main focus had been on filling vacancies due to staff shortages so it was not always possible to recruit female staff.

The Trust Board approved the Gender Pay Gap report.

4.3 Freedom to Speak Up (FTSU) Policy – NLG(23)015

Liz Houchin shared the report with the Board and requested approval of the Policy.

The Freedom to Speak Up Policy was approved.

4.4 Modern Slavery Act Statement – NLG(23)016

Simon Nearney referred to the report and sought approval from the Board.

The Modern Slavery Act Statement was approved.

4.5 Workforce Committee Highlight Report & Board Challenge – NLG(23)017

Sue Liburd referred to the highlight report and noted work at the Trust with Health Care Support Workers (HCSW) was being recognised nationally in respect of the recruitment methodology, and NLAG were now a beacon in this area. Dr Peter Reading highlighted the issues that had been resolved within Gastroenterology had been a huge achievement and had put the Trust in a more positive position. Dr Peter Reading highlighted NHSE had put in place a £500 payment for retained midwives post retirement which was a positive move. Lee Bond queried whether

the committee felt actions were in place sufficiently in terms of retention. Sue Liburd confirmed the committee were assured the actions were in place, however, there was a need for further innovation. In terms of best practice the actions being taken were the right actions, but delivery was not where it should be and it was recognised more was required. Lee Bond asked if that caveat could be added to reports to highlight that although work was being undertaken it was recognised further work was required.

Ellie Monkhouse advised there was frustration as there was a need for levelling up of incentives and investment in education and retention across all sites. It was felt that there was a need to invest to support and improve the retention of staff. Simon Nearney advised investments were being reviewed going forward and this would be discussed with University partners. In respect of additional support for nurse training, Simon Parkes offered support where required to progress this at Lincoln University.

Linda Jackson referred to an area of concern in respect of the lengthy waiting time for staff to receive occupational health interviews, which was impacting on the recruitment of staff. It was agreed this area was being reviewed.

5. Strategic Objective 3 – To Live Within our Means

5.1 Key Issues - Finance – Month 09 - NLG(23)018

Lee Bond referred to the report and noted it was expected that the end of year target should still be met. Sean Lyons queried where the productivity was being scrutinised. Gill Ponder explained this was reviewed in the Finance and Performance Committee (F&PC) but there was not a set matrix that could be reviewed. Dr Peter Reading requested a separate meeting with Shaun Stacey, Lee Bond and Dr Kate Wood to review this further.

Action: Dr Peter Reading, Dr Kate Wood, Shaun Stacey and Lee Bond

5.2 Annual Accounts – Delegation of Authority – NLG(23)019

Lee Bond confirmed the submission date for the final accounts was the 30 June. A request was made for the Board to approve that the Audit, Risk & Governance Committee (AR&GC) have the delegated authority to approve on behalf of the Board. Following discussion it was agreed that should an Extra-ordinary meeting of the Trust Board be required for further discussion this would be convened.

The Trust Board agreed to delegate the approval to the AR&GC.

5.3 Finance & Performance Committee Highlight Report and Board Challenge – Finance - NLG(23)020

Gill Ponder referred to the report and highlighted key points.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Key Issues – Strategic & Transformation – NLG(23)021

Ivan McConnell referred to the report and noted key highlights.

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 Terms of Reference – NLG(23)024

Simon Parkes referred to the report and sought approval of the terms of reference. The Audit, Risk & Governance Committee (AR&GC) Terms of Reference were approved.

8.2 Board Assurance Framework (BAF) – Quarter Three - NLG(23)025

Alison Hurley shared the report with the Board. It was noted the BAF had been reviewed at Board Committees.

9. Approval (Other)

9.1 Trust Management Board Terms of Reference – NLG(23)026

Dr Peter Reading referred to the report and advised of the changes made. After some discussion it was agreed one amendment would be made around workforce at paragraph 1.2.

The Trust Board approved the updated Terms of Reference.

9.2 Business Case for the Establishment of a Shared Procurement Collaborative – NLG(23) 027

Ed James referred to the report and highlighted key points and the risks involved.

Fiona Osborne suggested teams would need to be closely aligned to ensure the process worked and queried how this would be implemented. Ed James advised discussion had taken place with staff and some cross site working had already been put in place to highlight how different teams worked at other Trusts. Other opportunities had been considered by seconding staff to other Trusts which had supported the retention of staff.

Mr Kishore Sasapu queried what additional support would be provided for clinical groups to ensure this worked. Ed James explained there would be a need for representation at all sites, which would be supported by Business Partners being in place. Gill Ponder felt a number of roles were in system areas and queried whether they would be more suitably aligned to the digital changes, meaning those staff should be within the digital team and not procurement. Ed James explained

there would be a willingness to have support from other teams and this could be worked through.

In terms of medical engagement with the shared procurement, Ellie Monkhouse queried whether other health care professions would be considered and not just consultant staff. Ed James noted the points made by Ellie Monkhouse to take forward.

Sean Lyons queried specific roles attending relevant meetings and whether this had been clarified. Ed James advised this has not been put in place at present but individuals would be invited when required. Sean Lyons requested that a balance of those roles should be provided across all Trusts.

The Trust Board agreed to the shared procurement.

Post Meeting Note:
The Director of Corporate Governance had reviewed the governance process for the approval of the Shared Procurement Business Case and confirmed that the Business Case was not reviewed by the Finance and Performance Committee at its meeting in January 2023, as per its Terms of Reference. The Business Case had been reviewed by Trust Management Board at its meeting on 23 January 2023. The Finance and Performance Committee will not receive the business case for review, having been approved at Trust Board on 7 February 2023.

10. Items for Information

The following items were shared at the January 2023 meeting:

- F&PC Minutes – November & December 2022
- Q&SC Minutes – November & December 2022
- Nursing Assurance Report
- Midwifery Safe Staffing Review
- Workforce Committee Minutes – November 2022
- Communications Round-Up
- Documents Signed Under Seal

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

Board Development

Tuesday, 7 March 2023, Time: 9.00 am

Formal Trust Board Meeting

Tuesday, 4 April 2023, Time: 9.00 am

The Private Trust Board meeting was due to follow at 13:50 hours.

Sean Lyons closed the meeting at 13:24 hours.

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

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	7	7	Ellie Monkhouse	7	6
Dr Peter Reading	7	7	Simon Nearney	1	1
Lee Bond	7	6	Fiona Osborne	7	7
Christine Brereton	6	5	Simon Parkes	7	4
Stuart Hall	7	5	Gillian Ponder	7	7
Helen Harris	7	4	Michael Proctor	3	3
Linda Jackson	7	6	Maneesh Singh	3	3
Jug Johal	7	4	Shaun Stacey	7	7
Sue Liburd	4	4	Kate Truscott	4	4
Ivan McConnell	7	6	Michael Whitworth	3	3
Shauna McMahon	7	6	Dr Kate Wood	7	4

NLG(23)046

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2023/2024

Kindness · Courage · Respect

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Public Meeting

2023/24

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
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	04.04.2023	Discussion had taken place with the Executive Team. A paper was now to be discussed at the Trust Management Board on options to be put forward for staff incentives. The paper would be shared with the board following discussion at that meeting. Further update to be provided as part of the CEO update at the April 2023 meeting.			
2.2	07.02.2023	6 December 2022 Public Minutes - Items being referred to the TMB for recommendation		It was agreed a meeting would be held outside of the meeting on how to incorporate Best Practice Timed Pathways into the Integrated Performance Report as it was agreed this should not be the function of the TMB.	Dr Peter Reading / Shauna McMahon	04.04.2023	Further update to be provided at April 2023 meeting.			
5.1	07.02.2023	Key Issues - Finance - Month 09		Scrutiny of productivity being developed.	Dr Peter Reading, lee Bond, Shaun Stacey & Dr Kate Wood	04.04.2023	It was agreed a meeting would be held outside of the meeting to review this further.			

Key:

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

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?
3.2	06.12.2022	Quality & Safety Committee Highlight Report & Board Challenge - Best Practice Timed Pathways		Trust Management Board to review the cancer request to test Trust targets in line with Best Practice Timed Pathways (BPTP), and report the outcome to Q&SC.	Dr Peter Reading / Fiona Osborne	07.02.2023	This action would be monitored through the Quality & Safety Committee.			
3.2	06.12.2022	Quality & Safety Committee Highlight Report & Board Challenge -Seven-Day Working - Pathology		Pathology to present the case for seven-day working in the 2023-24 Business Planning process to aid delivery of BPTP, and report the outcome to Q&SC.	Shaun Stacey /Fiona Osborne	07.02.2023	This action would be monitored through the Quality & Safety Committee.			
3.3	06.12.2022	Safeguarding Vulnerabilities Annual Report		Action to be processed through Safeguarding.	Ellie Monkhouse / Safeguarding Team	07.02.2023	Action to be monitored by Safeguarding Team for next report			
4.1	06.12.2022	Key Issues - Workforce		Assurance to be provided to the Quality & Safety Committee on actions being undertaken around issues with recruitment of staff.	Sue Liburd / Simon Nearney	07.02.2023	Update to be provided to the Quality & Safety Committee. This action would be monitored by the committee.			
4.3	06.12.2022	Freedom to Speak Up Guardian Quarter Two Report		Communication to be shared with Trust staff on the processes of reporting concerns	Dr Peter Reading / Ade Beddow	07.02.2023	Update on communication shared to be provided at the February 2023 meeting. Update provided - communication circulated as requred.			
8.1	06.12.2022	Audit, Risk & Governance Committee Highlight Report & Board Challenge		Meeting to be held to ensure processes were in place for the body store requirements at Goole Hospital.	Shaun Stacey / Dr Kate Wood	07.02.2023	Update on assurance processes to be provided to the Audit, Risk & Governance Committee following the meeting held. The committee would retain oversight of this action.			
8.5	06.12.2022	New Code of Governance		Governor Briefing sessions to be arranged.	Helen Harris	07.02.2023	It was agreed Governor briefings sessions would be arranged when required.			

Key:

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

Page 3 of 3

NLG(23)047

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	4 April 2023	
Director Lead	Dr Peter Reading, Chief Executive	
Contact Officer/Author	Dr 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 matters of broad interest and/or not covered elsewhere on the Board agenda.	
Background Information and/or Supporting Document(s) (if applicable)	Not 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)	Not applicable.	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not 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

1. Impact of Industrial Action

Approximately three quarters of the Trust's junior doctors took strike action in accordance with the BMA's dispute with NHS England over pay, from 06.59 on Monday 13 March to 06.59 on Thursday 16 March.

Key services were maintained throughout this period with other doctors covering the work of doctors absent on strike, but 1,157 outpatient appointments and 57 elective procedures were cancelled to release those other doctors to cover key services. The clinical divisions rearranged every cancellation within 7 days. With respect to cancer patients, the Trust did not cancel many cancer cases as it managed to keep all the tumour sites going during the strike except for one tumour site, whose patients were picked up either proactively prior to the strike or within 7 days. Cancelled outpatient appointments have been re-appointed based on the risk stratification.

2. Winter Bank Incentives

After very careful review of the costs and benefits of previous Winter Incentive schemes and of approaches taken by other trusts, Winter Bank and Overtime Incentives were implemented in two phases – Phase 1 from 16 December 2022 to 31 January 2023, and Phase 2 from 1 February 2023 to 19 March 2023 – with the objective of increasing Bank and Overtime shift fill rates and reducing spend on agency staffing. Incentives were confined to certain staff groups where agency spend was particularly high – nurses, midwives, Allied Health Professionals (AHPs) and healthcare support workers, including AHP support workers, working in ward-based areas, outpatient departments and community settings, up to and including band 7. For Bank shifts worked, the incentive was a 20% increase on the hourly rate of pay whether a staff member was Bank only or Bank and substantive. Substantive staff had the opportunity to work Overtime as well as bank shifts with Overtime paid at 1.5 times the basic hourly rate. A £250 bonus was also available, depending on the number of bank/overtime hours worked.

Year-to-date figures (to end of February i.e. before Phase 2 had ended) indicate that the additional cost of the 20% Bank incentive and the £250 bonus is already £856,320, with further costs not yet accounted for. Impact data for Phase 2 was not yet available at the time of writing, but data for Phase 1 showed circa 600 more Bank nursing shifts (c. 12-13 per day), 600 more Bank HCA shifts and 1,135 additional Overtime hours being worked in this period compared to the same period in 2021-22. However, agency fill rates remained the same comparing this period for 2021-22 and 2022-23.

Given the financial pressures on the Trust as it approached Year End, the net additional cost of the scheme and in the absence of any demonstrable impact on agency spend, the Winter Incentives were terminated at the end of Phase 2 (19 March).

3. Use of Nitrous Oxide/Entonox

Background

In early March NHS Estates issued guidance regarding the management of exposure to Nitrous Oxide/ Entonox after instances of the Workplace Exposure Limit (WEL) being reported as being exceeded at some hospitals.

https://www.england.nhs.uk/long-read/guidance-on-minimising-time-weighted-exposure-to-nitrous-oxide-in-healthcare-settings-in-england/

The Royal College of Midwives has also written to all acute trust CEOs RCM requesting assurance that exposure was minimised through the use of the hierarchy of control as required within the COSHH regulations and that Trust Boards were full sighted on this issue.

NLAG Impact

The impact on NLAG is currently not thought to be significant as the highest potential concentrations that staff may be exposed to are within maternity and theatre areas. Within NLAG there are Anaesthetic Gas Scavenging Systems (AGSS) or dilution ventilation in use within these areas to reduce any exposure below the WEL. In SGH the AGSS operates within the labour ward rooms and in DPOW the birthing rooms are ventilated to above the 10 ACH threshold.

In addition, within the maternity services the Gas/Air used has a scavenging system on the breather unit which means that when the patient exhales through the unit the Entonox is removed and not released into the room. In theatres the AGSS is attached to the breathing mask.

There are some other areas where Entonox is used, and these areas are being checked against the measured ACH as a piece of work for Covid-19 issues has resulted in clinical areas having the ACH rate being measured. This means that where Entonox is identified as being used where there is no AGSS it can be quickly determined if the ACH is sufficient to dilute any Entonox below the WEL and staff are not excessively exposed.

Further work, including monitoring, reporting and assurance

The Medical Gas Committee and the Health, Fire & Safety Group are monitoring the information regarding possible Entonox exposure and will include within highlight reports to TMB progress and any issues. TMB received and approved a report on 20 March 2023, and Board Committee assurance will be provided through the Finance & Performance Committee (first report to the April 2023 meeting as meeting scheduling precluded its being presented to the March meeting).

In addition, all cylinders of Entonox in use are being traced to ensure that all areas where it is used are clearly identified. In the new Emergency Departments, a substitute is being used (Penthrox) and there is no piped Entonox installed. With the new SDEC areas the move is to remove the use of Entonox and the design ACH is based on the WHO guidance of 12 ACH (which is above the 10 ACH needed to reduce exposure). Also, some personal monitoring units will be purchased/hired to monitor exposure and validate the information known. The results of any monitoring will be reported to the forementioned groups.

Information to staff and patients to ensure breathing units are used appropriately will be reviewed and updated in addition to the above work.

4. Opening of new Emergency Department at Scunthorpe General Hospital

The new Emergency Department (costing £17.3 million to build) opened successfully on 16 March 2023. Full Urgent and Emergency Care services were maintained throughout the day as the old Department closed and the new one opened.

The opening of the new Department received substantial positive local media coverage.

5. Appointment of NLaG Director of Service Development as Interim Director of Strategy at Hull University Teaching Hospitals (HUTH)

Following the appointment of HUTH's Director of Strategy and Planning (Michelle Cady) to a post in another trust, NLaG has agreed to a request from HUTH for Ivan McConnell (NLaG Director of Strategic Development) to be seconded for 50% of his time to take on the role of Interim Director of Strategy and Planning at HUTH from 1 April 2023, pending the establishment of the substantive Group Executive leadership team for the two trusts. Ivan will continue to be Director of HAS (two days per week, split between HUTH and NLaG) for the period of this new secondment.

6. Quality Improvement (QI) Conference

Following the success of its first Quality Improvement Conference last year, the Trust is preparing to hold its second Quality Improvement Conference on 27 April 2023. This will be an opportunity to reflect on the organisation's improvement journey over the past year and celebrate improvements that benefit our patients and staff. It will recognise the remarkable efforts of our staff, even during exceptional busy periods, and their passion for improvement, for the benefit.

The keynote speaker for the conference will be Dr Yvette Oade, Regional Medical Director, who will share her experiences of how powerful building a Quality Improvement culture can be to a organisation's success. In addition, there will be Quality improvement initiatives showcased by frontline teams throughout the day with opportunity to discuss how we support teams to continue to make Quality Improvement in the future.

Dr Peter Reading
Chief Executive

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	4 April 2023	
Director Lead	Dr Peter Reading, Chief Executive	
Contact Officer/Author	Dr Peter Reading, Chief Executive	
Title of the Report	**Draft Trust Priorities for 2023-24**	
Purpose of the Report and Executive Summary (to include recommendations)	This paper presents for Board approval the Trust Priorities proposed for 2023-24. This paper has been developed by the Executive Team and their teams, was discussed at the Private Trust Board meeting on 7 March 2023 and has had modest amendments in light of that discussion. These 'headline priorities' will be supported with more detailed metrics and implementation plans in the Trust's business plan and in the individual objectives of Executive Directors.	
Background Information and/or Supporting Document(s) (if applicable)	Not 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
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Financial implication(s) (if applicable)	Applicable through the Trust's business planning processes.	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Objectives to further equality, diversity and inclusion, and to reduce health inequalities are included.	
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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Our promise to our staff and our stakeholders

What we will do in 2023-24

Delivering Today / Transforming Tomorrow

NLaG Trust Priorities 2023-24

Trust Priority 1 – Our People

- We will further develop how we seek to **attract and recruit** new staff by:
    - Developing **targeted** recruitment plans and practices at both a Place and ICS level to attract staff to a range of roles across the Trust, including hard to fill clinical roles, resulting in less reliance on bank and agency staff and associated premium spend. This will include targeted planning for specific clinical/medical roles and appropriate on-boarding for new starters.
    - Embedding **recruitment practices** that are fair, inclusive, responsive and provide a positive candidate experience.
    - Developing **workforce plans and initiatives** that tackle longer term workforce shortages. This will include the introduction of new roles, increasing the use of vocational programmes and greater support for veterans and reservists as we aim to widen participation.
    - Increasing the **reward and recognition** proposition for staff on appointment. This will include a greater access to benefits, flexible working practices and development opportunities.
    - Investing in educating and training future healthcare leaders, specialists, and general practitioners to attract and keep skilled employees in our organisation.

- We will **develop and care** for our own staff to **improve retention** by:
    - Developing **career pathways and training academies** that offer development opportunities for new and existing staff, utilising our apprenticeship levy wherever possible. This will include a particular focus on ACPs.
    - Continuing to invest in **values-based leadership development** with a view to creating caring and compassionate working environments.
    - Providing access to a range of benefits such as **flexible and hybrid working** and **retire and return** options that balance the needs of work and life.
    - Continuing to raise awareness of and expand access to responsive and preventative **health and wellbeing services.** This will include a specific focus on supporting colleagues with identified disabilities.
    - Forming alliances with other healthcare organisations to give our staff and trainees **networking opportunities and experience of varied work practices**.

- We will continue to improve our **culture and staff engagement** within the Trust by:
    - Developing annual culture objectives and metrics formed through staff feedback and the National Staff Survey. This will be overseen and monitored through the **Culture Transformation Board.**
    - Continuing to embed **Just and Learning Culture** practices into how we address adverse events that affect our staff.
    - Developing interventional **Organisational Development** programmes that support managers and teams to develop productive and vibrant working environments.
    - Strengthening our efforts to increase and celebrate the **diversity** of our workforce, developing strong staff networks to ensure an inclusive employee experience for all staff.

Trust Priority 2 – Quality and Safety of Care for our Patients

We will **improve safety** on the following five **Trust Quality Priorities**:

- **End of Life** – we will improve personalised palliative and end of life care to ensure patients are supported to have a good death.
- **Deteriorating patient** – we will improve recognition and responding to the deteriorating patient in patients age 16+.
- **Sepsis** – we will improve recognition and response to sepsis in patients.
- **Medication safety** – we will the improve the safety of prescribing weight dependent medication to adults.
- **Mental Capacity** - we will Increase the compliance and quality of Mental Capacity Act (MCA) assessments and best interest recording.

We will continue to implement and embed **actions flowing from our CQC inspection** in 2022.

We will improve safety by **sharing key learning** through multiple routes to enable the messages to become embedded.

We will work towards transitioning from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF) in 2023 culminating in the publication of a **Trust Patient Safety Incident Response Plan (PSIRP)**.

We will continue to participate in **national audit** and act on national and outlier alerts, and ensure we keep our services up to date by reviewing and changing practice, based on best practice guidance from NICE.

We will develop our new QI Strategy, implement our dosing model and strengthen the role of the QI council.

- We will work in collaboration with our LMNS (Local Maternity and Neonatal System) on improvement of Maternity Services based on national improvement plans and work towards completion of the Maternity Self Assessment Tool, and pursue exit from Maternity Support Programme.

- We will prepare the organisation for the changes to statutory **Liberty Protection Safeguards** (due summer 2022)

- We will continue to ensure compliance with **Safe Staffing** requirements in line with national workforce safeguards.

- We will continue to maintain the highest standards of **Infection Prevention and Control**.

[1] These are subject to confirmation through the Quality Account process.

Trust Priority 3 – Restoring and Developing Services for our Patient

- We will **increase the number of people we can diagnose, treat, and care for in a timely way** through doing things differently, accelerating partnerships, and making effective use of the resources available to us, across health and social care. This will include offering our facilities to provide 'mutual aid' to neighbouring trusts if their waiting times are longer than ours.

- By keeping our patients safe, offering the right care, at the right time and in the right setting, we will deliver **10% more activity** in 2023/24 when compared to levels of activity in 2019/20, including:

    - Significantly **reducing the backlog** of patients waiting for care in the Trust through implementation of our Outpatient Transformation Programme and discharging patients as per national clinical best practice pathways.
    - **Reducing long waits** for treatment by reducing the number of patients waiting above 65 weeks to zero by March 2024
    - By March 2024, increasing **Patient Initiated Follow-Ups** (PIFU) to 5% of all outpatient attendances, maintaining Advice and Guidance (A&G) services at 16% of first outpatient attendances, and supporting the reduction of unnecessary Follow Ups by a minimum of 25%, against 2019/20 activity levels.
    - Improving performance against **cancer waiting times** standards:
        - 62-day performance – ensuring that no more than 102 patients are waiting over 62 days by March 2024;
        - Delivering the Faster Diagnosis Standard of 75% by March 2024;
        - Increasing treatment volumes by 13%.
    - Ceasing having any **patients waiting for 12-hours** or more in our emergency departments by March 2024.
    - Significantly improving the number of patients waiting to be admitted to wards from the emergency department within one hour.
    - Maintaining utilisation of **Same Day Emergency Care** (SDEC) above national average and at 40%.
    - Significantly reducing the time **ambulances** wait in our current emergency departments to **handover** care to achieve the following:
        - 65% of handovers in under 15 minutes
        - 95% of handovers in under 30 minutes
        - No handovers waiting more than an hour
    - Opening our **new Integrated Acute Assessment Units** in DPOW and SGH during 2023, co-located with the new Emergency Departments opened during 2023/24.
    - Patients being seen more quickly in Emergency Departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.
    - Supporting our ambulance service partners improve ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.
    - Improving the responsiveness and increasing the capacity of **community care** to support timely hospital discharge:
        - Achieving full geographic coverage urgent community response - 8am to 8pm, 7 days a week and cover all 9 clinical conditions or needs of the national 2-hour guidance;
        - Improving productivity so as to reach more patients in under 2 hours to exceed the minimum 70% threshold of people seen within 2 hours by December 2023;

- Completing the comprehensive development of virtual wards (including hospital at home) towards a national ambition of 40-50 virtual beds per 100,000 population by December 2023.

Trust Priority 4 – Reducing Health Inequalities

- We will work at system level to reduce pre-pandemic and pandemic related Health Inequalities, using related waiting list data that is embedded within performance frameworks to measure access, outcomes and experience for **BAME populations and those in the bottom 20% of IMD (Index of Multiple Deprivation)** scores.

- We will improve the length of stay for patients who have **alcohol dependency** from North East Lincolnshire (identified as an area of additional need) and provide support to manage and improve their health in the long term.

- We will provide additional support and treatment to **tobacco** dependent inpatients, high risk outpatients, and pregnant women under our care.

- Our **maternity services** will prioritise those women most likely to experience poorer outcomes, including women from BAME backgrounds and women from the most deprived areas.

- We will focus on ensuring that **patients with learning disabilities or autism** suffer no additional disadvantages when using or accessing our services, with a particular focus on waiting lists.

- We will strengthen our support to young people going through **transition** in their care to adult services.

Priority 5 – Collaborative and System Working

- Jointly with Hull University Teaching Hospitals (HUTH), we will implement Group executive leadership and associated governance collaborations.

- Jointly with HUTH, we will roll out to more specialties and further embed in those specialties already included, the Humber Clinical Collaboration Programme (formerly the Interim Clinical Plan.

- We will play a full part in the work of the **Humber and North Yorkshire Health and Care Partnership (Integrated Care Board)**, including the Collaborative of Acute Providers (CAP), the Community Collaborative, the three Place-based partnerships of North Lincolnshire, North East Lincolnshire, and the East Riding of Yorkshire, and associated clinical and professional networks.

- We will play a full part in other **national and regional networks**, including professional, service delivery and improvement (e.g. GIRFT), and operational.

- We will work together with partners across Humber and North Yorkshire to develop our approach to **population health management and prevention**.

Trust Priority 6 – Strategic Service and Estate Development and Improvement

- With partners in the **Humber Acute Services Review**, we will progress the Programme to Consultation in Q2 2023 with a view to having a Decision Making Business Case and Decision agreed by the end of Q4 2023/24.

- We will agree the approach that we will take to securing **Strategic Capital Investment** in our infrastructure with a focus on both DPoW and SGH. This will include identification of the potential capital investment and funding options and completion of Business Cases for agreement with the Trust Board and ICB.

- We will secure funding for the **Community Diagnostic Centre (CDC)** in Scunthorpe and design a procurement approach which allows the build to be complete by end of Q4 2023/2024; and we will develop an outline business case to support the procurement and build of a 'spoke' CDC scheme in Grimsby with a focus on ophthalmology by Q4 2023/2024.

- We will continue to invest **into our estates and equipment**, including new Same Day Emergency Care and Acute Assessment Units at both DPOW and SGH, and refurbishments of Theatres &7 & 8 at DPoW and A at SGH.

Trust Priority 7 - Finance

- We will achieve the **Trust's 2023/24 Financial Plan**.

- We will play our full part in the achievement of the 2023/24 Humber and North Yorkshire HCP **system financial control total**.

Trust Priority 8 – Digital

We will move towards a "smarter hospitals" environment while working within our current constraints, including by:

- Developing a consolidated Digital Strategy for NLaG and HUTH to enable joined-up working and to improve capacity to proactively engage with the business and clinicians to align Digital and IT Infrastructure to the wider organisation strategy.

- Completing the procurement for a single EPR for the four acute Trusts in the ICS, with a proposed implementation strategy to achieve HIMSS Level 5 Digital Maturity.

- Achieving final phase completion of shared PAS, new LMS at HUTH, single ICS Maternity Solution, Single Sign On, and Robotic Process Automation.

- Achieving approval for Enterprise Content/Document Management Systems. Digitising **Health Records** as a priority, followed by corporate paper processes to support paper-lite/paperless working.

- Creating a consolidated diagnostics plan including SharePlus (RIS), EIS, access and sharing between NLaG and HUTH and the wider ICS. This will include completion of the eye referral system from community to acute care.

- Expanding the tracking of RFID and Scan4Safety to enable real time collection of information.

- Reviewing and implementing a modern and combined network and hosting service to enhance security, capacity and deliver new and improved service levels 24/7 with capacity to support new digital innovations (i.e Artificial Intelligence, robotics).

- Reducing operational complexity through adopting best practice IT Service Management processes and accreditation to enable a high standard of performance excellence. Operate Sustainably through strong technology business management methods, capacity management, and programme prioritisation.

- Reviewing all applications in the estate against clinical and corporate priorities and the future view of the EPR systems to reduce complexity, reduce wasted cost and to enable infrastructure change.

- Continuing to develop digital skills and knowledge across the organisations engaging with end-users to foster a culture that embraces technology and leverages digital champions to support sustained digital transformation.

Trust Priority 9 – The NHS Green Agenda

- We will continue to promote, develop, and embed the **NHS Green agenda** into the Trust, specifically, procurement policies, staff energy champions, Net Zero Heroes, travel, waste, and recycling.

- Building on our success in eliminating single use plastic in all areas possible, we will increase the amount of waste we redirect for recycling, by reduce all waste streams and ensuring they are compliant with their routes for disposal

- At SGH, we will continue to explore all funding streams to provide **energy conservation** schemes to include a new energy centre. We are growing the use of electric and low emission fleet within the Trust vehicles with over 30% of the fleet now fully electric.

- At DPOW, we will continue to work with North East Lincolnshire Council to explore and develop a **district heating network** across the locality, including a new energy centre coupled with energy conservation measures such as LED lighting.

NLG(23)049

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 4th April 2023
Director Lead	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Chief Medical Officer Simon Nearney, 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 5. **4. Workforce** The executive summary of the Workforce section is provided over on page 7. **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 ☐ 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)	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: March 2023

1. ACCESS & FLOW – Shaun Stacey

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

- Outpatient Summary Letters to be with GPs within 7 Days
- Cancer – Two Week Wait
- Cancer – Two Week Wait Breast Symptomatic

Lowlights: (share 3 areas of challenge/struggle)

- Outpatient Overdue Follow Up (Non RTT)
- Cancer Waiting Times – 104+ Days GP Referrals
- Cancer – 28 Day Faster Diagnosis

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Outpatient Overdue Follow Up (Non RTT)	Targeted work with specialties to increase the number of patients on a PIFU pathway in line with expected trajectory.	Adding patients to a PIFU would remove the patient from the Follow Up List and thus reduce the number of Overdue Follow Ups.
Cancer Waiting Times – 104+ Days GP Referrals	Timely removal of patients from cancer tracking once non-malignancy confirmed.	Removing patients in a timely manner will eliminate the declaration of incorrect long waiters.
Cancer – 28 Day Faster Diagnosis	Consultant led STT Endoscopy service for Colorectal will provide more streamlined service with faster diagnosis and treatment plan.	Streamlined service will increase diagnostic capacity within 28 days of referral

1. QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

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

- The Trust has reported 20 C.difficile onset cases since 1st April 22 with a trajectory of 21. The Trust is performing very well compared to peer trusts.
- The total number of falls reported has decreased for the third consecutive month.
- Complaint responses in timescales have recovered from Q2 decrease. The reduction in complaints over 60 working days continues.
- SHMI continues to be within the expected range (102.79 for the period November 2021 – October 2022).
- VTE risk assessment rate continues to meet target since May 2022.
- Duty of Candour rate maintained at 100%

Lowlights: (share 6 areas of challenge/struggle)

- The case threshold has been exceeded for Pseudomonas aeruginosa. Due to success of considerable reduction of cases in previous years, a case threshold of 7 is challenging
- The number of pressure ulcer incidents reported in January 2023 has increased and the same increase has been seen in January for the last three years suggesting a seasonal variation.
- For FFT we saw the seasonal reduction in patient feedback and a slight reduction in the overall organisational response rate, with 89% of those respondents rated they would recommend the Trust
- Although there has been a decline in the percentage of patients admitted to IAAU with an actual weight recorded on EPMA or Web V from 42.5% in December 2022 to 38.75% in January 2023, the past 3 months data has shown a statistically significant improvement compared to the data recorded in the previous 12 months due to the new facility at DPoW ECC to weigh patients in the ambulance arrivals area.
- Two National patient safety alerts were received in January 2023 relating to the use of oxygen cylinders where patients do not have access to medical gas pipelines systems and the supply of licensed and unlicensed epidural infusion bags. An extraordinary Medical Gas Committee was convened in response to the oxygen cylinders alert and all necessary steps were taken to complete the action by the deadline date. The tight deadline for the alert relating to epidural infusion bags proved challenging as both alerts required Pharmacy resource (alert received on the 23 January and was due for closure by the 27 January).

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Recording patient weight	Changes have been made to the EPMA system to encourage prescribers to add a weight when prescribing Paracetamol. A separate weight tab is planned to be added to EPMA to make it easier for staff to access and will act as a prompt to ensure weight is recorded. Amendments have been made to EPMA and WebV to enable weight data to be reported from the data warehouse which will enable greater oversight to facilitate targeted improvement support work.	Improvement in recording of patient weight.

1. WORKFORCE – Simon Nearney

Highlights:

- The Medical vacancies position is 14.5% this continues to be below target of 15%
- The current PADR position is 83% against a target of 85%. This has seen a significant improvement over the last month with an increase of 3%
- Unregistered Nursing vacancy positions 13.3% continues to decrease and now fallen in the expected range, however this is still above target of 8%

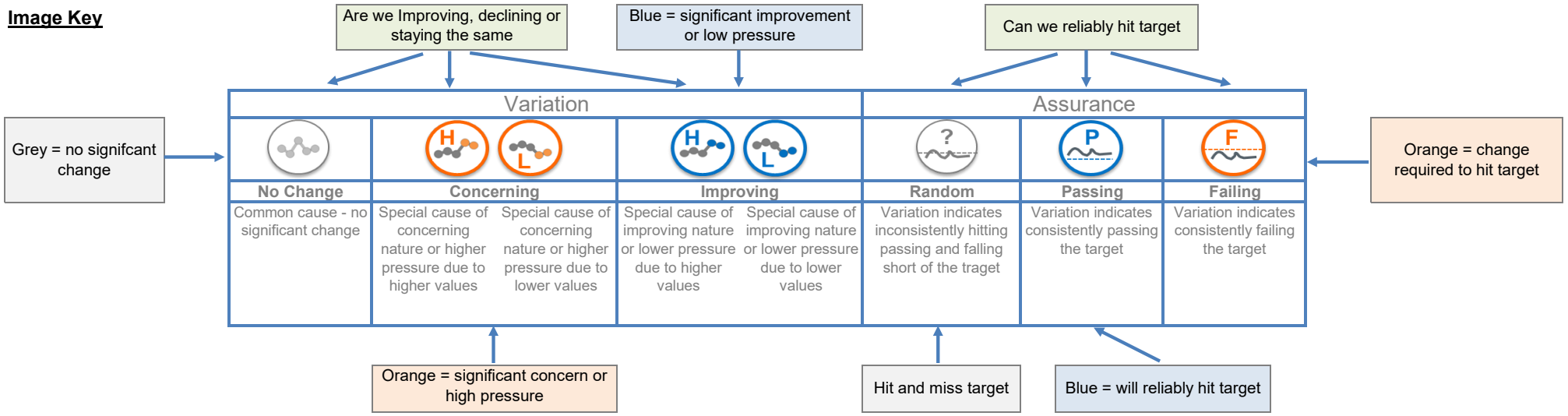
Lowlights:

- The Core Mandatory Training position overall currently stands at 89% which is below target of 90%.
- Turnover continues to be above the 10% target, the latest turnover data point is 11.7%
- Registered Nursing vacancy positions continues to be high at 12.8% against a target of 8%

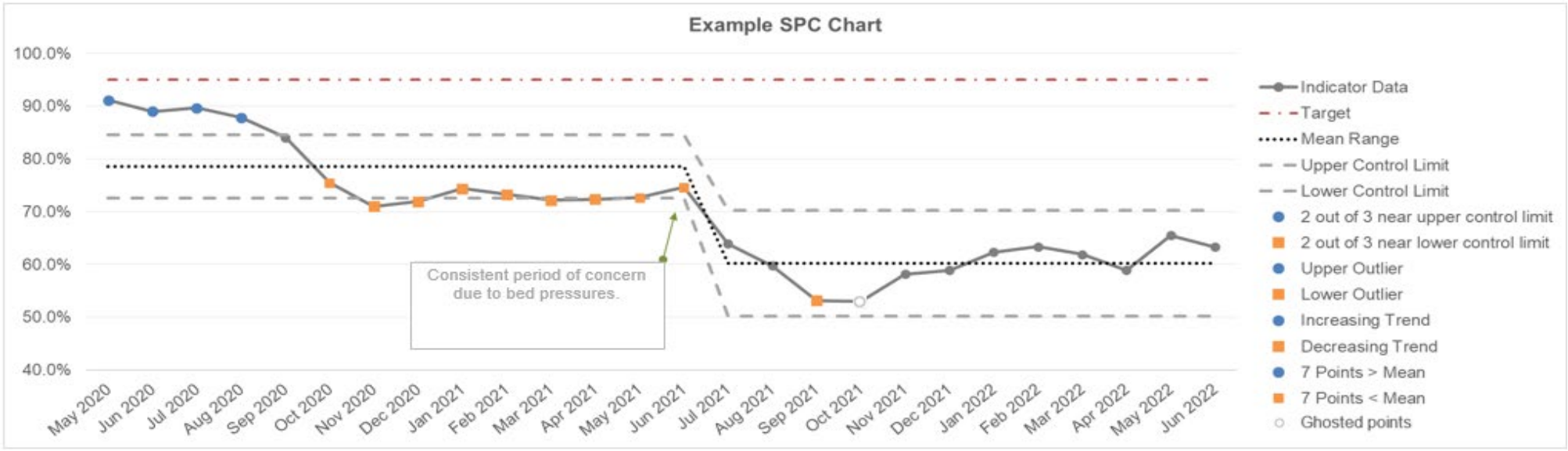
Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Core and Role Specific Training - To address the Non-attendance at classroom-based (core and role specific) courses is now being monitored monthly and shared with HRBPs to support discussions relating to mandatory training compliance with managers. There is currently a significantly high Did Not Attend rate, work is in progress to add Did Not Attend data to Power BI dashboards so that managers have Did Not Attend information in real time and can address concerns as they arise. Hotspot area of low compliance for Fire Safety due to high volume of staff requiring in –person classroom delivery with limited classroom availability. **Registered Nursing Vacancies** - Availability of accommodation can delay recruitment processes. CPD Team capacity to support international nurses. Significant increase in cost of flights adding pressure to international nurses.	**Core and Role Specific Training -** A further measure to reduce levels of non-attendance has now been established. Once staff enrol onto a course in ESR (Electronic Staff Record), a calendar invite is sent directly to their account, and any changes to times / venues are automatically updated as a clear reminder to attend. **Registered Nursing Vacancies** - Continue sourcing of nursing candidates via the Talent Acquisition Team - 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 marketplace.	**Core and Role Specific Training -** Improvement on Training compliance **Registered Nursing Vacancies** - An improved vacancy position is anticipated to reduce turnover rates and support staff retention alongside Nursing career frameworks and introduction of nursing apprenticeships will see reliance on international nurse sourcing reduce longer term. Funding bid for 23/24 has been successful, with plans to appoint 119 international nurses in the financial year.

Northern Lincolnshire and Goole NHS Foundation Trust

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.

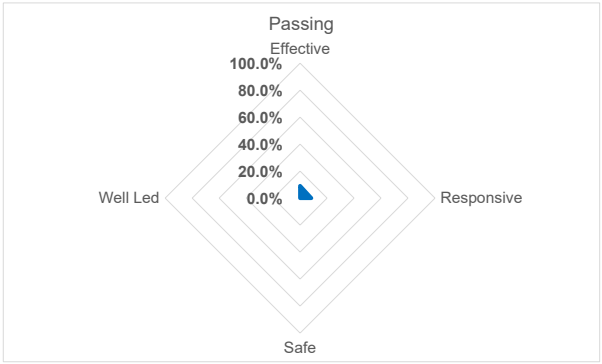
Radar

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

Northern Lincolnshire and Goole NHS Foundation Trust

Consistently Passing

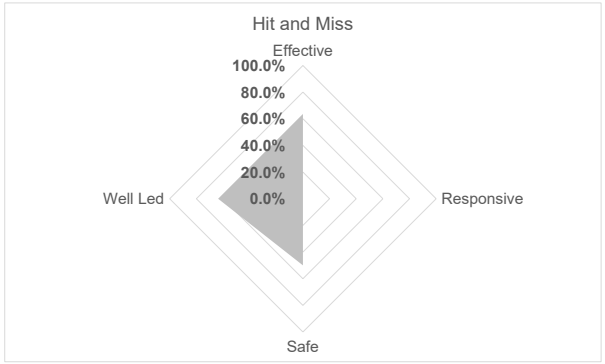
Total: 2



% Outpatient Non Face To Face Attendances
Total Inpatient Waiting List Size

Hit and Miss

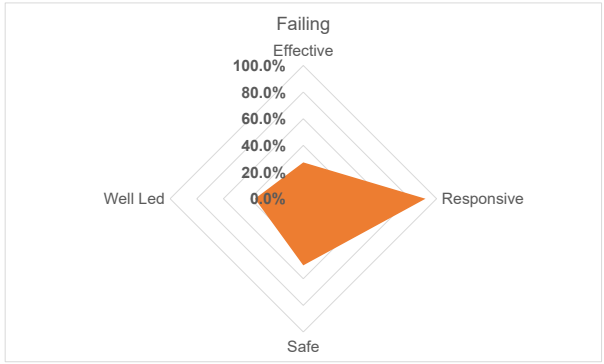
Total: 15



% Discharge Letters Completed Within 24 Hours of Discharge
% Patients Discharged On The Same Day As Admission (excluding daycase)
Bed Occupancy Rate (G&A)
Core Mandatory Training Compliance Rate
Duty of Candour Rate
Medical Staff 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
Complaints Responded to on time
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
PADR Rate
Percentage Under 18 Weeks Incomplete RTT Pathways*
Turnover Rate
Venous Thromboembolism (VTE) Risk Assessment Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
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		% Patients Discharged On The Same Day As Admission (excluding daycase) Duty of Candour Rate Medical Staff PADR Rate Unregistered Nurse Vacancy Rate Trustwide Vacancy Rate	Outpatient Did Not Attend (DNA) Rate Number of Incomplete RTT pathways 52 weeks* Venous Thromboembolism (VTE) Risk Assessment Rate PADR Rate Combined AfC and Medical Staff PADR Rate
		L			
	Common Cause			% Discharge Letters Completed Within 24 Hours of Discharge Bed Occupancy Rate (G&A) % of Extended Stay Patients 21+ days Inpatient Elective Average Length Of Stay Inpatient Non Elective Average Length Of Stay Complaints Responded to on time	% 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* 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	Core Mandatory Training Compliance Rate Role Specific Mandatory Training Compliance Rate Registered Nurse Vacancy Rate Medical Vacancy Rate	Number of Overdue Follow Up Appointments (Non RTT) 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
		L			

Scorecard - Access and Flow

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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Planned	% Under 18 Weeks Incomplete RTT Pathways*	Feb 2023	64.7%	92.0%	Alert	L	SPCFailing
	Number of Incomplete RTT pathways 52 weeks*	Feb 2023	511	0	Alert	L	SPCFailing
	Total Inpatient Waiting List Size	Feb 2023	11,878	11,563	Alert	H	SPCPassing
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Feb 2023	33.3%	1.0%	Alert		SPCFailing
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Feb 2023	30,413	9,000	Alert	H	SPCFailing
	Outpatient Did Not Attend (DNA) Rate	Feb 2023	6.3%	5.00%	Alert	L	SPCFailing
	% Outpatient Non Face To Face Attendances	Feb 2023	26.7%	25.00%	Alert	L	SPCPassing
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Feb 2023	56.6%	85.0%	Alert		SPCFailing
	Cancer Waiting Times - 104+ Days Backlog*	Feb 2023	40	0	Alert		SPCFailing
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Feb 2023	33.3%	75.0%	Alert		SPCFailing
	Cancer - Request To Test In 14 Days*	Feb 2023	82.2%	100.0%	Alert		SPCFailing
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Feb 2023	55.8%	95.0%	Alert		SPCFailing
	Number Of Emergency Department Attendances	Feb 2023	11,697	No Target			n/a
	Ambulance Handover Delays - Number 60+ Minutes	Feb 2023	837	0	Alert		SPCFailing
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Feb 2023	780	0	Alert	H	SPCFailing
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Feb 2023	488	0	Alert	H	SPCFailing
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Feb 2023	43.2%	40.0%		H	SPCVariation
	% of Extended Stay Patients 21+ days	Feb 2023	13.5%	12.0%			SPCVariation
	Inpatient Elective Average Length Of Stay	Feb 2023	1.9	2.5			SPCVariation
	Inpatient Non Elective Average Length Of Stay	Feb 2023	3.7	3.9			SPCVariation
	Number of Medical Patients Occupying Non-Medical Wards	Feb 2023	344	No Target	Alert	H	n/a
	% Discharge Letters Completed Within 24 Hours of Discharge	Feb 2023	87.8%	90.0%			SPCVariation
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Feb 2023	16.8%	30.0%	Alert		SPCFailing
	Bed Occupancy Rate (G&A)	Feb 2023	91.8%	92.0%			SPCVariation
COVID	Number of COVID patients in ICU beds (Monthly)	Feb 2023	2	No Target		L	n/a
	Number of COVID patients in other beds (Monthly)	Feb 2023	176	No Target			n/a
	% COVID staff absences (Monthly)	Feb 2023	13.4%	No Target			n/a

Scorecard - Quality and Safety

NHS Northern Lincolnshire and Goole NHS Foundation Trust

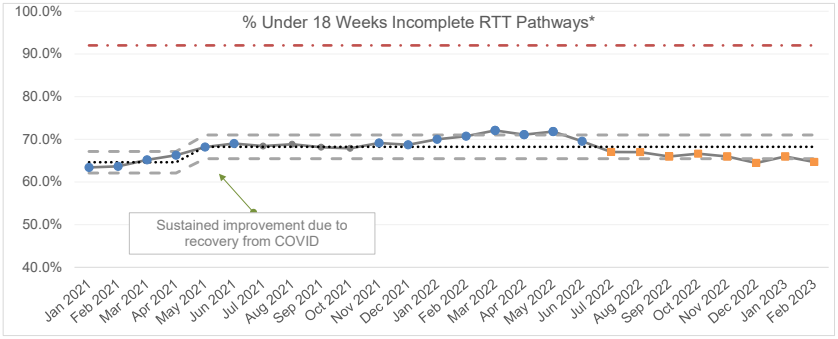
Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
n/a is stated when 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)*	Jan 2023	0.00	see analysis			n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Jan 2023	0.34	see analysis			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Jan 2023	0.00	see analysis	**Highlight**	L	n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Jan 2023	0.05	see analysis			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Jan 2023	0.49	see analysis			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Sep 2022	98.9	As expected		L	As expected
	Summary Hospital level Mortality Indicator (SHMI)	Sep 2022	102.5	As expected		L	As expected
Safe Care	Patient Safety Alerts actioned by specified deadlines	Jan 2023	50%	50%	**Alert**	L	n/a
	Number of Serious Incidents raised in month	Jan 2023	12	No target			n/a
	Occurrence of 'Never Events' *(Number)*	Jan 2023	0	0		n/a	n/a
	Duty of Candour Rate	Jan 2023	100%	100%		H	?
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Jan 2023	4.4	No target	**Highlight**	L	n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Jan 2023	4.9	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Feb 2023	96.1%	95.0%	**Alert**	H	F
	Care Hours Per Patient Day (CHPPD)	Jan 2023	8.6	No target			n/a
	Mixed Sex Accommodation Breaches	Jan 2023	6	0		n/a	n/a
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Dec 2022	5.3	No target			n/a
	Complaints Responded to on time	Dec 2022	79.0%	85.0%			?
	Friends and Family Test (FFT)						
	Number of Positive Inpatient Scores	Jan 2023	478 out of 510	No target		n/a	n/a
	Number of Positive A&E Scores	Jan 2023	235 out of 307	No target		n/a	n/a
	Number of Positive Community Scores	Jan 2023	59 out of 62	No target		n/a	n/a
	Number of Positive Outpatient Scores	Jan 2023	188 out of 201	No target		n/a	n/a
	Number of Positive Maternity Antenatal Scores	Jan 2023	22 out of 25	No target		n/a	n/a
	Number of Positive Maternity Birth Scores	Jan 2023	24 out of 24	No target		n/a	n/a
	Number of Positive Maternity Post-Natal Scores	Jan 2023	1 out of 1	No target		n/a	n/a
	Number of Positive Maternity Ward Scores	Jan 2023	44 out of 49	No target		n/a	n/a

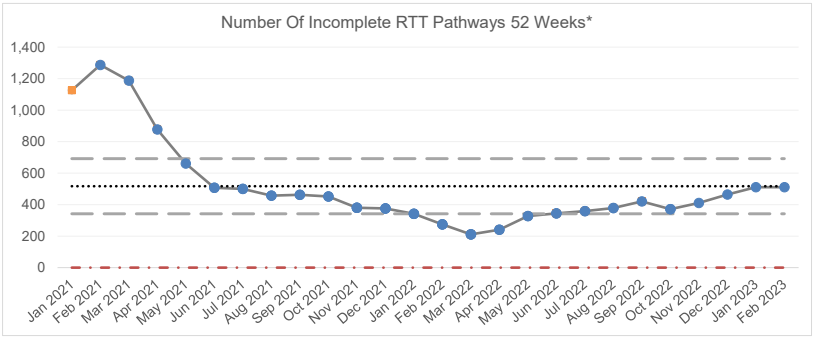
Scorecard - Workforce

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.

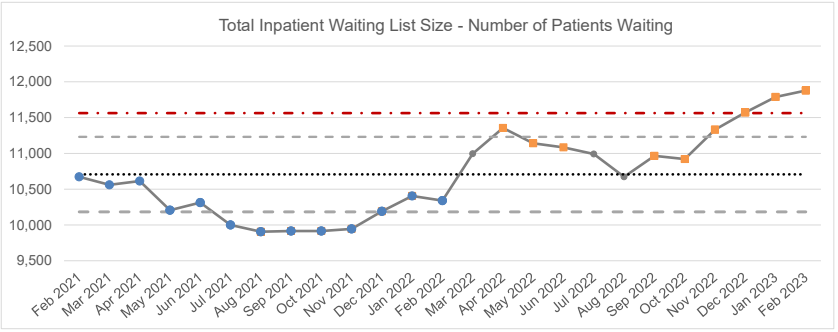
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate	Jan 2023	13.3%	8.0%	Highlight		
	Registered Nurse Vacancy Rate	Jan 2023	12.8%	8.0%	Alert		
	Medical Vacancy Rate	Jan 2023	14.5%	15.0%	Alert		
	Trustwide Vacancy Rate	Jan 2023	11.4%	8.0%	Highlight		
Staffing Levels	Turnover Rate	Feb 2023	11.7%	10.0%	Alert		
	Sickness Rate	Jan 2023	5.6%	4.1%	Alert		
Staff Development	PADR Rate	Feb 2023	83.0%	85.0%	Alert		
	Medical Staff PADR Rate	Feb 2023	91.0%	85.0%	Highlight		
	Combined AfC and Medical Staff PADR Rate	Feb 2023	83.7%	85.0%	Alert		
	Core Mandatory Training Compliance Rate	Feb 2023	89.0%	90.0%	Alert		
	Role Specific Mandatory Training Compliance Rate	Feb 2023	75.0%	80.0%	Alert		



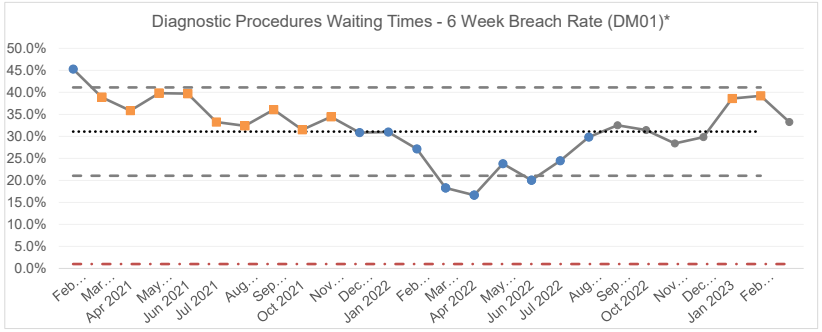
Feb 2023	Target	Variance	Assurance
64.7%	92.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target



Feb 2023	Target	Variance	Assurance
511	0	Special cause of improving nature or lower pressure due to lower values	Consistently falling short of the target



Feb 2023	Target	Variance	Assurance
11,878	11,563	Special cause of concerning nature or higher pressure due to higher values	Consistently passing the target



Feb 2023	Target	Variance	Assurance
33.3%	1.0%	Common cause - no significant change	Consistently falling short of the target

Data Analysis:

Under 18 weeks incomplete*: Following a period of improvement, the trend is showing special cause concern for the last 8 months. 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 gradually increased over the past year, however continues to show sustained 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: The number of patients on the waiting list over the past 10 months has increased and variance is showing special cause concern, with the last three months breaching the national target. The indicator can reliably be expected to meet the target.

Diagnostics 6 Week Wait (DM01)*: Performance remains within the expected range, with the last 3 months' data sitting between the mean and the upper process limit. Data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

- Increased 52 week waits
- Consultant workforce vacancies in Cardiology, Gastroenterology and Respiratory
- The division continue to balance the risk of patient flow 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 and sickness, vacancy and leave position (SGH Anaesthetics)
- Diagnostic Demand is greater than capacity
- Increase in cancer demand and unplanned care demand impacting on diagnostic performance
- OPEL 4 status

Key Risks:

- Increased levels of Acute/unplanned activity affecting delivery of scheduled elective activity
- Potential further COVID waves and staff sickness
- Unable to mitigate the activity gaps of tenders not being realised in ENT and Ophthalmology
- Theatre nurse staffing vacancy, retention and high sickness rates
- Risk to 78+ week wait RTT position for March 2023 due to on going acceptance of Mutual Aid from York and HUTH
- Ability to reach diagnsotic performance targets

Actions:

- Working towards to reviewing RTT 35 weeks in some specialties (March 23)
- Ongoing use of the Independent Sector (March 23)
- Recovery aided with additional sessions by NLaG clinicians (March 2023)
- Continue to utilise St Hugh's for new patients for Ophthalmology and General Surgery when waiting lists allow (March 23)
- Robust recruitment plan for theatres with external company (July 23)
- HIT Theatres completed but further actions required to embed changes in some specialties (June 23)
- Paediatric Service review & patient flow review to take place including C&D analysis of outpatients, elective and non elective pathways inc ward attenders (April 2023)

Mitigations:

- Robust processes in place to regularly review waiting lists and focus on long waiting and high risk patients.
- Locum staff in place where able to secure
- Weekly assurance that on the planning numbers we continue to see a reduction in longer waiters and movement towards constitutional standards
- Clinical risk stratifiation to ensure allocation of appointments, including pre-anaesthetic assessment is led by clinical priority of patients
- Escalation route for diagnostic risks in place

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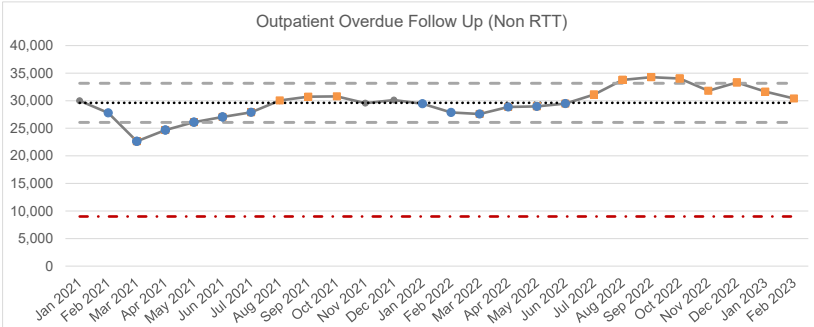
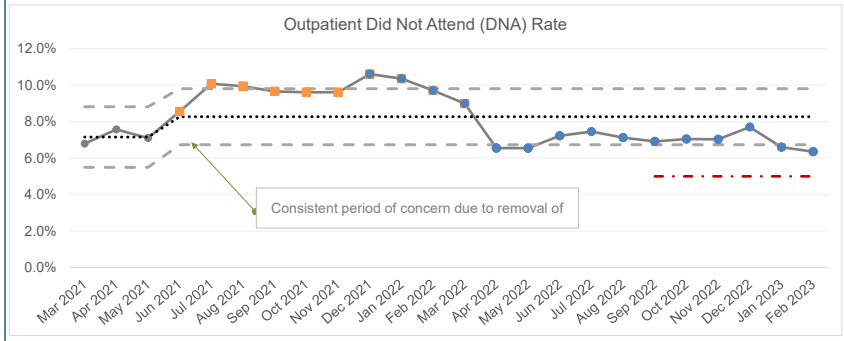
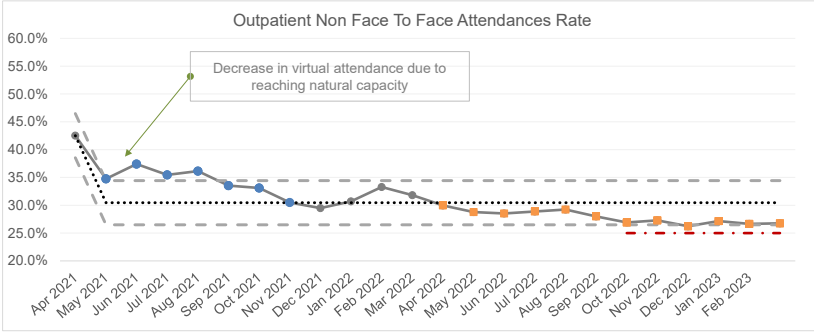


Feb 2023	Target	Variance	Assurance
30,413	9,000	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target



Feb 2023	Target	Variance	Assurance
6.3%	5.0%	Special cause of improving nature or lower pressure due to lower values	Consistently falling short of the target



Feb 2023	Target	Variance	Assurance
26.7%	25.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently passing the target

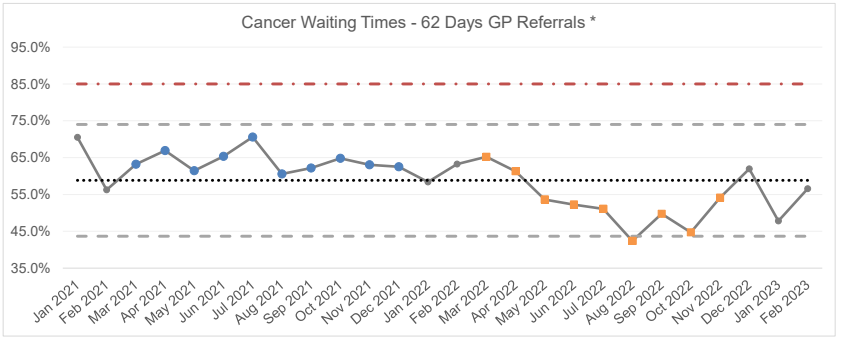
Data Analysis:
Outpatient Overdue follow up: Performance has recorded concern for the past 8 months. For the last 2 years the indicator has consistently failed the target of 9,000 by some margin. Current data indicates that the target will not be met without action, planned actions outlined below.
Outpatient DNA rate: Process limit recalculation from June 21. Following a period of concern, the indicator has recorded improvement for over a year. The target of 5% commenced in 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 a year, registering special cause concern. However, performance is reliably achieving the ICS target. Local target is 32% by end March 2023.

Challenges:
- Balance between delivering sufficient capacity to esure reduction in overdue follow ups and the requirement to reduce follow ups by 25%
- The number of patients put on a PIFU pathway is significantly under the 5% target
- System financing models are not conducive to system working with funding arrangements for the CHN model post 22-23 financial year remains challenging

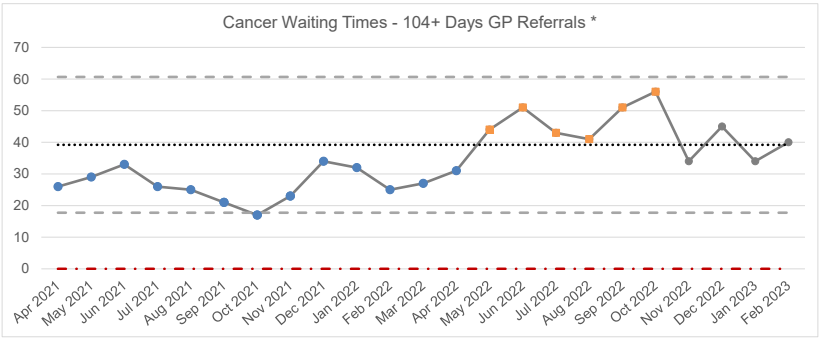
Key Risks:
- Increased levels of unplanned activity affecting delivery of scheduled elective activity
- Clinical buy-in across some specialities to embed PIFU as standard clinical practice
- Inability to secure a long-term finance model for CHN when pump prime funding expires from March 2023. There is a risk that lack of resource would initiate premature closure of the project
- There is significant risk as regards the follow up backlog unless there is significant focus on changing traditional models of working through embracing PIFU as part of the patient's pathway, adoption of A&G and ensuring patients are discharged where there is no clear benefit from a follow up appointment

Actions:
- Targeted work with specialties to increase the number of patients on a PIFU pathway in line with expected Trajectory (March 23)
- Further collaborative work with Primary Care Networks (March 23)
- Heart Failure at home being trialled as part of PKB in Cardiology (March 23)
- Deep dive into DNA - Further analysis underway on those patients who persistently DNA/Cancel their appointment (April 23)
- Working with Clinical Leads to engage all speciality leads to include PIFU in pathways where clinically appropriate (March 23)
- GIRFT Clinically led Outpatient Guidance is being evaluated against recommended specialities. When evaluation is completed, gaps will be identified and specialiity plans developed to implement changes to working practice where recommended (June 23)
- Paediatric Service review & patient flow review to take place including C&D analysis of outpatients, elective and non elective pathways inc ward attenders (April 2023)

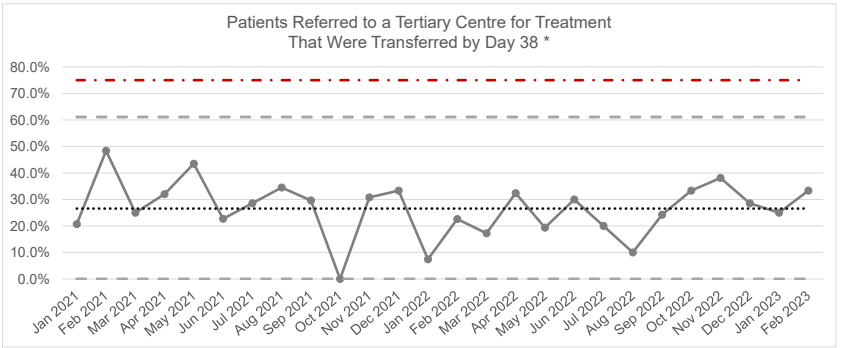
Mitigations:
- Clinicians engaged with following the access policy with regards to DNAs
- Specialty Level trajectories for achieving a reduction in the backlog of overdue follow ups, increasing PIFU numbers and improved response times to A&G in the Business Planning for 23-24
- Director of Place at North LIncs is co-ordinating a group to try and secure funding to support the CHN Model from March 2023 onwards



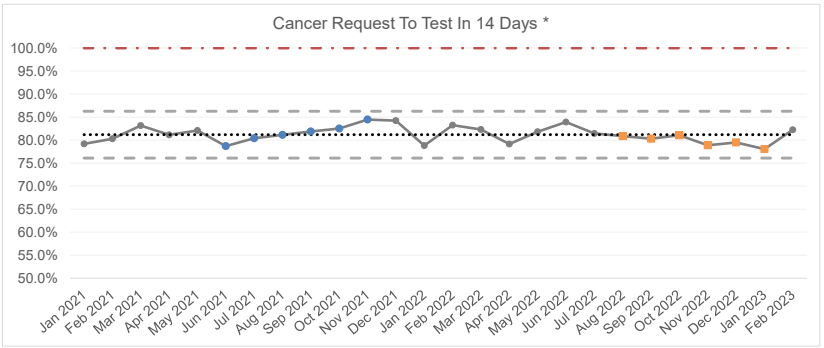
Feb 2023	Target	Variance	Assurance
56.6%	85.0%	Common cause - no significant change	Consistently falling short of the target



Feb 2023	Target	Variance	Assurance
40	0	Common cause - no significant change	Consistently falling short of the target



Feb 2023	Target	Variance	Assurance
33.3%	75.0%	Common cause - no significant change	Consistently falling short of the target



Feb 2023	Target	Variance	Assurance
82.2%	100.0%	Common cause - no significant change	Consistently falling short of the target

Data Analysis:

62 days GP referral*: Performance has shown a broadly decreasing trend for the last year, sitting below the mean for 9 of those months. 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*: Performance has varied within the process limits for the last 2 years, however data points for the last 4 months are sitting close to the mean. The indicator is consistently failing the target and current data indicates that the target will not be met without action, planned actions outlined

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. The 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 (62 day pathways)
- UpperGI and Colorectal referrals is a challenge but the teams are working to improve to ensure the right patients receive the diagnostics required
- 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, patient choice.
- Notable increase in Urological Cancer referrals over last 3 months and increase in 62 day breaches due to TURBT no longer being classed nationally as a first treatment.

Key Risks:

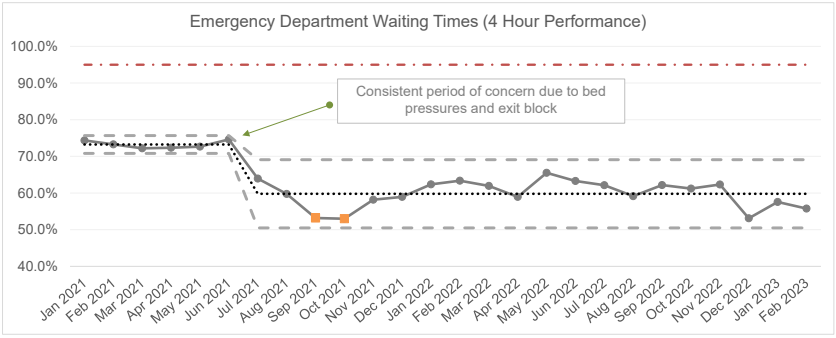
- There are a number of issues related to visiting consultant services (e.g urology, oncology), tertiary based staging scans (EUS, PET CT) which affect the ability to transfer (IPT) for treatment by Day 38 - when pts transfering to HUTH.
- Request to test (14 days) - in order to meet 28 day Faster Diagnosis 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
- For UpperGI and Head & Neck surgery is carried out in Hull which is currently causing significant delay
- Covid +
- One Clinician at SGH running STT UGI service - manageable as small numbers but during leave and sickness leaves service vulnerable
- HUTH have relocated Urology oncologist to Breast, which is causing a significant risk to waiting times

Actions:

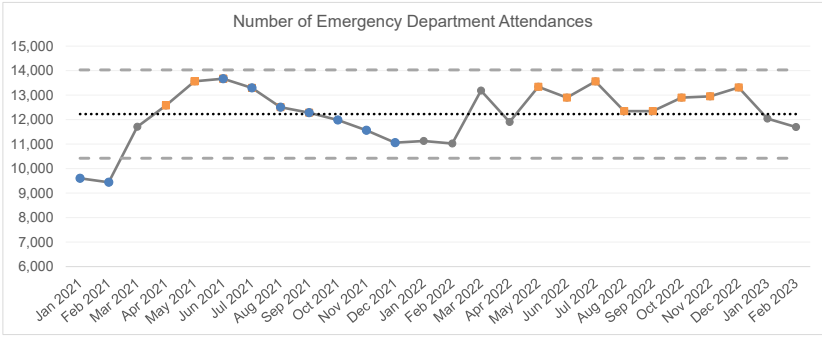
- UpperGI - consultant led straight to test delayed but expected to commence soon (June 23)
- Single Lung MDT with HUTH & NLaG (June 23)
- Timely removal of patients from cancer tracking once non-malignancy confirmed - further targetted daily actions by Cancer Trackers / Service Managers (March 23)
- Colorectal recovery plan in place with improvements already seen to 28 day faster diagnosis pathway - further actions to be implemented with all short and medium term actions (March 23)
- Urology service review completed with additional one stop clinics introduced - impact on pathways being monitored over the next 8 weeks (March 23)
- Redesign Family Services outpatient cancer 2ww capacity to match Capacity & Demand forecast (Apr 23)

Mitigations:

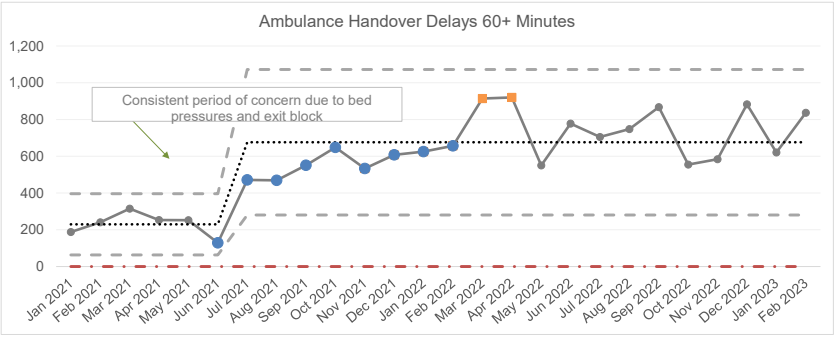
- 62 day performance is being reviewed and managed weekly
- Cancer Improvement Plans developed
- The pathway analyser tool that has been developed within NLAG (using the IST tool) and the in depth analysis of pathways will enable teams to identify where improvements in NLAG can be achieved.
- The joint 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
- Micro-management of the completion of cancer packs with any incomplete after 5 working days - this is escalated to Quad level to resolve with clinicians
- Funding approved to recruit to Band 3 and Band 2 admin support
- Urology agency consultant currently in post to support the cancer work until cancer consultant fully returned.



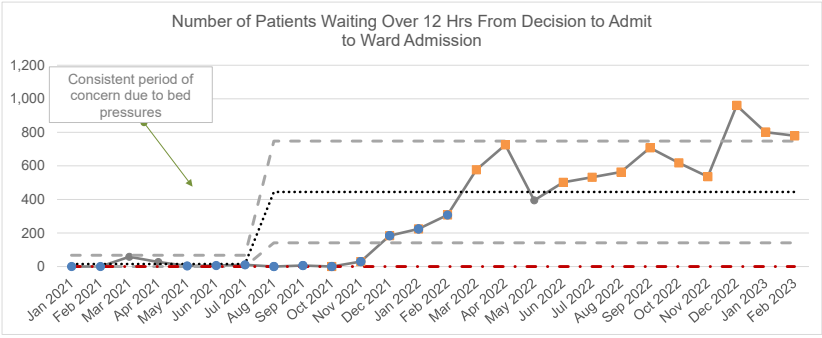
Feb 2023
55.8%
Target
95.0%
Variance
Common cause - no significant change
Assurance
F
Consistently falling short of the target



Feb 2023
11,697
Target
No Target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant



Feb 2023
837
Target
0
Variance
Common cause - no significant change
Assurance
F
Consistently falling short of the target



Feb 2023
780
Target
0
Variance
H
Special cause of concerning nature or higher pressure due to higher values
Assurance
F
Consistently falling short of the target

Data Analysis:

ED 4 hour waiting: Following the significant deterioration in the summer of 2021, 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: Following performance moving closer to the upper range of the data in 2022 due to an increased number of attendances, 2023 data shows a return to the mean.

Ambulance handover 60+ minutes: Process limits re-calculated from July 21. Performance remains 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, with the past 3 months exceeding the upper process limit. 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
- SDEC regularly running at full capacity.
- Funding currently unavailable to increase the Urgent Care Service to 24hours a day

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
- The current substantive SDEC staffing establishment does not meet the requirement for the increased service hours in place to support operational activity.

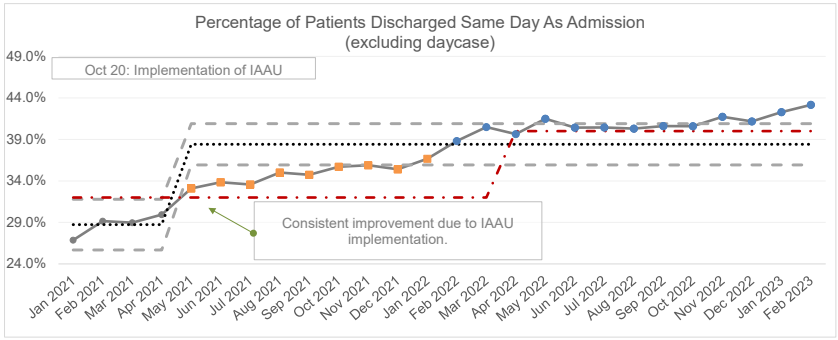
Actions:

- Work continues on the new build increase footprint with SGH New Emergency Department going live (March 23)
- Business Case submitted in relation to extra staffing requirements to support implementation of RAT Model to help imrpve flow and ambulance handover times (April 23)
- Combined Ambulance Handover and Patient Flow Improvement Plan has been produced and presented to parternship agencies (June 23)
- Review of all Urgent Care Services across Northern Lincolnshire has commenced to look at reducing pressure across the system (April 23)
- QI project is being initiated to improve the flow within the department with further work taking place (Oct 23)

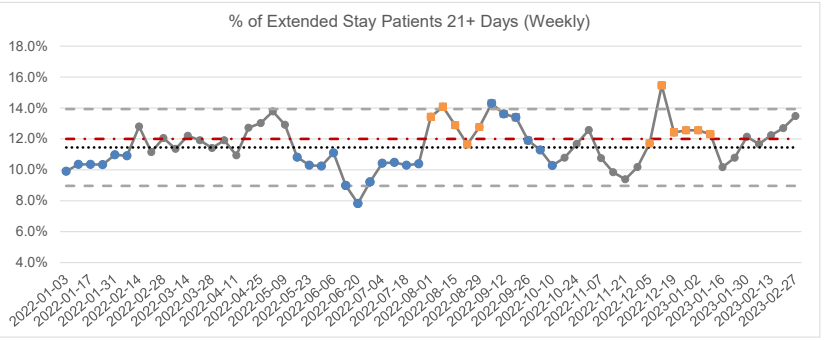
Mitigations:

- Urgent Care System continues to meet performance target
- Senior clinician reviews taking place in ambulances when delays to offloading occur
- 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
- Fast track paediatric process in place and working well
- Increased staffing in ED
- 2 hourly board rounds with EPIC and Clinical Coordinator with nursing care needs monitored through care round document – risk assess for pressure ulcers, falls, nutrition, hydration, comfort
- SDEC NIC attends 08:00 board round to support identification of patients suitable for SDEC and ACP in department from 08:00
- Alternatives to trolleys – beds, recliner chairs
- Funding now approved for SDEC staffing establishment, recruitment ongoing
- Working with Single Point of Access to improve direct referrals to SDEC (GP/EMAS).
- Virtual ward, OPAT and Home first now implemented

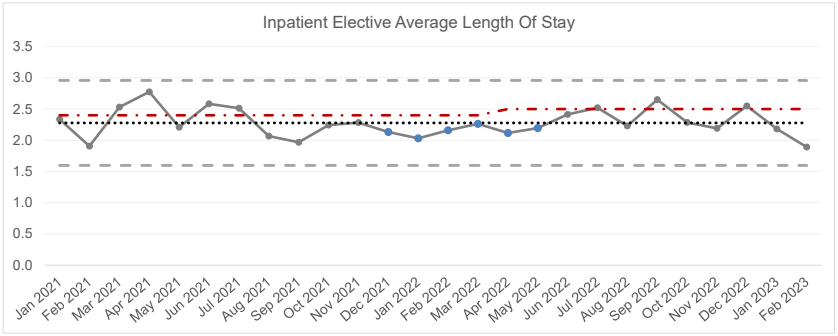
Northern Lincolnshire and Goole NHS Foundation Trust



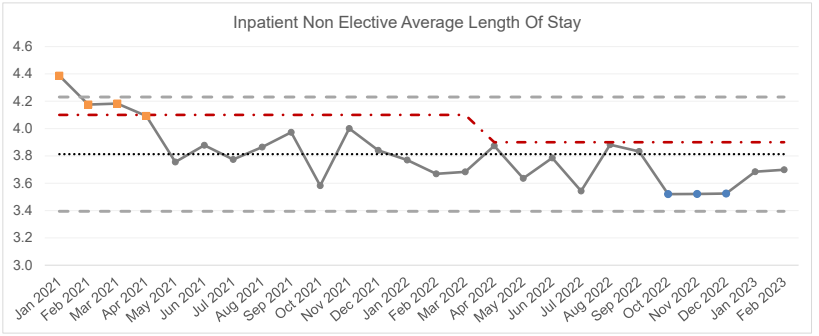
Feb 2023	Target	Variance	Assurance
43.2%	40.0%	Special cause of improving nature or lower pressure due to higher values	Inconsistently hitting passing and falling short of the target



Feb 2023	Target	Variance	Assurance
13.47%	12.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Feb 2023	Target	Variance	Assurance
1.9	2.5	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Feb 2023	Target	Variance	Assurance
3.7	3.9	Common cause - no significant change	Inconsistently hitting passing and falling short of the target

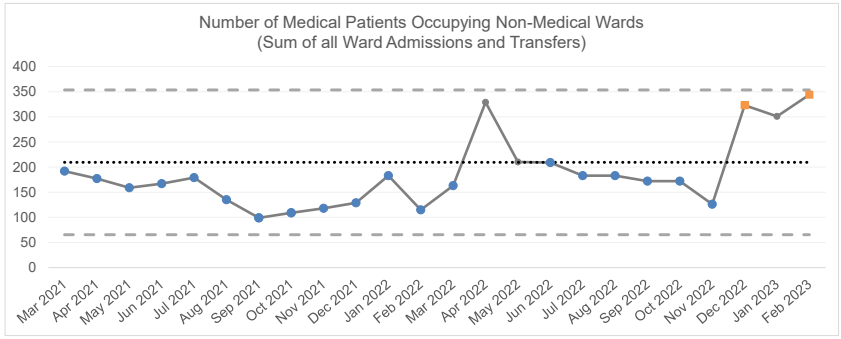
Data Analysis:
Discharged same day as admission: Note: Local target increased from 32% to 42% from April 22. Performance shows sustained improvement with recent data points showing the highest performance since 2020. The target can be expected to achieve and fail at random.
% Extended stay 21+ days: 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 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 shown 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:
- Consultant substantive vacancies
- Increased medical staff sickness
- Covid & IPC constraints remain
- 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 impeded by discharge lounge at DPOW being ustilised as an inpatient area

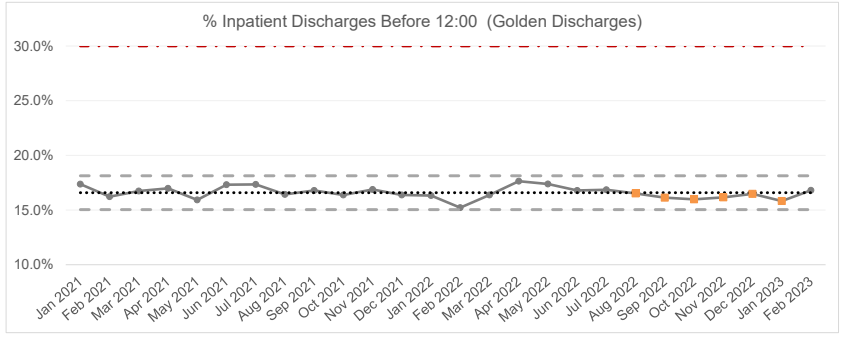
Key Risks:
- Space and capacity issues within SDEC/IAAU
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- Covid-19/Norovirus impacting phsyical capacity within the current footprint
- High acuity levels and patients means more patients require further support on discharge

Actions:
- Review of Demand and Capacity across specialties to quantify current context and identify any imbalances and required remedial action in place (July 23)
- Increase of capacity within OPAT work remains ongoing (June 23)
- System wide action plan in place to support patient flow (June 23)

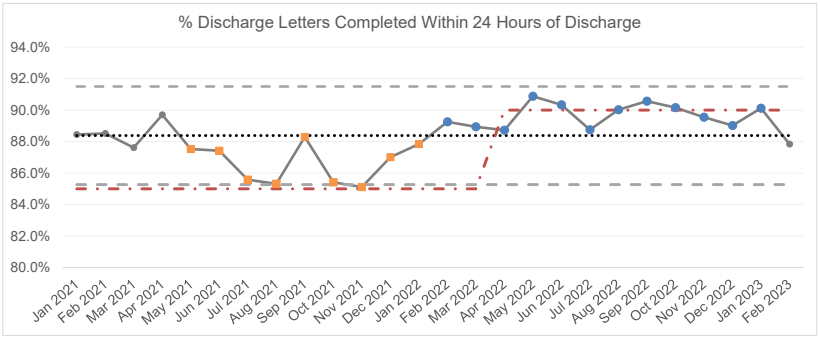
Mitigations:
- Virtual ward, OPAT and Home first now implemented
- Work taking place within care homes to support falls, therapy and training provided within NL, SAFE service now operating direct referrals from UCS & SPA to enable anticipatory/proactive management of frialty
- 2 hour community Response
- Single Point of Access
- Acute and Community joint work group established between Medicine and Community & Therapies
- CRT GP suporting Category 3 & 5 calls
- 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



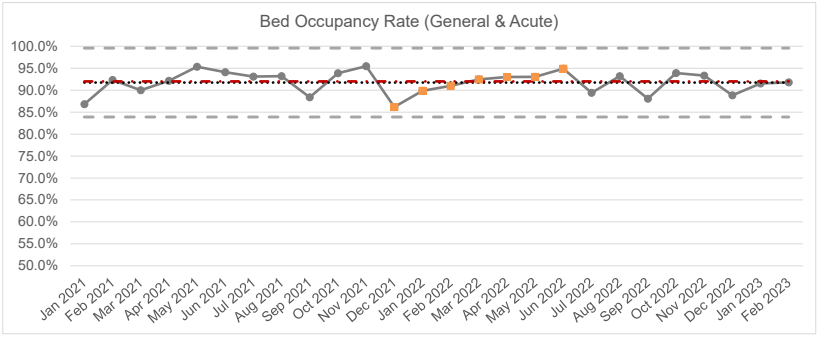
Feb 2023	Target	Variance	Assurance
344	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant



Feb 2023	Target	Variance	Assurance
16.8%	30.0%	Common cause - no significant change	Consistently falling short of the target



Feb 2023	Target	Variance	Assurance
87.8%	90.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Feb 2023	Target	Variance	Assurance
91.8%	92.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target

Data Analysis:
Medical Outliers: Note: The analysis of this indicator is very sensitive to ward re-categorisations including any temporary agreed usage of wards out of usual scope. Following a period of stability, the last 3 months have recorded a sharp increase in numbers which has triggered special cause concern.
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 despite falling below the mean for February 23. The indicator can be expected to achieve and fail the target at random.
Inpatient discharges before 12:00: Performance is currently stable following a 6-month period of special cause concern. 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:
- Consultant substantive vacancies
- Increased medical staff sickness
- Covid & IPC constraints remain
- Exit block due to social care constraints (staffing, interim bed availability, lack of packages of care availability)
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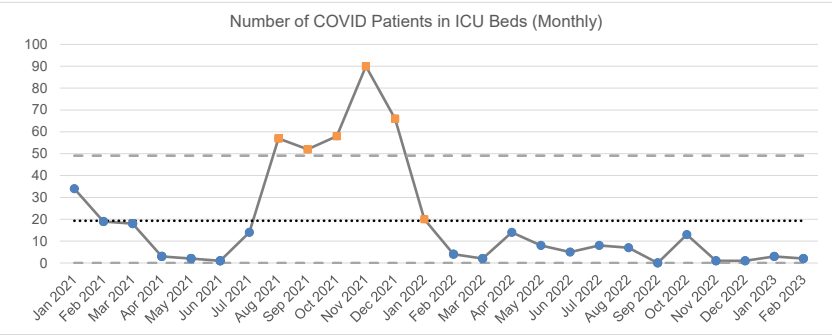
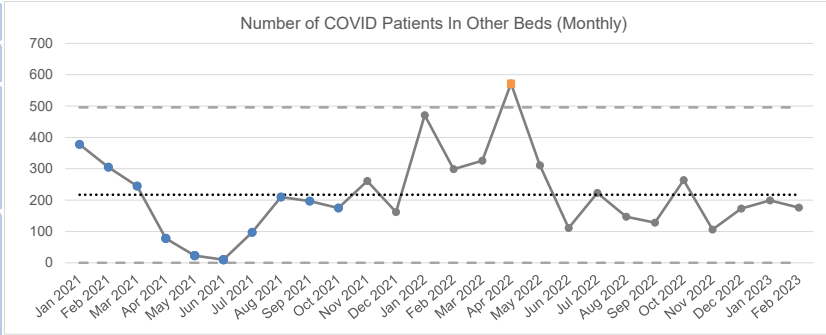
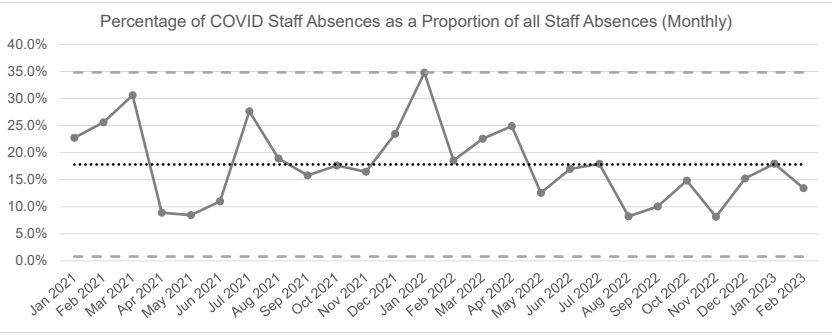


Feb 2023	2
Target	No Target
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	There is no target, therefore target assurance is not relevant



Feb 2023	176
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant



Feb 2023	13.4%
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target, therefore target assurance is not relevant

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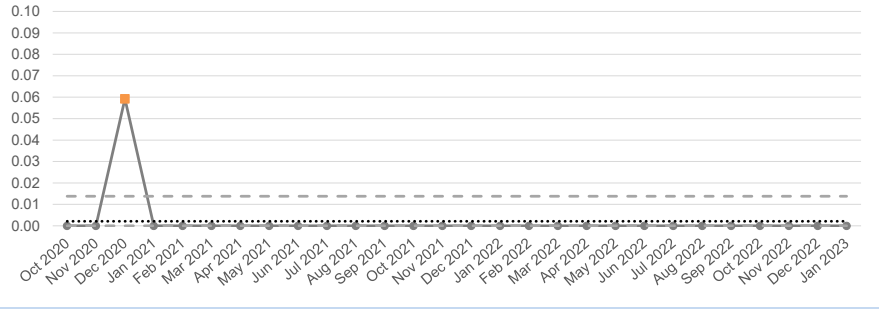
Data Analysis:
COVID Patients In ICU beds: Note: calculations changed to Monthly as of Feb 23. The number of COVID patients in ICU beds has consistently recorded lower than 5 for most of 2022 and remains predominantly at the lower bounds of the process limits for this indicator.
COVID Patients In Other Beds: Note: calculations changed to Monthly as of Feb 23. 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: Note: calculations changed to Monthly as of Jan 23. The rate has been volatile since 2021 with repeated changes between concerning and improving performance. Data for the last 4 months has been approaching the mean, registering no cause for concern.

Challenges:
• Minimal side rooms available within Critical Care
• Flu cases appearing

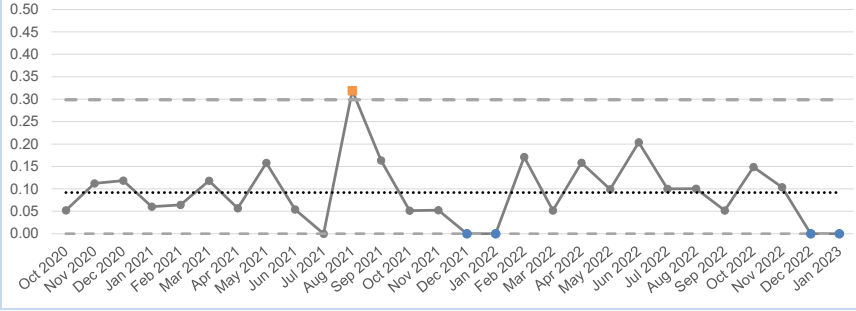
Key Risks:
• Inability to manage high levels of activity within Critical Care

Actions:
• Review Critical Capacity at all OPS meetings, monitor

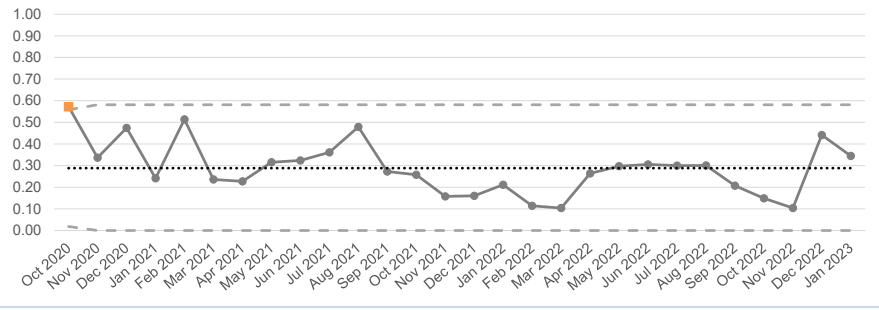
Mitigations:
• Utilise Critical Surge plan



Jan 2023
0.00
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Jan 2023
0.00
*Target
see analysis below
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
There is no target, therefore target assurance is not relevant



Jan 2023
0.34
*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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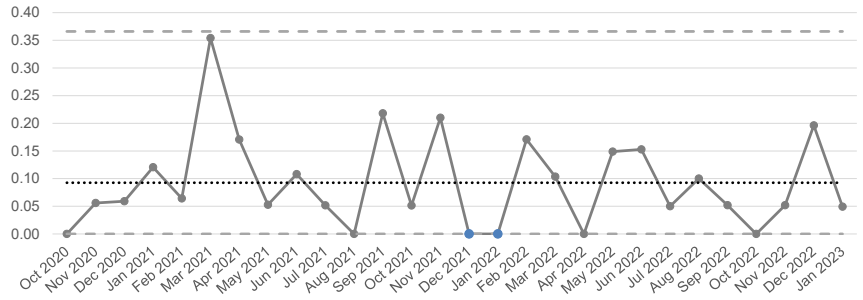
Data Analysis:
MRSA: Performance is stable and within the expected range of the data. The YTD figure is 0 against an annual target of 0.
C Diff: Performance is stable and within the expected range of the data. The YTD figure is 19 against an annual target of 21.
E Coli: Performance is stable and within the expected range of the data. **T**he YTD figure is 54 against an annual target of 65.

Commentary:
Ecoli Bacteraemia numbers as predicted. Cdiff numbers stable

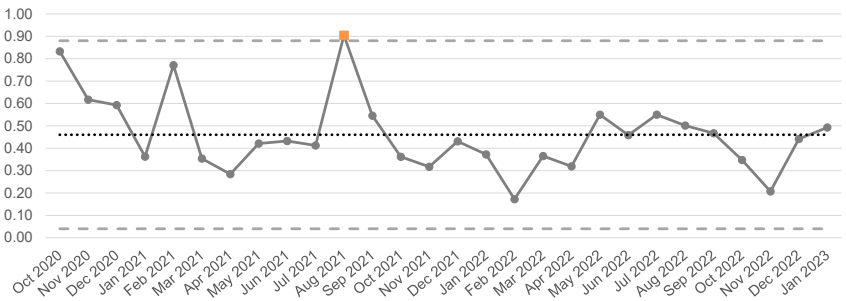
Northern Lincolnshire and Goole NHS Foundation Trust

Number of MSSA Infections (Rate Per 1000 Bed Days)



Jan 2023
0.05
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Number of Gram Negative Infections (Rate Per 1000 Bed Days)



Jan 2023
0.49
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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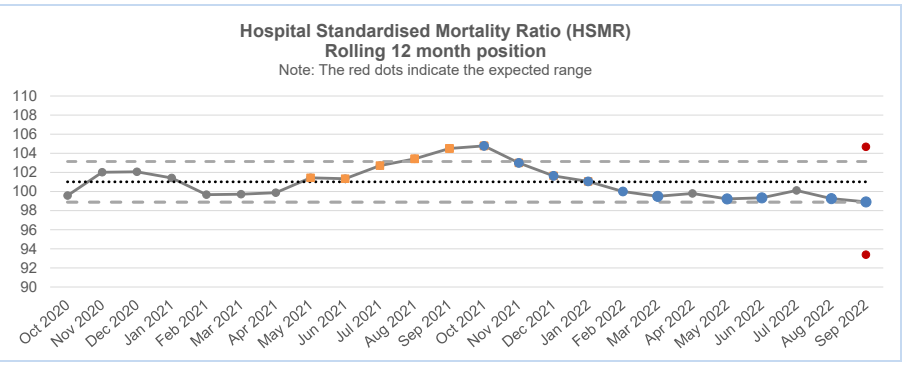
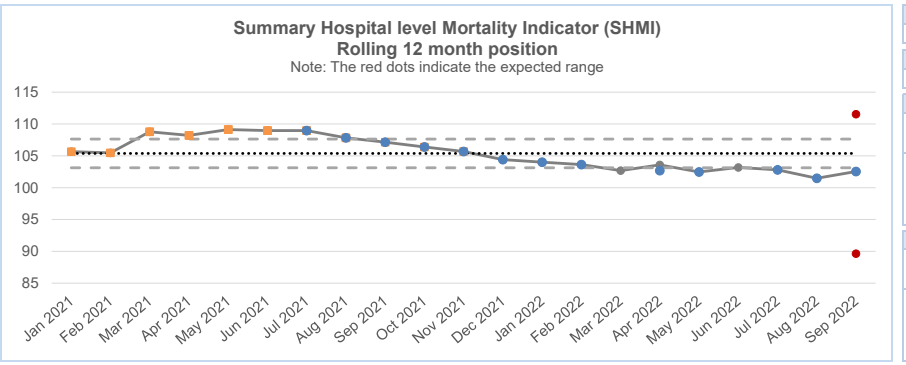
Data Analysis:
MSSA: Performance is stable and within the expected range of the data. The YTD figure is 16, there is no annual target.
Gram Neg: Performance is stable and within the expected range of the data. The YTD figure is 86 against an annual target of 97.

Commentary:
MSSA and Gram Negative Bacteraemia numbers are as expected



Sep 2022
98.9
Target
As expected
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Within 'as expected' range



Sep 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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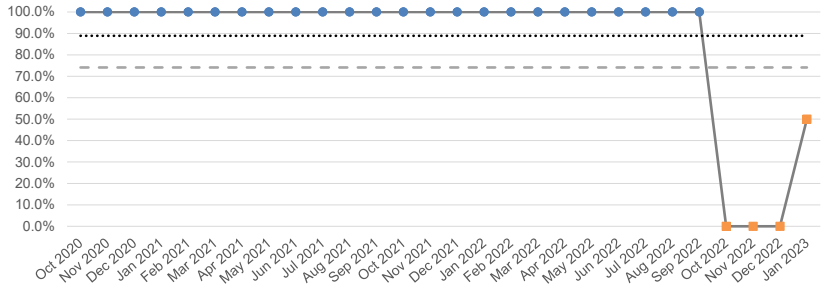
Data Analysis:
HSMR: Our contract with HED has come to an end. Until we have a new supplier it is not possible to update this chart. The data represents a rolling 12 month position.
SHMI: Our contract with HED has come to an end. Until we have a new supplier it is not possible to update this chart. The data represents a rolling 12 month position.

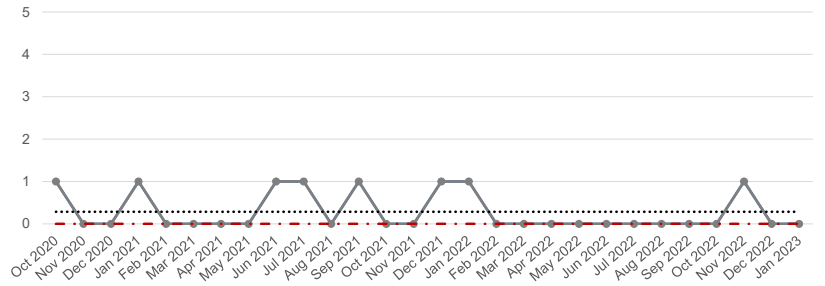
Commentary:
The Trust has a SHMI of 102.79 for the period November 2021 - October 2022, which is in the 'as expected' banding.

Patient Safety Alerts to be actioned by specified deadlines



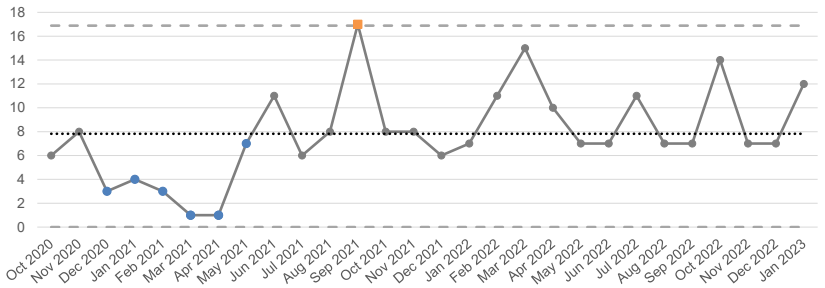
Jan 2023
50.0%
Target
No target
Variance
Special cause of concerning nature or lower pressure due to lower values
Assurance
There is no target therefore target assurance is not relevant

Occurrence of 'Never Events' (Number)



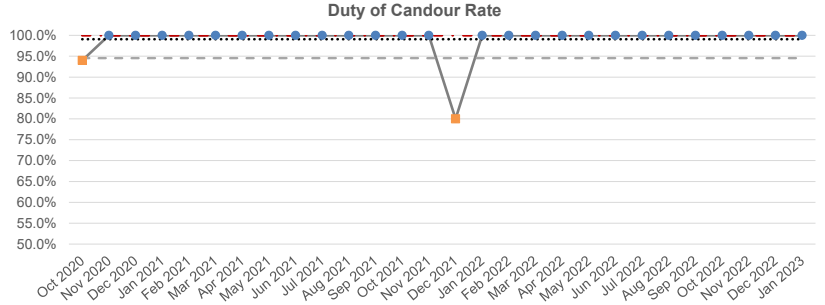
Jan 2023
0
Target
0
Variance
The data are not appropriate for an SPC chart, therefore varaince is not relevant
Assurance
The data are not appropriate for an SPC chart, therefore assurance is not relevant

Number of Serious Incidents Raised in Month



Jan 2023
12
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

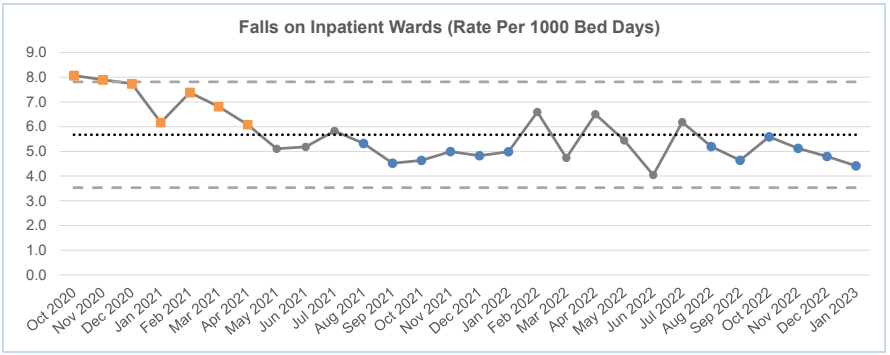
Duty of Candour Rate



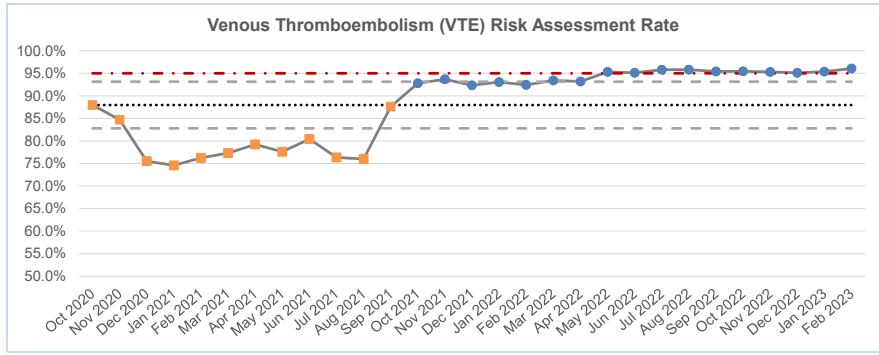
Jan 2023
100.0%
Target
100.0%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target

Data Analysis:
Patient Safety Alerts: Following a sustained period of recording 100%, the past four months figures have deteriorated and as such are recording concern. This suggests a change in process or counting method.
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 more than two years.

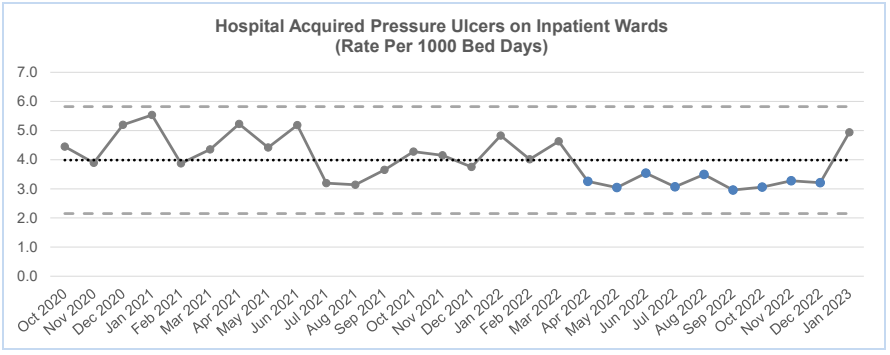
Commentary:
Two National Patient Safety Alerts were issued in January 2023 relating to the use of oxygen cylinders where patients do not have access to medical gas pipelines systems and the supply of licensed and unlicensed epidural infusion bags. An extraordinary Medical Gas Committee was convened in response to the oxygen cylinders alert and all necessary steps were taken to complete the action by the deadline date.
The epidural infusion bags alert had a tight deadline (received on the 23 January and was due for closure by the 27 January) and was the second alert of the month that required input and action from the Pharmacy team. Steps have been taken by the Pharmacy team to address the actions and the products in use and current stock holding have been reviewed to establish the impact of the supply shortage. Alternative products have been selected for use and the associated controlled documents have been reviewed and updated. Web V documents have also been updated with the new drugs. The alert will be closed once the amended controlled documents have gone through the appropriate channels for scrutiny and approval.



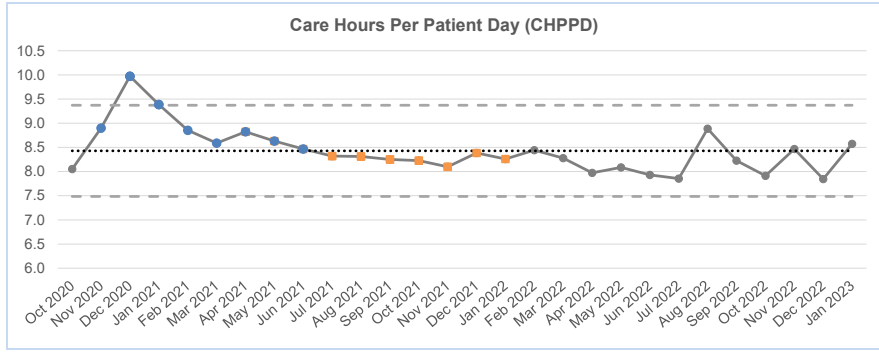
Jan 2023
4.4
Target
No target
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
There is no target therefore target assurance is not relevant



Feb 2023
96.1%
Target
95.0%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Consistently failing the target



Jan 2023
4.9
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

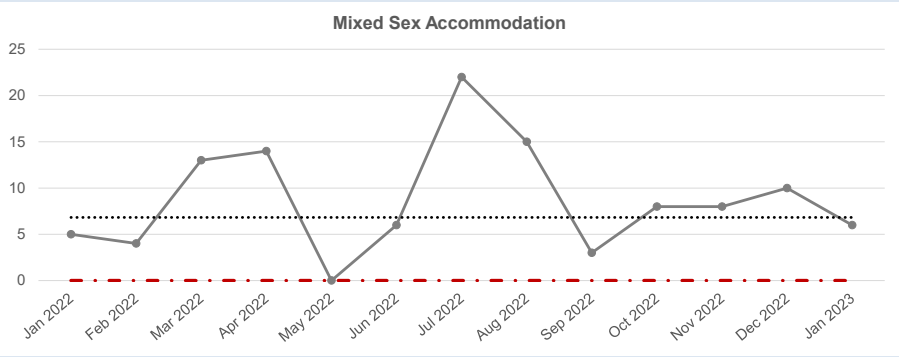


Jan 2023
8.6
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

Data Analysis:
Falls on Inpatient Wards: For the last six months the figures have fallen below the average and as such the indicator is recording improvement.
VTE Risk Assessment: Performance has shown a significant improvement for almost one and a half years. For the past nine months the target has been met. However, more data is needed to provide assurance that the target will consistently be met.
Hospital Acquired Pressure Ulcers: Performance is consistently within the expected range for the data.
Care Hours Per Patient Day: Performance continues within the expected range for the data.

Commentary:
Falls - the number of reported falls continues to demonstrated and improvement.

Hospital Acquired Pressure Ulcers - there was a significant increase in the number of reported pressure ulcers in January 2023. The majority of these were Category 2. A thematic review was completed which identified no new themes or trends. There has been an increase in reported pressure ulcers in January for the previous 2 years which indicates a seasonal trend. The number of reported pressure ulcers has returned to the "as expected" range in February 2023.



Jan 2023	Target	Variance	Assurance
6	0	There is currently insufficient data, therefore variance is not relevant	There is currently insufficient data, therefore assurance is not relevant

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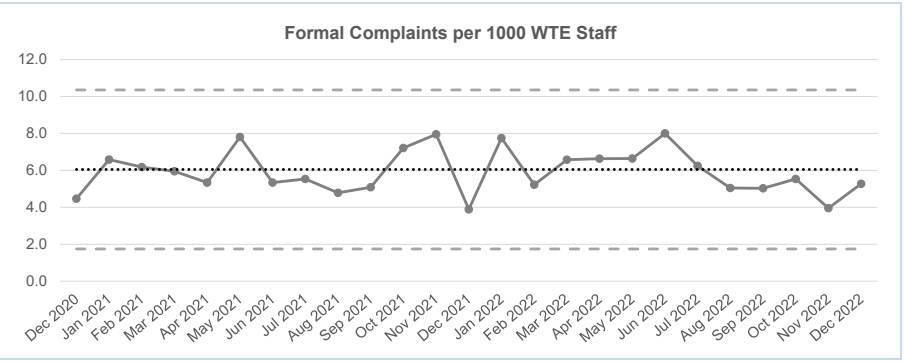
Data Analysis:
Mixed sex accommodation: There is insufficient data for SPC presentation.

Commentary:



Dec 2022	**5.3**
Target	**No target**
Variance	Common cause - no significant change
Assurance	There is no target therefore assurance is not relevant

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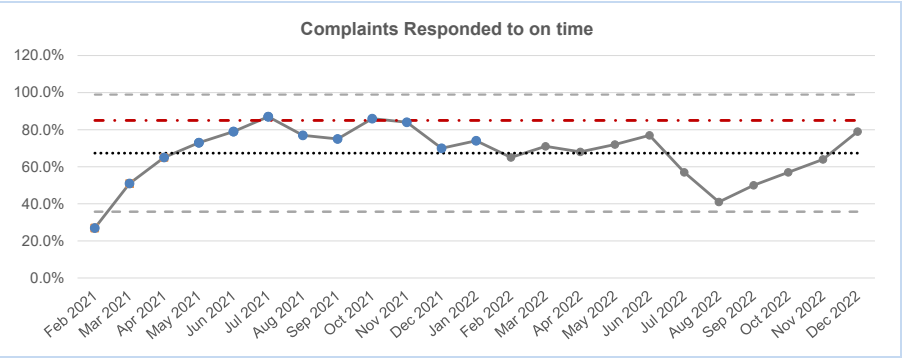

Dec 2022	**79.0%**
Target	**85.0%**
Variance	Common cause - no significant change
Assurance	Inconsistently hitting passing and failing the target

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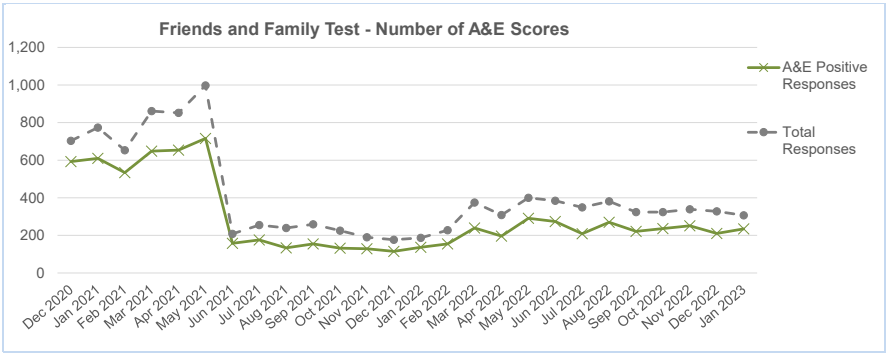
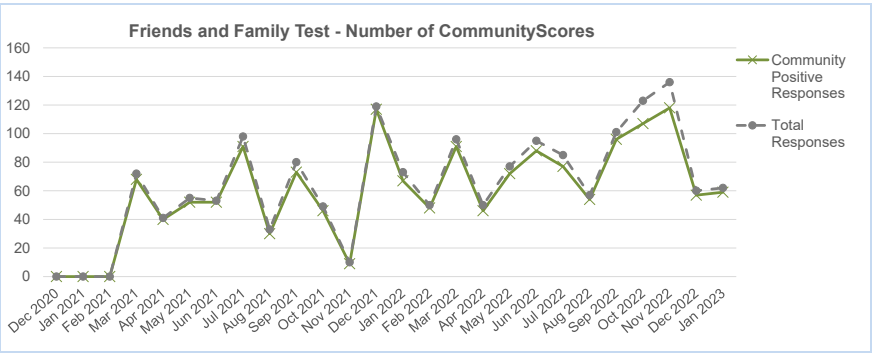
Data Analysis:
Formal Complaints: The data continues within the expected range.
Complaints Responded to on time: The data continues within the expected range but is consistently failing the target. Current data indicates that the target will not be met without action, planned actions outlined below.

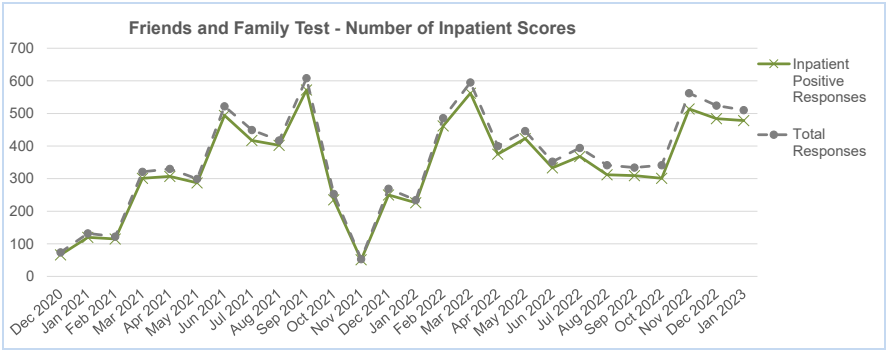
Commentary:
Progress
> Responses in timescales have recovered from Q2 decrease.
> Temp PALs Manager providing opportunity for Complaint Manager to focus just on formal complaints
> Delays in development of learning module in Ullysses continue due to lack of inhouse specialist resource ,all requests going through company
> Caseload management tool now reinstated
Risks
> Increased time required by clinical staff to manage complex complaint investigations remains an ongoing concern
> Sustained compliance against KPI of 85% closed complaints managed in timescale , ongoing risk
> Reputational risk to Trust , ongoing risk
Mitigation
> Weekly Central Team Support and Challenge Meetings
> Chief Nurse Reporting
> PRIMS
> Monthly and weekly complaint report and feedback
> Escalation processes
> Divisional meetings with PALs and Complaint Manager
> Learning in all upheld complaints



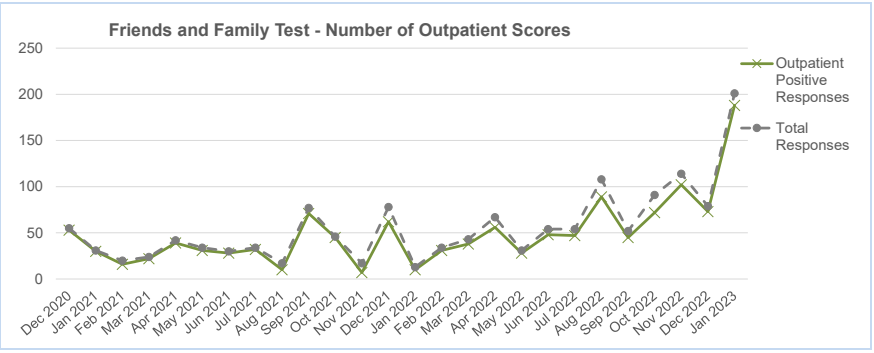
Jan 2023
235 out of 307
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jan 2023
59 out of 62
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jan 2023
478 out of 510
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



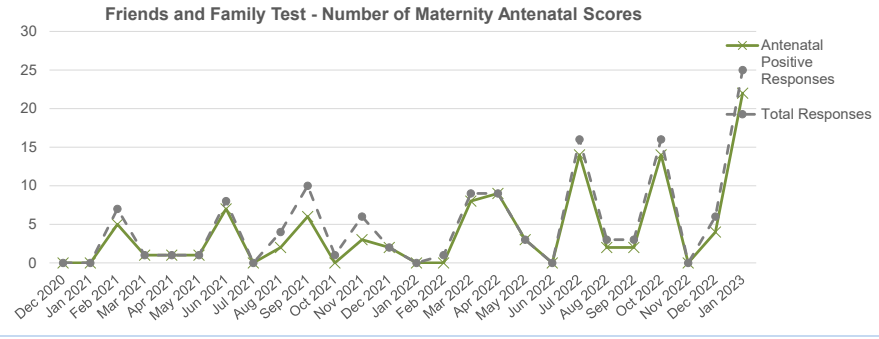
Jan 2023
188 out of 201
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

Data Analysis:
A&E FFT: The majority of respondents continue to provide positive feedback.
Community FFT: The majority of respondents continue to provide positive feedback.
Inpatient FFT: The majority of respondents continue to provide positive feedback.
Outpatient FFT: The majority of respondents continue to provide positive feedback.

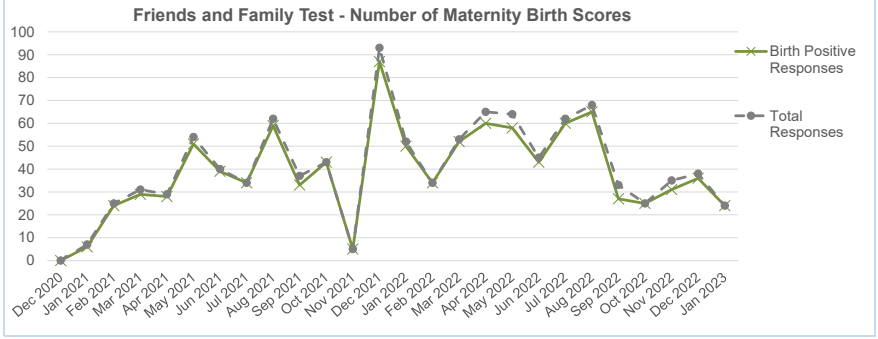
Commentary:
Progress
> Lack of consistent improvements in responses across Trust
> PE Manager exploring data accuracy and collection methods - survey streamlining request to be made
> Patient Experience Manager undertaking engagement meetings with ward managers/dept leads as ongoing part of role

Risks
> Temporary Patient Experience Manager post due to complete March 31st 2023
> Increased clinical activity and priorities means that FFT conversations are challenging
> 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

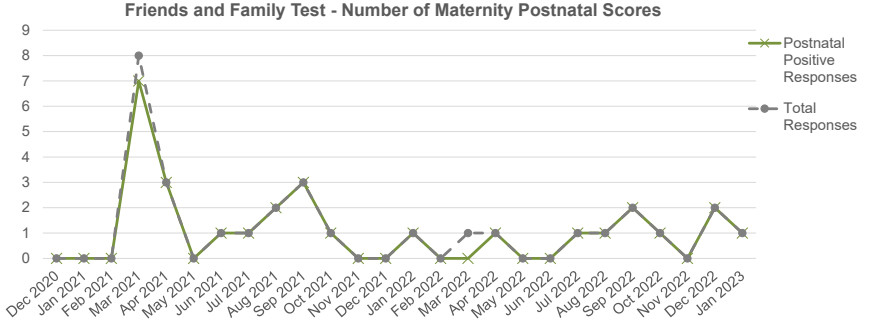
Mitigation
> Weekly meetings with IWGC
> Temporary Patient Experience Manager has priorities
> Divisional Patient Experience Meetings highlighting issues
> Quarterly Divisional reported shared with PEG
> Utilisation of new patient experience dashboard to share FFT data divisionally via Metrics
> Wisespread access across all areas for aptients to leave feedback , including trust websites and social media



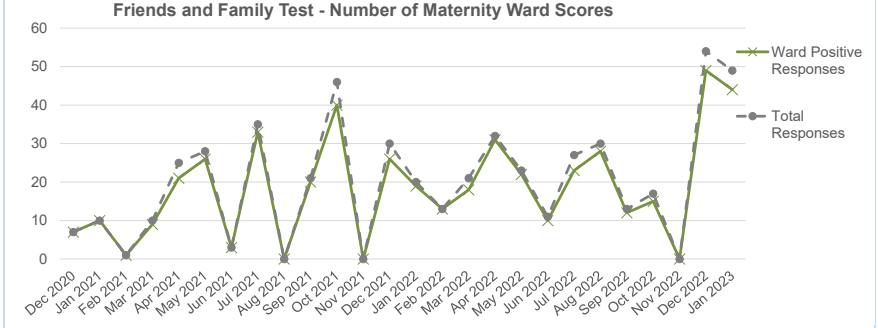
Jan 2023
22 out of 25
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jan 2023
24 out of 24
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jan 2023
1 out of 1
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Jan 2023
44 out of 49
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

Data Analysis:

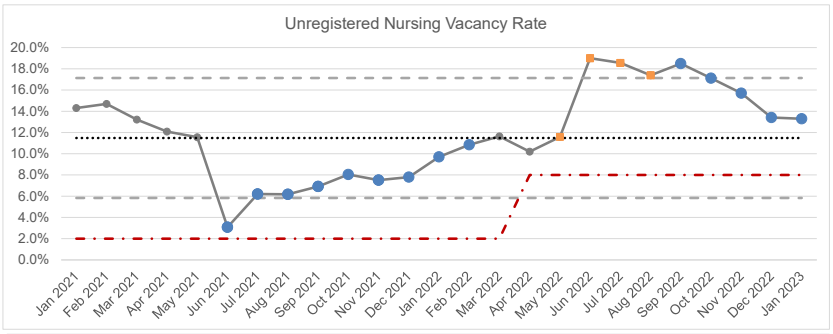
Maternity Antenatal FFT: The majority of respondents continue to provide positive feedback.
Maternity Birth FFT: The majority of respondents continue to provide positive feedback.
Maternity Postnatal FFT: All respondents for the past 10 months have recorded positive feedback. However, survey uptake is low.
Maternity Ward FFT: The majority of respondents continue to provide positive feedback.

Commentary:

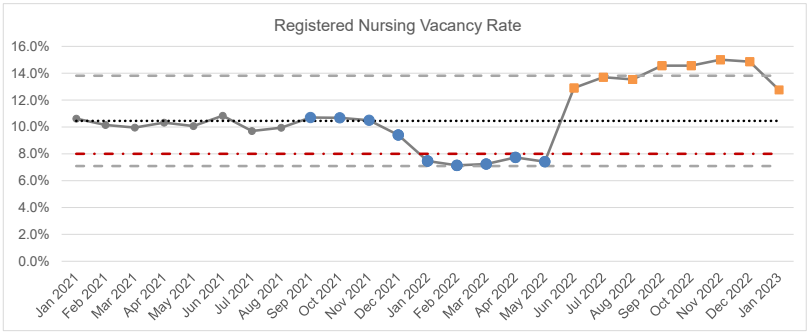
Progress
> Coninued variation in response numbers - reflecting the need for further embedding
> Patient Experience Manager meeting with ward managers for enagement purposes

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

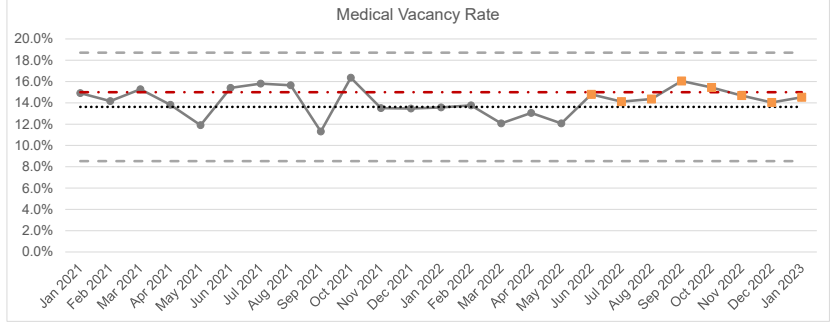
Mitigation
> Weekly meetings with IWGC
> Release of Patient Experience Manager to focus on FFT
> Divisional Patient Experience Meetings highlighting issues
> Quarterly Divisional reported shared with PEG
> Utilisation of new patient experience dashboard to share FFT data divisionally via Metrics
> Other feedback routes - MPV, social media , After Thoughts clinics



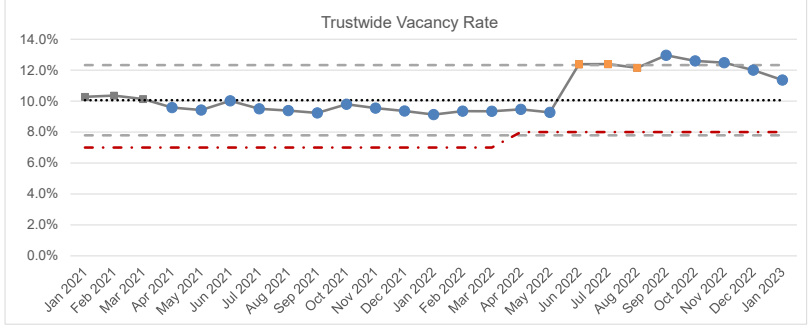
Jan 2023
13.3%
Target
8.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target



Jan 2023
12.8%
Target
8.0%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target



Jan 2023
14.5%
Target
15.0%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target



Jan 2023
11.4%
Target
8.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target

Data Analysis:
Unregistered Nursing Vacancies: After a short period of deterioration, the vacancy rate has gradually reduced and has currently fallen within the expected range.
Registered Nursing Vacancies: After a period of improvement, performance has started to deteriorate in the last eight months and is now recording concern.
Medical Vacancy Rate: Performance has been stable and as expected for over a year. The previous 8 months indicate concern. Due to this the target can be expected to be achieved and failed at random.
Trustwide Vacancy Rate: Current data indicates an improvement over the past five months, currently falling within the expected range.

Commentary:
Unregistered Nursing Issues/Risks: Retention of HCAs, 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 implemented with a pool process in place. Mass recruitment of HCAs implement as BAU, with events planned each quarter. Last recruitment event took place January 2023, with a large uptake from candidates and appointments made now undergoing checks and starting in role. Theapproach taken by NLAG regarding sourcing and new to care has been recognised by NHSi/e as good practice

Actions: Continue allocations of pipeline HCAs and facilitate starts as soon as possible, undertake continuing mass recruitment events.

Registered Nursing 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.

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. Plans for International Nurses have been exceeded with 91 started by January. Further 10 planned for Q4. Nursing career frameworks and introduction of nursing apprenticeships currently being recruited to will will see reliance on international nurse sourcing reduce longer term. Funding bid for 23/24 has been succcessful, with plans to appoint 119 international nurses in the financial year.

Commentary Vacancies Cont/d:

Medical Issues/Risks: Availability of accomodation can delay recruitment processes.

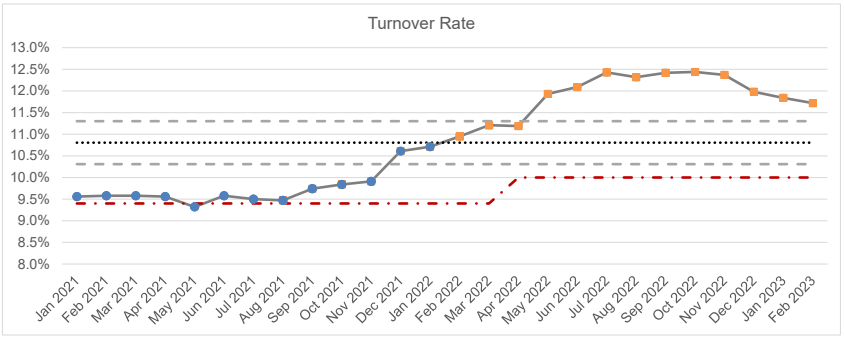
Actions: Ongoing recruitment activity across specialties. Commence UK based sourcing via Talent Acquisition Team.

Mitigations: Recruitment team continuing to engage with candidates.. A pipeline of 46 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. Issues have been resolved with Royal College of Physicians, opening up the MTI pipeline again. UK sourcing via Talent Acquisition Team commencing January 2023.

Trustwide 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.



Feb 2023
11.7%
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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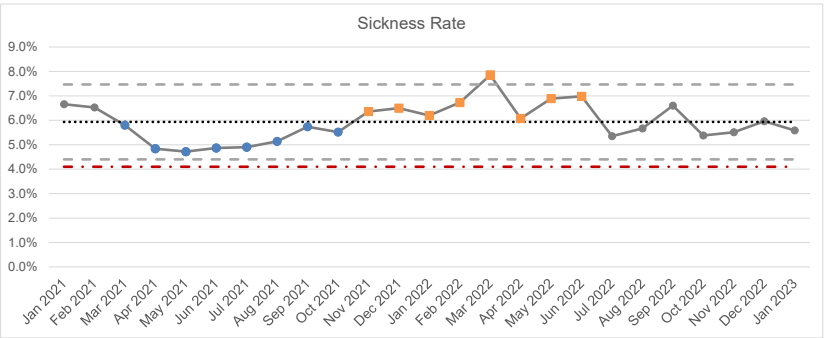

Jan 2023
5.6%
Target
4.1%
Variance
Common cause - no significant change
Assurance
Consistently failing the target

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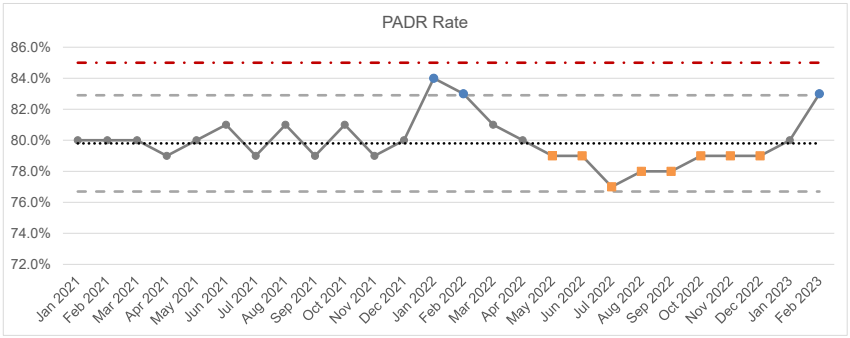
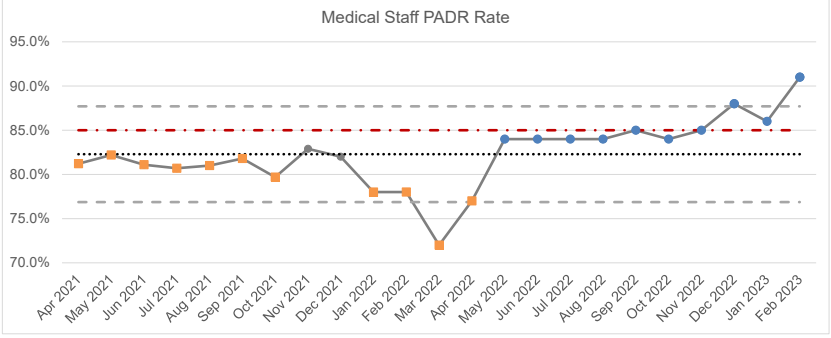
Data Analysis:
Turnover Rate: After having stayed fairly stable during the peak of pandemic, the turnover rate has been steadily increasing since the end of summer 2021 and has recorded concerning performance for the past year
Sickness Rate: Following a period of concern, the past few months of Sickness rate has been stable and is within the expected range. Current data indicates that the target will not be met without action. Planned actions outlined below.

Commentary:
Turnover remains a high although decreasing. Turnover is impacted by many areas, developing a clear understanding as to why people leave the Trust is a key priority. The Trust is currently completing a data cleansing exercise that will enable effective reporting. This will be accompanied by an updated leaver process that will allow the Trust to assess leavers questionnaires with a view to building trends into response actions. We know already two of the clear reasons people leave is to either retire or to progress. In response the Trust is continues to build career pathways that enable on-going progression and is also developing enhanced flexible retirment options to encourage and enbale individuals to stay with the Trust longer whilst begining to wind down from their professional careers.

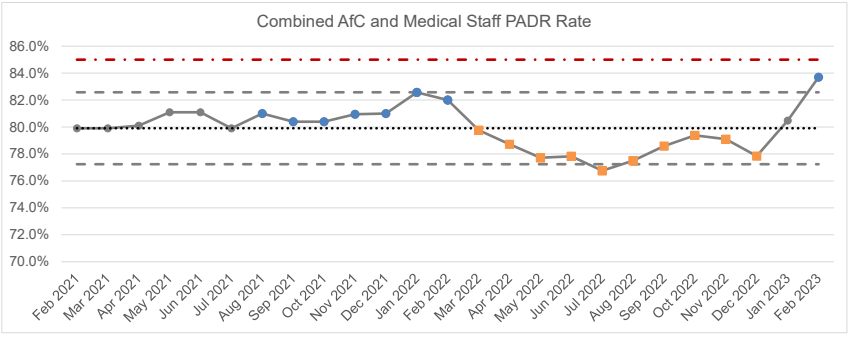
Reasons for sickness and absence, beyond the seasonal cold and flu period, show a sharp increase of work related stress, anxiety and depression, prompting a more active managerial approach to monitoring earlier signs through "stay well conversations", the implementation of regular "health and wellbeing conversations" in addition to the usual PADRs, and signposting to supporting services. In addition, ongoing work is taking place to ensure managers are competent in the management of sickness, we know early and robust intervention results in fewer and shorter sickness cases.. A full review of the managing attendance toolkit is underway to help streamline the approach and documentation, and to enable more meaningful conversation to be had with managers and their staff. A key focus here is to reduce the burden on managerial time when addressing sickness concerns. There has been a strong focus on long term sickness management this has resulted in an increased number of staff progressing through to a case review hearing. A more focused approach is being developed to enable a more robust medical sickness process - clinical leads are being supported to ensure doctors are being managed in line with standing sickness processes, this has been identified as a particular gap. This is being piliioted within the medicine division with a view to increase levels of sickness managment for doctors.



Feb 2023
83.0%
Target
85.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Consistently failing the target



Feb 2023
91.0%
Target
85.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target



Feb 2023
83.7%
Target
85.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Consistently failing the target

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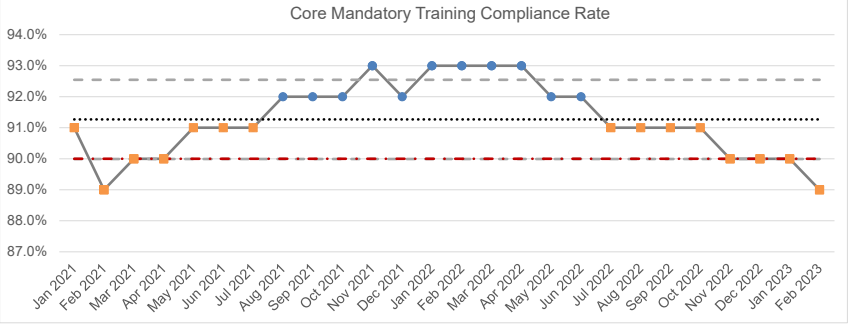
Data Analysis:
PADR Rate: After a period of deterioration, significant improvement has been seen in the last two months. PADR rate has been statistically improving in the last twp months compared to previous months.
Medical Staff PADR Rate: Performance has been predominantly within the expected range for the past two years with an improvement seen over recent months.
Combined AfC and Medical Staff PADR Rate: Following previous months of concern, last two months performance has been statistically improving towards the target.

Commentary:
The Education team continue to communicate with individual line managers where PADRs are out of compliance. This continues to have a positive impact on improving compliance rates across the Trust. The team are currently reviewing the format of the PADR to ensure it remains meaningful and inline with our current trajectory. The team are also exploring the introduction of a leadership PADR in line with launch of the Trust leadership development programmes.

Chief Medical Officer Directorate continues to monitor and support doctors to ensure they are compliant with medical appraisal procedures. There is now a recruitment drive to appoint 4 more appraisers to ensure that resources can keep up with the increase in number of doctors that require appraisal going forward and this will ensure the continued improving nature.



Feb 2023
89.0%
Target
90.0%
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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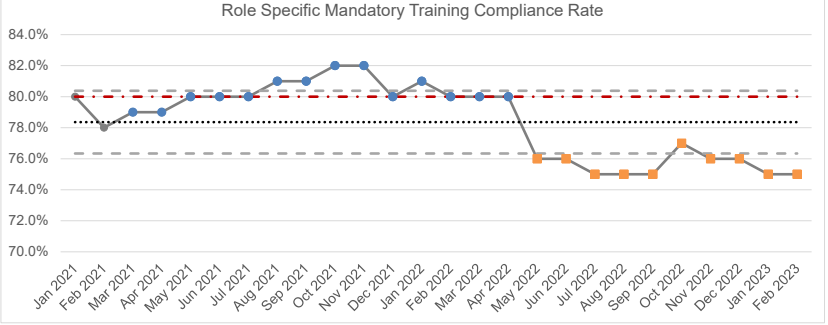

Feb 2023
75.0%
Target
80.0%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target

This space is intentionally blank

Data Analysis:
Core Mandatory Training: The last eight months has recorded a concern, and the latest month has fallen outside the expected range.
Role Specific Mandatory Training: After a long run of stable and improving performance, this indicator has deteriorated over the past ten months and is now outside of the expected range, recording a concern.

Commentary:

The lowest compliance across all courses for core mandatory is Fire Safety which has, following the impact of Covid, had higher volumes of staff requiring in-person, classroom delivery. The numbers of classes for Fire Safety has been increased and are all open for enrolment on ESR but the did not attend (DNA) / withdrawn (WD) rate for February 2023 was 54%.
Non-attendance at classroom-based (core and role specific) courses is now being monitored monthly and shared with HRBPs to support discussions relating to mandatory training compliance with managers. Work is in progress to add DNA data to Power BI dashboards so that managers have DNA information in real time and can address concerns as they arise.
A further measure to reduce levels of non-attendance has now been established. Once staff enrol onto a course in ESR, a calendar invite is sent directly to their account, and any changes to times / venues are automatically updated as a clear reminder to attend.
All staff are now required to complete Fraud Awareness within their core mandatory compliance. This course will be part of the core compliance reporting process from 4.4.23 and compliance currently stands at 68%. The T&D administration team are now targeting individuals who have not, yet, completed this course to ensure they become compliant by the end of March.
The half day Corporate Induction is now established at DPOW and SGH and continues to be utilised to embed the Trust Values and emphasise the importance of attending core and role specific mandatory training for all roles within the Trust. Due to Gray's Room (lecture theatre) in SGH being currently out of action, the next induction for Scunthorpe staff has been moved off site in order to accommodate numbers. This has the potential to impact attendance and will be reviewed by the T&D team throughout the period where Gray's room cannot be utilised.

The highest volume of staff out of compliance for a specific competency within role specific is Resuscitation – Level 2 – Adult Basic Life Support, with levels of out of compliance remaining consistently above 1200. To address this, the T&D team have planned a Resuscitation Level 2 Fortnight from 20.3.23 to 31.3.23, with 40 classes across the two-week period offering 480 places. The T&D administration team have targeted all staff out of compliance and all classes are now fully booked. The team will review the impact on compliance following completion of all activity.
Further action to address low role specific compliance includes the development of structured yearly plans for all Moving and Handling and Resuscitation programmes, accounting for all current staff out of compliance and monthly numbers coming out of compliance from 1.3.23 to 31.3.24. Plans will consider resources available (trainer, equipment, space) and will be monitored throughout the year to assess impact.

IPR Appendix - National Benchmarked Centiles

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 17/03/2023

* 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	Feb 23	64.7%	92.0%	63	64 / 170	Jan 23
	Planned	Number of Incomplete RTT pathways 52 weeks	Feb 23	511	0	63	63 / 169	Jan 23
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Feb 23	33.3%	1.0%	22	123 /157	Jan 23
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Feb 23	56.6%	85.0%	30	95 / 135	Jan 23
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Feb 23	55.8%	95.0%	8	54 / 100	Jan 23
	Urgent Care	Number Of Emergency Department Attendances	Feb 23	11,697	No target	45	80 / 145	Jan 23
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Feb 23	780	0	9	139 / 153	Jan 23
	Flow	Bed Occupancy Rate (General & Acute)	Feb 23	91.8%	92.0%	43	90 / 157	Q3 22/23
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Feb 23	6.3%	5.0%	63	61 / 161	Jan 23
	COVID	Number of COVID patients in ICU beds (Weekly)	Feb 23	2	No target	26	151 / 203	Jan 23
	COVID	Number of COVID patients in other beds (Weekly)	Feb 23	176	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	Jan 2023	0	No target	100	1 / 137	Dec 22
	Infection Control	Number of E Coli Infections	Jan 2023	7	No target	87	19 / 137	Dec 22
	Infection Control	Number of Trust Attributed C-Difficile Infections	Jan 2023	0	No target	94	9 / 137	Dec 22
	Infection Control	Number of MSSA Infections	Jan 2023	1	No target	65	48 / 137	Dec 22
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Sep 2022	102.5	As expected	47	65 / 121	Oct 22
	Safe Care	Number of Serious Incidents Raised in Month	Jan 2023	50	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Jan 2023	8.6	No target	30	137 / 194	Dec 22
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Feb 2023	96.1%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Dec 2022	5.3	No target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Number of Positive Inpatient Scores	Jan 2023	478 / 510	1	36	88 / 136	Jan 23

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Jan 2023	5.6%	4.1%	46	117 / 214	Oct 22

Scorecard - 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.

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Planned	Percentage Under 18 Weeks Incomplete RTT Pathways*	Feb 2023	64.7%	92.0%	Alert			Board
	Number of Incomplete RTT pathways 52 weeks*	Feb 2023	511	0	Alert			Board
	Total Inpatient Waiting List Size	Feb 2023	11,878	11,563	Alert			Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Feb 2023	33.3%	1.0%	Alert			Board
	Number of Incomplete RTT Pathways*	Feb 2023	35,527	No Target	Alert		n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Feb 2023	19,271	No Target	Alert		n/a	FPC
	% of Inpatient Live Waiting List Risk Stratified	Feb 2023	100.0%	99.0%				FPC
	% of Inpatient Live Waiting List Overdue Risk Strat Date	Feb 2023	42.7%	37%	Alert			FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Feb 2023	30,413	9,000	Alert			Board
	Outpatient Did Not Attend (DNA) Rate	Feb 2023	6.3%	5.00%	Alert			Board
	% Outpatient Non Face To Face Attendances	Feb 2023	26.7%	25.00%	Alert			Board
	% Outpatient summary letters with GPs within 7 days	Feb 2023	71.5%	50.0%	Highlight			FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Feb 2023	83.4%	99.0%	Alert			FPC
	% of Outpatient Waiting List Overdue Risk Strat Date (New and Review)	Feb 2023	26.5%	23.0%			n/a	FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Feb 2023	56.6%	85.0%	Alert			Board
	Cancer Waiting Times - 104+ Days Backlog*	Feb 2023	40	0	Alert			Board
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Feb 2023	33.3%	75.0%	Alert			Board
	Cancer Request To Test In 14 Days*	Feb 2023	82.2%	100.0%	Alert			Board
	Cancer Waiting Times - 2 Week Wait*	Feb 2023	96.7%	93.0%				FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Feb 2023	93.8%	93.0%				FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Feb 2023	73.0%	75.0%				FPC
	Cancer Waiting Times - 31 Day First Treatment*	Feb 2023	97.0%	96.0%				FPC
	Cancer Waiting Times - 31 Day Surgery*	Feb 2023	90.9%	94.0%				FPC
	Cancer Waiting Times - 31 Day Drugs*	Feb 2023	100.0%	98.0%				FPC
	Cancer Waiting Times - 62 day Screening*	Feb 2023	83.3%	90.0%				FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Feb 2023	55.8%	95.0%	Alert			Board
	Number Of Emergency Department Attendances	Feb 2023	11,697	No Target			n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Feb 2023	837	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Feb 2023	780	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Feb 2023	488	0	Alert			Board
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Feb 2023	43.2%	40.0%				Board
	% of Extended Stay Patients 21+ days	Feb 2023	13.5%	12.0%				Board
	Inpatient Elective Average Length Of Stay	Feb 2023	1.9	2.5				Board
	Inpatient Non Elective Average Length Of Stay	Feb 2023	3.7	3.9				Board
	Number of Medical Patients Occupying Non-Medical Wards	Feb 2023	344	No Target	Alert		n/a	Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Feb 2023	87.8%	90.0%				Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Feb 2023	16.8%	30.0%	Alert			Board
	Bed Occupancy Rate (G&A)	Feb 2023	91.8%	92.0%				Board
	Percentage of patients re-admitted as an emergency within 30 days	Feb 2023	9.3%	No Target			n/a	FPC
	% of Extended Stay Patients 7+ days	Feb 2023	48.1%	No Target	Alert		n/a	FPC
	% of Extended Stay Patients 14+ days	Feb 2023	25.0%	No Target	Alert		n/a	FPC
COVID	Number of COVID patients in ICU beds (Monthly)	Feb 2023	2	No Target			n/a	Board
	Number of COVID patients in other beds (Monthly)	Feb 2023	176	No Target			n/a	Board
	% COVID staff absences (Monthly)	Feb 2023	13.4%	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)*	Jan 2023	0.00	see analysis			n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Jan 2023	0.34	see analysis			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Jan 2023	0.00	see analysis	Highlight		n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Jan 2023	0.05	see analysis			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Jan 2023	0.49	see analysis			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Sep 2022	98.9	As expected			As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Sep 2022	102.5	As expected			As expected	Board
	Number of patients dying within 24 hours of admission to hospital	Feb 2023	12	No target			n/a	Q&S
	Number of emergency admissions for people in the last 3 months of life	Feb 2023	161	No target			n/a	Q&S
	Out Of Hospital (OOH) SHMI	Aug 2022	140.1	110.0	Alert			Q&S
	Structured Judgement Reviews - Rate Completed of those required	Aug 2022	76.0%	100.0%	Alert			Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Jan 2023	50.0%	No target	Alert		n/a	Board
	Number of Serious Incidents raised in month	Jan 2023	12	No target			n/a	Board
	Occurrence of 'Never Events' *(Number)*	Jan 2023	0	0		n/a	n/a	Board
	Duty of Candour Rate	Jan 2023	100.0%	100.0%				Board
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Jan 2023	4.4	No target	Highlight		n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Jan 2023	4.9	No target			n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Feb 2023	96.1%	95.0%	Alert			Board
	Care Hours Per Patient Day (CHPPD)	Jan 2023	8.6	No target			n/a	Board
	Mixed Sex Accommodation Breaches	Jan 2023	6.0	0		n/a	n/a	Board
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Dec 2022	5.3	No target			n/a	Board
	Complaints Responded to on time	Dec 2022	79.0%	85.0%				Board
	Friends and Family Test (FFT)							
	Number of Positive Inpatient Scores	Jan 2023	478 out of 510	No target		n/a	n/a	Board
	Number of Positive A&E Scores	Jan 2023	235 out of 307	No target		n/a	n/a	Board
	Number of Positive Community Scores	Jan 2023	59 out of 62	No target		n/a	n/a	Board
	Number of Positive Outpatient Scores	Jan 2023	188 out of 201	No target		n/a	n/a	Board
	Number of Maternity Antenatal Scores	Jan 2023	22 out of 25	No target		n/a	n/a	Board
	Number of Maternity Birth Scores	Jan 2023	24 out of 24	No target		n/a	n/a	Board
	Number of Maternity Postnatal Scores	Jan 2023	1 out of 1	No target		n/a	n/a	Board
	Number of Maternity Ward Scores	Jan 2023	44 out of 49	No target		n/a	n/a	Board
Observations	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Feb 2023	90.7%	90.0%				Q&S
	Percentage of Child Observations Recorded On Time (with a 30 min grace)	Jan 2023	76.5%	90.0%				Q&S
	Escalation of NEWS in line with Policy	Dec 2022	7.0%	No target		n/a	n/a	Q&S
	Clinical assessment undertaken within 15 minutes of arrival in ED	Jan 2023	41.0%	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)*	Dec 2022	59.0%	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)*	Dec 2022	0.0%	90.0%		n/a	n/a	Q&S
	Rate of Children Screened for Sepsis using the Sepsis Screening and Action Tool	Jan 2023	36.4%	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	Jan 2023	29.0%	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)*	Jan 2023	68.8%	No target			n/a	Q&S
	Percentage of patients admitted to IAAU with an ACTUAL weight recorded on EPMA or WebV *(based on Manual Audit)*	Jan 2023	38.8%	No target			n/a	Q&S
	Percentage of patients admitted to IAAU whose weight was 50kg (+/- 6kg) who complied with prescribing weight for dosing standard	Jan 2023	33.0%	No target			n/a	Q&S
	Reduction in patients prescribed an antibiotic	Sep 2022	56.9%	50.0%		n/a	n/a	Q&S
	Percentage of Medication Omissions for Ward Areas Using EPMA	Jan 2023	2.4%	No target			n/a	Q&S
	Antibiotic prescriptions have evidence of a review within 72 hours	Sep 2022	68.8%	70.0%		n/a	n/a	Q&S

Scorecard - Workforce

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Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Vacancies	Unregistered Nurse Vacancy Rate	Jan 2023	13.3%	8.0%	Highlight			Board
	Registered Nurse Vacancy Rate	Jan 2023	12.8%	8.0%	Alert			Board
	Medical Vacancy Rate	Jan 2023	14.5%	15.0%	Alert			Board
	Trustwide Vacancy Rate	Jan 2023	11.4%	8.0%	Highlight			Board
Staffing Levels	Turnover Rate	Feb 2023	11.7%	10.0%	Alert			Board
	Sickness Rate	Jan 2023	5.6%	4.1%	Alert			Board
Staff Development	PADR Rate	Feb 2023	83.0%	85.0%	Alert			Board
	Medical Staff PADR Rate	Feb 2023	91.0%	85.0%				Board
	Combined AfC and Medical Staff PADR Rate	Feb 2023	83.7%	85.0%	Alert			Board
	Core Mandatory Training Compliance Rate	Feb 2023	89.0%	90.0%	Alert			Board
	Role Specific Mandatory Training Compliance Rate	Feb 2023	75.0%	80.0%	Alert			Board
Disciplinary	Number of Disciplinary Cases Live in Month	Feb 2023	8	No Target			n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Feb 2023	0	12				WFC
	Number of Suspensions Live in Month	Feb 2023	4	No Target	Alert		n/a	WFC
	Average Length of Suspension (Weeks)	Feb 2023	0	No Target			n/a	WFC

Appendix C - Glossary

A&E	Accident and Emergency
AfC	Agenda for Change
CHPPD	Care hours per patient day
DM01	Diagnostic Waiting Times and Activity
DNA	Did not attend
EPMA	Electronic Prescribing and Medicines Administration
FFT	Friends and Family Test
GP	General Practitioner
HSMR	Hospital Standardised Mortality Ratio
HUTH	Hull University Teaching Hospital
IAAU	Integrated Acute Assessment Units
LOS	Length of Stay
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-susceptible Staphylococcus aureus
NEWS	National Early Warning System
NLAG	Northern Lincolnshire and Goole NHS Trust
OOH	Out of Hospital
PADR	Performance Appraisal and Development Review
RTT	Referral to Treatment
SHMI	Summary Hospital Mortality Index
VTE	Venous Thromboembolism

NLG(23) 050

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	4 April 2023	
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 (covering February & March)**	
Purpose of the Report and Executive Summary (to include recommendations)	The Trust Board is to note the Quality and Safety Committee highlight report including the following recommendations: • to support additional Pharmacist recruitment activity due to the potential fragility of the service. • to review the allocation of non-clinical tasks being completed by clinical staff for appropriateness.	
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

NLG(23)050

Highlight Report to Trust Board

Report for Trust Board Meeting on:	4 April 2023
Report From:	Incorporating Quality & Safety Committees held on 1 March and 28 March 2023

Highlight Report:

Pharmacy have demonstrated that there is a challenged position on recruitment to Pharmacist posts at Scunthorpe, with support from Grimsby for remote work. There remain 8 Whole Time Equivalent (WTE) vacancies from a 9.6 WTE establishment, despite a range of recruitment options being explored. The Pharmacy Team are working closely with Human Resources colleagues but requested further assistance in talent acquisition and creation of recruitment videos.

As part of the Nursing Assurance report the topic of non-clinical tasks being completed by clinical staff was identified, with recognition that this may take time from patient care activities. The appropriate use of clinical staff resources and consideration of non-clinical staff contributions, with roles such as ward clerks and potentially physician assistances reducing the burden were discussed.
It was noted that there had been an increase in shift fill rates correlating with pay incentives for bank staff, increasing the Care Hours per Patient Day.

Positive signs were identified with Hospital-level Mortality Indicator (SHMI) rates being within expected range reflecting a sustained improvement. There is focus on out of hospital SHMI, linked to the end-of-life recognition by colleagues in primary care, where there may be potential to avoid admission to hospital.

End of Life care for both community and inpatients remains a priority focus, with demonstrated improvements in training for syringe driver use, ensuring patients have timely care when requiring this intervention. An “Always Quality Initiative Event” scheduled for 9 March was discussed and seen as a positive approach to contribute to Trustwide End of Life improvements.

The rate of C. difficile cases remains at 21 against a target of 21. Despite highlighting a high risk during the year that the Trust may breach this target the Committee recognised this result as being a significant achievement and one of lowest national infection rates in the country.
Cancer reporting to the Committee in its current format have frequently been deferred due to operational pressures although the reporting of cancer services to the Committee in parallel with the Finance and Performance Committee has seen improvements. The Committee members will be undertaking a review of the information it receives to reduce the pressure operationally and maintain appropriate levels of assurance on the quality and safety of patient care. This will consider the reporting frequency and content to optimally achieve oversight of quality and safe issues.

Cardiology services presented a proposal to change to a more centralised service at Grimsby in line with the model used for 8 months before covid-19, with benefits foreseen with Cardiologist recruitment and retention. The expected impact of 20-50 more patients per year will need to be transferred from Scunthorpe in addition to the patients already transferred for interventional needs site to Hull University Teaching Hospitals Castle Hill site or Grimsby.

The proposal was discussed, and assurance was evident there would be no reduction in the quality and safety of patient care overall.

The Quality Priorities have been approved by the Committee and are recommended for approval through the Board of Directors.

The Surgical and Critical Care Division reported improvements in their complaints management and waiting list of ophthalmology patients, with ongoing optimisation for reducing 52 week waits and no patients waiting 78 weeks. The wellbeing of patients having to wait longer on a waiting list remains a concern as lists are further reduced.

Maternity transformation and improvement plans have been outlined with recognition of achievements in Ockenden action planning, Clinical Negligence Scheme for Trusts (CNST) compliance submission and planned engagement with Local Maternity and Neonatal System and regional team. An objective of exiting the Maternity Improvement Programme was shared and supported by the Committee.

Pressure ulcers has been reviewed as a deep dive exercise. The Committee were assured that effective systems are in place to manage incidents, identify learning opportunities and collaborate with Integrated Care Board Place quality teams.

Confirm or Challenge of the Board Assurance Framework:

Action Required by the Trust Board:

The Trust Board is asked to note the key points made and recommend:

- Pharmacist recruitment support is requested due to the potential fragility of the service.
- Consider reviewing the reallocation of non-clinical tasks being completed by clinical staff in other ways.

Fiona Osborne
Non-Executive Director

NLG(23)051

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 4 April 2023
Director Lead	Ellie Monkhouse, Chief Nurse/ Executive Maternity and Neonatal Safety Champion
Contact Officer/Author	Nicola Foster, Head of Nursing – Gynaecology and Breast Services and Deputy Head of Midwifery
Title of the Report	**Maternity Oversight Report**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this new highlight report is to provide the Trust Board with oversight of the trust's maternity services. Highlights of key areas are summarised for assurance and information. The Board is asked to note this report and its contents. **1. Workforce** • Midwifery vacancy rate demonstrates a slightly improving picture in February, although remains challenging. Positively the first cohort of four international midwives have commenced in post in March. • Accredited Midwifery Support Worker training commencing at University of Hull from September 2023 • Pastoral and Retention midwife role of supporting midwives (specifically early career) impacting positively on the service. **2. Clinical Negligence Scheme for Trusts (CNST)** The Trust have reported compliance with all 10 safety actions within the Maternity Incentive Scheme for the second successive year. **3. Ockenden Report** The Trust's action plan following the initial Ockenden Report is now complete and work is progressing on the immediate and essential actions to improve maternity care, supported by the multidisciplinary team. **4. Quality Improvement** Current ongoing Quality Improvement (QI) projects within maternity services include: • Induction of Labour • Maternity Triage • Thermoregulation of the new-borns. Proposed QI project: • Review of provision of Antenatal Clinic and Day Units cross site (to include capacity, demand, criteria and staffing) **5. Patient Experience and Service User Feedback** The Family Services Division continues to receive relatively low numbers of new complaints and PALS concerns. For February 2023 maternity services held 3 open complaints, 1 closed and 2 new.

	Maternity services are currently without a Maternity Voices Partnership (MVP) Lead and we are supporting the LNMS with recruitment to this important role. However, contingency is in place through access to the regional MVP lead for support during this time. **6. Maternity Safety Support Programme** The Trust is on the Maternity Safety Support Programme hosted by NHSEI via the national maternity team, led by the Chief Midwifery Officer for England. The NHSEI maternity services self-assessment tool forms the basis for the exit process from the programme, aided by national organisational benchmarks, our submission of our 2nd year of a full CNST compliance and improvement in the recent CQC report, and is updated to TMB and the Trust Board to ensure senior level oversight and involvement. The report describes current compliance with the self-assessment tool, areas for improvement and identified actions, and provides assurance on monitoring and reporting arrangements. The self-assessment outcomes provide assurance of good self-assessed compliance with the majority of descriptors used to benchmark organisations in the core principles of good safety standards within maternity services and offers assurance that the trust's maternity operational service delivery meets national standards, guidance, and regulatory requirements. Opportunities for improvement have been identified and translated into an action plan which will be progressed by the Family Services division with trust wide/corporate support. These actions will be monitored through divisional governance with board assurance provided via the divisions regular report to the Quality & Safety Committee, through to trust board. The self-assessment tool will be monitored through the Maternity Improvement and Transformation Board chaired by the Chief Nurse. **7. Maternity Safety Champions** Maternity safety champions work at every level – Trust, regional and national. Locally there are embedded monthly walk arounds across the maternity and neonatal services by the Safety Champions alternating the site venue each time. This provides an opportunity for the Safety Champions to speak with staff to understand concerns and safety issues they may have and to provide 'floor to board' communication. As part of the Maternity Safety Champions work there is also a *Shout Out Wednesday* event each month which enables escalation by all staff of any safety concerns as well as the mailboxes open to all. An action log is collated from the Safety Champion walk arounds as well as the other safety escalation initiatives,

	ensuring learning and improvement opportunities are captured and progress monitored. **8. Patient Safety Incident Response Framework (PSIRF)** Awaiting guidance for maternity training requirements – National Webinars planned and attended. **9. Upcoming External Visit** The National Maternity Team are planning an assurance visit in May 2023 (no further details available as yet).	
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

Maternity Oversight Report

March 2023

CONTENTS

1. Workforce/Staffing

Maternity fill rates are monitored monthly against the planned ward establishments, for January 2023 the fill rate varies between 81.0% and 97.2%. Some of this variation is due to the flexibility within maternity to move staff to the area of greatest need at SGH or condensing to 3 wards rather than 4 at DPOW to ensure patient safety.

Maternity Wards Fill Rates and CHPPD **Jan 2023**

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**91.0%**	**▼ -1.1%**	**77.6%**	**▼ -5.8%**	**12.2**	**▼ -2.10**
Registered Nurses and Midwives	90.6%	▼ -1.5%	76.1%	▼ -9.3%	7.7	▼ -1.37
Care Staff	91.8%	▼ -0.4%	80.3%	▲ 0.4%	4.5	▼ -0.73
Central Delivery Suite	**83.7%**	**▲ 5.8%**	**46.0%**	**▼ -26.6%**	**33.5**	**▲ 3.63**
Registered Nurses and Midwives	81.0%	▲ 3.0%	36.4%	▼ -37.4%	26.1	▲ 2.03
Care Staff	94.8%	▲ 17.2%	85.4%	▲ 17.7%	7.4	▲ 1.60
Jasmine & Honeysuckle	**97.2%**	**▲ 10.6%**	**79.3%**	**▲ 9.2%**	**13.0**	**▲ 3.42**
Registered Nurses and Midwives	95.5%	▲ 9.8%	79.2%	▲ 10.5%	8.6	▲ 2.21
Care Staff	100.6%	▲ 12.3%	79.6%	▲ 6.6%	4.4	▲ 1.20
Ward 26 SGH	**88.3%**	**▲ 7.6%**	**66.1%**	**▲ 13.4%**	**7.0**	**▼ -0.19**
Registered Nurses and Midwives	86.6%	▲ 7.0%	62.1%	▲ 9.3%	5.0	▼ -0.16
Care Staff	92.7%	▲ 9.1%	76.8%	▲ 24.4%	2.0	▼ -0.03
Total	**90.4%**	**▲ 5.5%**	**68.4%**	**▼ -2.3%**	**12.1**	**▲ 0.51**

Maternity staffing is discussed at the trust 9:00 staffing meeting with the maternity staffing OPEL system (below) used to identify the level, A maternity escalation policy is escalated as required to ensure all areas are safely covered to meet the demands at the time.

OPEL Status	AN & PN ward beds	Delivery beds capacity	Unable to provide 1-1 care in established labour	CDS/LDRP Coordinator not supernumerary	Delays in elective work for non-elective reason	Neonatal Services	Escalation Required	Actions Required
GREEN Patient flow maintained. Additional support is not anticipated.	No delays in admission, discharge or transfers (internal or external)	Bed capacity available for activity	1-1 care given to all women	Coordinators supernumerary	No delays in elective work	NICU open	None required	None Level One
AMBER The local maternity service is starting to show signs of pressure.	Enough beds for CDS to transfer to ward but not elective activity (eg induction of labour)	High activity with high bed occupancy but beds remain available	Moving staff to be able to provide 1-1 care	Coordinators supernumerary	Delays in elective activity for > 4 hours	Neonatal service is experiencing difficulty in meeting anticipated demand	Matron, LDRP / CDS coordinator, consultant obstetrician, neonatal coordinator.	Action as per Maternity Services Escalation Policy DCP267 4 HOURLY REVIEW Level Two
RED The local maternity service is experiencing major pressures compromising patient flow and safety and continues to increase.	Not enough delivery beds for CDS to transfer or elective activity	Upper limits of bed capacity, no potential bed capacity within 2 hours	Unable to provide 1-1 care to women in established labour	Temporarily providing direct care to antenatal/postnatal women whilst extra support for CDS is provided	Delays in elective activity for > 4 hours	Closed	Trust exec on call/Gold on call, Consultant obstetrician on call, Neonatal consultant on call, Head of Midwifery/Deputy Head of Midwifery/Matron (Silver on call out of hours)	Action as per Maternity Services Escalation Policy DCP267 2 HOURLY REVIEW Level Three
BLACK Pressure in the local maternity service continues to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised.	0 beds	0 beds	Unable to give 1-1 care to women in established labour	Not supernumerary	Unable to transfer to another Trust	Closed	Trust executive on call/Gold on Call/ Head of Midwifery (silver on call out of hours) Consultant Obstetrician on call, Neonatal Consultant on call.	Action as per Maternity Services Escalation Policy DCP267 HOURLY REVIEW Level Four

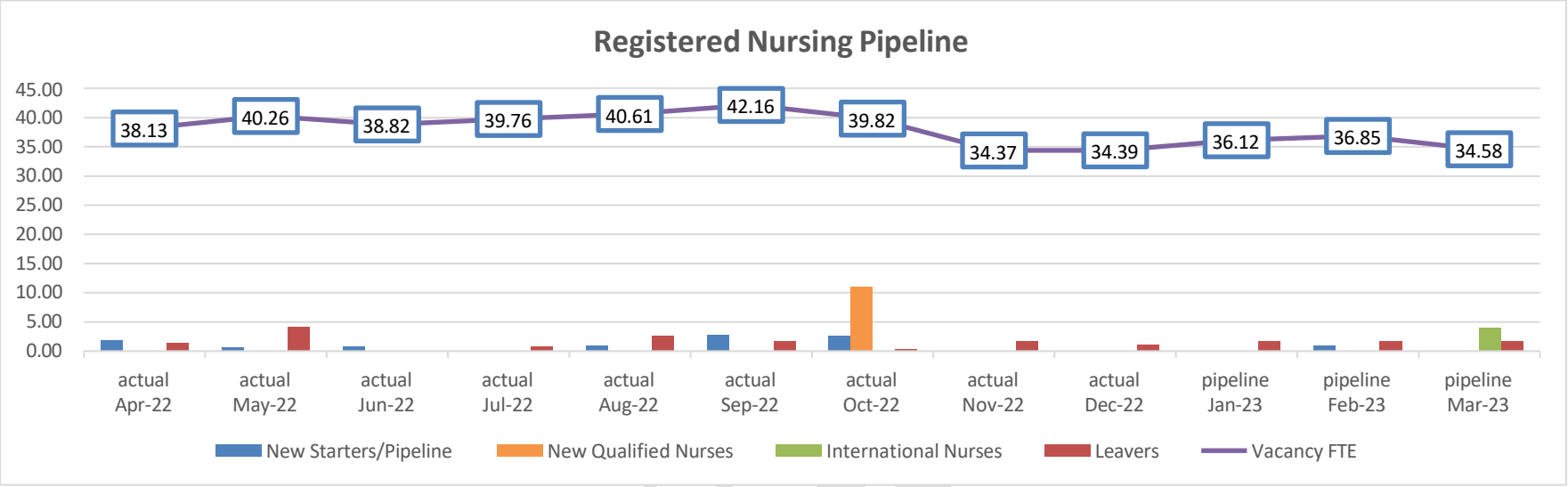
Vacancies for registered midwives in January 2023 stood at 15.4 WTE. A reduction is seen due the recruitment of newly qualified midwives in Quarter 3 of 22/23. There is planned international recruitment of midwives with 4 starting in Feb 23 and a further 12 international midwives to be recruited and start between April and Dec 23.

The Midwife to Birth Ratio target is for the ratio to be below 1:28. The Midwife to Birth Ratio has throughout 2022 been below the target which gives assurance safety was maintained in line with the target. In December 2022 the ratio was 1:24. The dashboard below shows other Midwifery metrics including red flags which has seen an increase in December. The highest reasons are ‘delay of 2 hours or more between admission for induction and beginning of process’ and ‘community staff have been called in to work on the unit. The correlates with vacancies and fill rates.

Trustwide Maternity Dashboard

Indicator	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Midwife to Birth Ratio	24.4	24.5	24.0	24.9	25.1	25.0	26.2	26.2	25.8	24.8	22.9	24.8
Red Flags	33.0	37.0	23.0	30.0	24.0	18.0	34.0	16.0	9.0	17.0	9.0	20.0
(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)	2.0	6.0	2.0	2.0	1.0	1.0	5.0	0.0	1.0	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	2.0	1.0	1.0	2.0	3.0	2.0	2.0	1.0	1.0	0.0	3.0
(c) Missed medication during an admission to hospital	0.0	1.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	3.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	1.0	0.0	0.0	0.0	0.0	0.0	2.0	2.0	0.0	0.0	0.0	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0
(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	3.0	6.0	5.0	3.0	11.0	6.0	13.0	5.0	4.0	5.0	3.0	9.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	3.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	21.0	22.0	14.0	24.0	10.0	8.0	10.0	6.0	3.0	11.0	3.0	6.0
Continuity of Carer %	16.0	20.0	20.0	19.0	20.0	18.0	12.0	12.0	12.0	14.0		
In Receipt of %	9.0	16.0	7.0	11.0	8.0	11.0	9.0	8.0	9.0	8.0		
CoC In Receipt of %	47.0	67.0	49.0	69.0	68.0	58.0	70.0	72.0	68.0	66.0		
Continuity Team Caseload	497.0	485.0	490.0	524.0	488.0	488.0	305.0	305.0	295.0	311.0		
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	90.5	90.3	92.1	88.1	88.0	88.1	84.1	84.1	85.5	89.0	96.2	88.0
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		
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	32.0	30.7	32.2	46.6	47.3	43.5	44.5	45.2	51.7	41.6	41.1	40.4
Vacancies - Registered	27.6	27.2	28.2	38.1	40.3	38.8	39.8	40.6	42.2	39.8	34.4	34.4
Vacancies - Unregistered	4.5	3.5	4.1	8.5	7.0	4.7	4.7	4.6	9.6	1.8	6.7	6.0
Serious Incidents	2.0	0.0	1.0	0.0	0.0	0.0	0.0	2.0	1.0	0.0	0.0	1.0
Complaints	1.0	0.0	2.0	2.0	1.0	3.0	2.0	3.0	1.0	3.0	2.0	0.0
PALS	7.0	4.0	4.0	5.0	6.0	5.0	1.0	6.0	5.0	6.0	4.0	3.0
Sickness Absence (Division) %	8.4	7.2	8.0	8.8	5.9	5.8	6.8	6.4	6.0			

Maternity recruitment plans



A further 12 internationally recruited midwives are due to join the Trust between April – December 2023.

2. Patient Experience/Service User feedback

The following section details the feedback received via Formal Complaints, PALS concerns and the Friends and Family Test. This information is taken from January – February 2023 and includes performance data and themes.

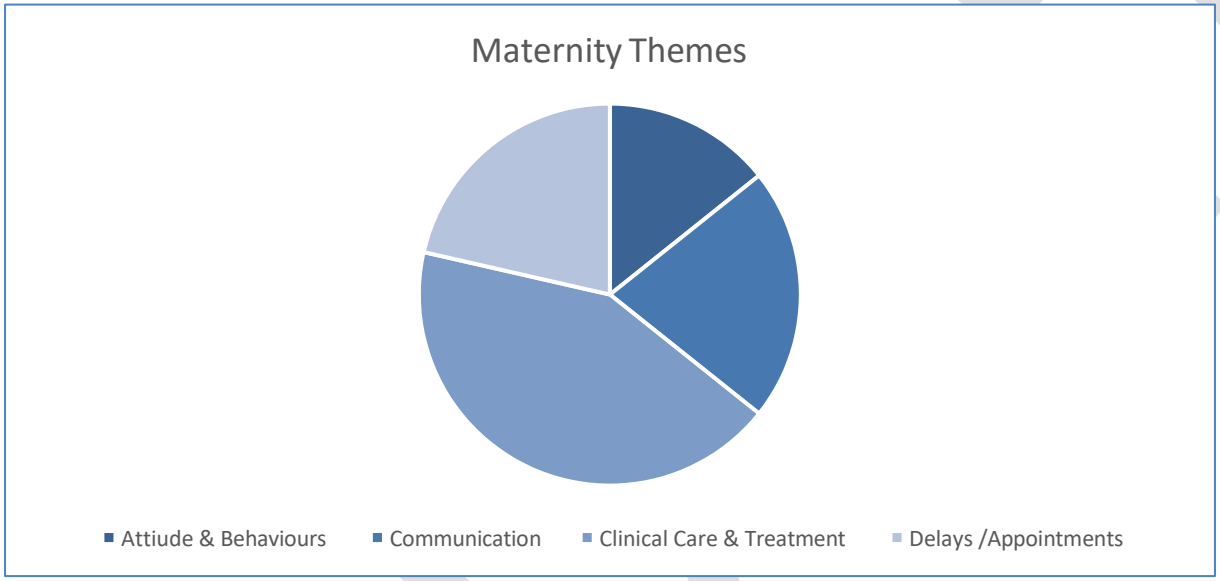
Formal Complaints and PALS Data

Obstetrics/maternity	Jan-23	Feb-23
Number complaints open/ongoing	1	3
Number of open complaints out of timescale	0	0
Number complaints closed this month	2	1
Number of new complaints	1	2
	Jan-23	**Feb-23**
Number of PALS open	1	3
Number of PALS out of timescale	1	1
Number of PALS closed this month	4	2
Number of new PALS	4	3
	Jan-23	**Feb-23**
% of complaints closed within timescale (KPI 85%)	**100%**	**NA**
Average length of time to respond to complaints closed (working days)	53	**N/A - withdrawn**
% of PALS closed within timescale (KPI 60%)	**75%**	**0%**
Average length of time to respond to PALS closed (working days)	6	10

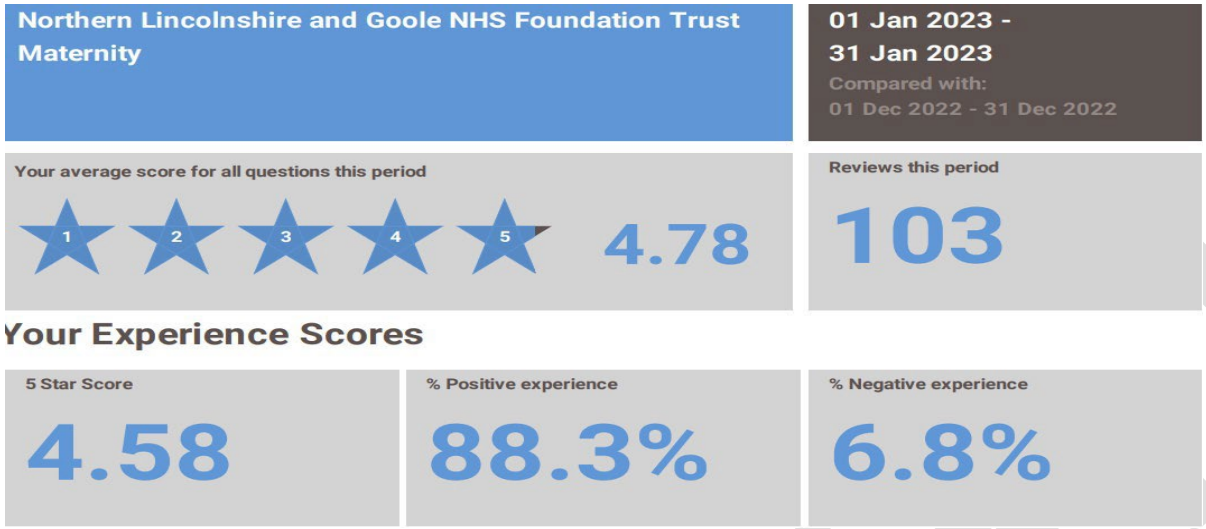
The Division continue to have relatively low numbers of new complaints and PALS.

Themes arising from closed cases indicate the percentage of feedback relates to clinical treatment. This is both in the maternity inpatient and outpatient setting, with hysteroscopy and colposcopy procedures mentioned as a recurring theme in reported feedback.

Attitude and behaviours, communication and appointment concerns feature almost equally. As the numbers are quite low some caution is advised on making generalisations but further review of the gynaecology reviews may be advised.



Friends & Family Test Feedback



A slight decreased in the percentage of positive experiences from the previous month has been noted, with an improvement in the number of reviews received. Work remains ongoing with Ward/Department Managers to increase encouraging patients to complete feedback. Ward 26 and Blueberry Ward continue to provide consistent numbers of feedback.

Themes overall highlight that woman felt staff were caring, compassionate, supportive, friendly, and helpful. However, ward 26 feedback was conflicting with examples of midwives not being supportive and this feedback has already been shared with the unit manager.

3. Assurance

One 15 Steps visit took place within Maternity Services during January 2023, this was to the Antenatal Outpatient Clinic at Scunthorpe General Hospital. The department had not been visited before and therefore does not have a previous rating, on this occasion there were areas for consideration requiring improvement noted. The team have been supported to complete an improvement plan and are working towards actions.

Acute 15 Steps Challenge Visits			
Date of Visit	Ward/Department	Rating 2023	Previous Rating
12/01/2023	Antenatal OPD, SGH		NA

Areas for Consideration and Action

Standards	Themes	Actions
Standard 1: Observation	**Patient identifiers:** • Patient confidential details and demographics on display throughout the department (outside clinic rooms, in sluice with door propped open, in clinical room with door propped open)	• Doors that should be kept closed no longer propped open and expected practice communicated to staff within the department • Covers made to protect personal information outside of Clinic rooms
	Information: • Relevant posters not displayed throughout the department – PALS, Uniform poster • Out of date Notice boards and leaflets • Staffing information board blank	• Relevant leaflets obtained and displayed • Out of date information removed • New ‘time to sine board’ to source in alignment with DPOW clinic

		• Staffing board to be updated daily by shift lead
Standard 2: Documentation	**Not completed in outpatient areas**	
Standard 3: Patient Feedback	**Minimal areas for consideration** • Patients not aware of wait times (electronic display not in use)	• Shift Lead to communicate delays to front desk and ensure electronic display in use
Standard 4: Staff Feedback	**No areas for consideration noted Staff feedback OUTSTANDING**	

4. Feedback

Maternity Safety Champions

The role of the Trust Board Safety Champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, LMNS leads, the Regional Chief Midwife and Lead Obstetrician and the Trust Board to understand, communicate and champion learning, challenges and successes.

There are embedded monthly walk rounds across the maternity and neonatal services by the Safety Champions alternating the venue each time. It provides an opportunity for the Safety Champions to speak with staff to understand concerns and safety issues they may have and to provide the 'floor to board' communication.

The walk round on 23 February 2023 was to the maternity areas at Scunthorpe and discussion included staffing levels within the Pregnancy Assessment Centre and a request to review staffing establishment in that area. It was also highlighted that some women had lengthy waits to be seen by a doctor in the Antenatal Day Unit and suggested solutions were shared between the Safety Champions and the staff.

A midwife on the Central Delivery Suite highlighted an issue with translation service access in the community setting and work is on-going to improve accessibility to services.

As part of the Maternity Safety Champions work there is also a Shout Out Wednesday event each month which enables escalation by all staff of any safety concerns as well as the mailboxes open to all.

An action log is collated from the Safety Champion walkrounds as well as the other safety escalation initiatives that the Maternity service has as mentioned above.

Date Raised	Site DPOW/SGH/ Trustwide	Concern Raised	Actions Required	Responsible Person	Action by Date	Status	Evidence Of Completion
	SGH	Safe retrieval of patient from birth pool maybe compromised due to not being able to access two sides of the pool.	Escalated to delivery suite manager and coordinators following clinical simulation	Kendra Thomas.	~~11/05/2021~~ 31/1/23		Delivery suite coordinators and manager looking at the potential to have a more appropriately fitted pool in the room that allows greater access to the patient. This involves a cost implication if the pool were to be replaced. 11/8/22 awaiting update 14/12/22 with Iona Johnson, looking for HTF funding, however awaiting an estimate. 18.01.23 Iona approached the HTF. The HTF agreed but there is now an issue with us topping up the funding to upgrade the pool. 15.03.23 Spoken to ward manager and we are no further on with this at present. Funding and priority are the issues.
	SGH	Ward 26 assessment room needs a window blind. Women getting burnt via sunlight during heat wave No Privacy.	Emailed Ward 26 Managers to see if there had been a request to estates and facilities. If not to log a call.	Claire Brothwell Shaliny Marjara	~~21/07/2021~~ 31/1/23		Costings have been made for one to be made and fitted. In the hands of ward 26 managers. 11/8/22 awaiting update. Still not installed, awaiting update from ward manager. 6/12/22 still awaiting update from ward manager. 14/12/22 still no blind - CB looking into going ahead and ordering. 18.01.23 blind has been asked for at mini refurbishment. 15.03.23 Mini refurbishment under way now.
	DPOW	Emergency Buzzer in ADU not audiable on maternity floor.	Discussed with HOM, call bells are on the risk register. There is project ongoing to upgrade system. Interim plan discussed to have fast 2222 bleep added as a speed dial option/ labour co-ordinator on speed dial to be added to ADU phones.	Colleen Gray	~~17/11/2021~~ 31/1/23		Work on-going, awaiting quote for replacement system 6/12/22 update awaited 14/12/22 on-going, Iona leading. Email sent reuqesting update 28/02/23.
	Trustwide	Dopplex Centrale 3 system issues. Not enough licenses.	Requires escalation to Linda Keech.	Linda Keech Natalie Jenkin	31/12/2022		In progress 11/8/22 awaiting update 6/12/22 awaiting update 14/12/22 on-going. 15.03.23 No further update due to the link person not being at work at present.
20/04/2022	Trustwide	Safe care live not fit for purpose. Midwife asked if we could have a midwifery specific report as she felt it does not reflect our workload. She also felt bereavement care needed updating to 1:1 care.	Email sent to Nicky Foster 22/04/22	Colleen Gray	~~22/04/2022~~ 31/1/23		22/04/22 this is a known issue nationally and there is a rating criteria. 16/11/22 this has been escalated to Derek Conlon by Colleen Gray about pulling COC midwives through from e-roster and adding babies on. Colleen is chasing this up. 6/12/22 awaiting update. 18.01.23 Matron is still communicating to appropriate persons involved about the system. 15.03 23 no update at present.
19/10/2022	DPOW	Holes in theatre floor - previously been reported but no action has been taken as yet. Tracy Martin has liaised with Iona Johnson who was chasing up estates.	Has been reported previously to estates and Iona Johnson	Tracy Martin	31/01/2023		28/10/22 Further email sent to Iona Johnson to advise that repairs have still not been completed and is an infection control risk. 28/10/22 Iona will liaise with facilities regarding this. 6/12/22 update requested. 28/02/23 email sent for further update. 08/03/23 update from Tracy Martin that this is still ongoing.
21/12/2022	DPOW	Some partners inappropriately dressed on the wards and in rooms. Some partners going to the water fountain with tops off and in rooms with tops off or just in boxers. When approached by staff and asked to dress accordingly staff have received abuse.	Partner information posters are currently in rooms which reference partners to be appropriately dressed. This recurrent issue be discussed with MVP.	Vicki Booth	31/01/2023		28/02/23 responsible lead has been off sick thereofer has not been discussed. Email sent to Nicky Foster 28/02/23 regarding approaching MVP. 21/03/23 Vicki Booth has written a patient information leaflet and is now out for comments.
21/12/2022	DPOW	Stores cages left obstructing maternity theatre corridor, not enough room to fit a bed through and dangerous in an emergency situation. This has previously been raised as a concern. Photo's taken and emailed to Bill Parkinson.	Email sent to Bill Parkinson & Iona Johnson (Iona already aware of situation as previously raised by a coordinator)	Bill Parkinson Iona Johnson Tracey Martin	31/03/2023		22/12/22 email from Iona to Keith Fowler & Keith Leech regarding providing further storage but also porters practices. Meeting arranged for 07/02/23, will request update. 28/02/23 email sent to ask for update on issue. 08/03/23 furteher update from Tracy Martin that this is still ongoing.
18/01/2023	SGH	Most of the wall mounted lamps on CDS are in a poor state of repair. Many are origonal from 1992 and the arms will not stay up and the light bulbs fall out unexpectedly. These lights have a very important part in providing the calm atmosphere and light that is conducive to the quality of the enviroment the patient is labouring and delivering in.	Replacement with new safe and up to date wall mounted lights	Kendra Thomas	30/08/2023		Informed ward manager. Has previously enquired and been told cost is an implication with these items. I will send an email to ask for response to initiate a possible outcome. 15.03.23 New wall Lamps are going to be ordered to replace room wall lamps.
23/02/2023	SGH	Staffing within PAC is 3.2 and the establishment is 5.32. Despite this, it is being expected that they will release staff to work in the Triage	Escalated to Deputy Head of Midwifery	Nicola Foster	31/03/2023		To be noted within Minutes from the Triage Implementation meeting and acknowledged
23/02/2023	SGH	Patients frequently have lengthy delays of being reviewed by a doctor in the ADU of up to 2-3 hours	Escalation SOP to be produced and ratified through Governance	Natalie Jenkin/ Miss Gandhi	31/05/2023		Ratified SOP
23/2/2023`	SGH	Increased number of baby readmissions due to weight loss and jaundice	Encourage to complete incident forms for these to be investigated	Natalie Jenkin	31/03/2023		Minutes from Manager's Meeting
23/02/2023	SGH	Parents not adhering to the safe sleeping recommendations of babies not wearing hats after 24 hours	Discussion at Manager's Meeting	Natalie Jenkin	31/03/3023		Minutes from Manager's Meeting
23/02/2023	SGH	Time wasted in the community due to Language Line taking 10-15 minutes for each patient to connect	Encouraged to log each case for evidence for escalation to PALS	Natalie Jenkin	31/03/2023		Minutes from Manager's Meeting
15/03/2023	SGH	Staff are disposing of non-disposable instruments	The ward manager has arranged for the HSDU to take back all the instruments used and dispose of them appropriately.	Kenra Thomas	31/06/2023		15.03.23 In the hands of the manager.
15/03/2023	SGH	FSE adapters keep being removed from the CTG stands and we do not have one for each monitor	Manager to have a container to keep them centrally so staff can retrieve one as needed.	Kendra Thomas	31/04/2023		15/03/2023 in the hands of the manager.
15/03/2023	SGH	There is a national shortage of the fibronectin cartridges. None available in the country at present	Manager has placed an order to receive the partosure tests to cover until the cartridges can be obtained. An order for the cartridges is already in place.	Kendra Thomas	31/06/2023		15/03/2023. Partosures have been ordered.

Service User Feedback

Currently the Trust is without a Maternity Voices Partnership (MVP) lead due to retirement however we continue to gain service user feedback from many sources including social media. We are working with our service users in many areas of the service including the provision of partners staying overnight as used to happen prior to the pandemic. We are also keen to understand what is important to our service users which will be incorporated and threaded through the Maternity Strategy.

Whilst the appointment of a MVP chair is arranged, we continue to utilise opportunities to gain feedback including Friends and Family, national Maternity Survey and social media. There is a LMNS wide 'Ask A Midwife' facebook group which is popular amongst women and their families to access and is also a means of imparting up to date information, public health messages – Safe Sleeping, Thermoregulation etc and also events such as Antenatal Education .

5. Quality Improvement

Transforming Maternity Triage Services

The Ockenden report outlines a number of recommendations in relation to how maternity services should conduct triage for pregnant women with medical related concerns who are 16 week plus. These recommendations outline the need to follow a recognised model of triage to priorities timely assessment, i.e. the Birmingham Symptom Specific Obstetric Triage System (BSOTS).

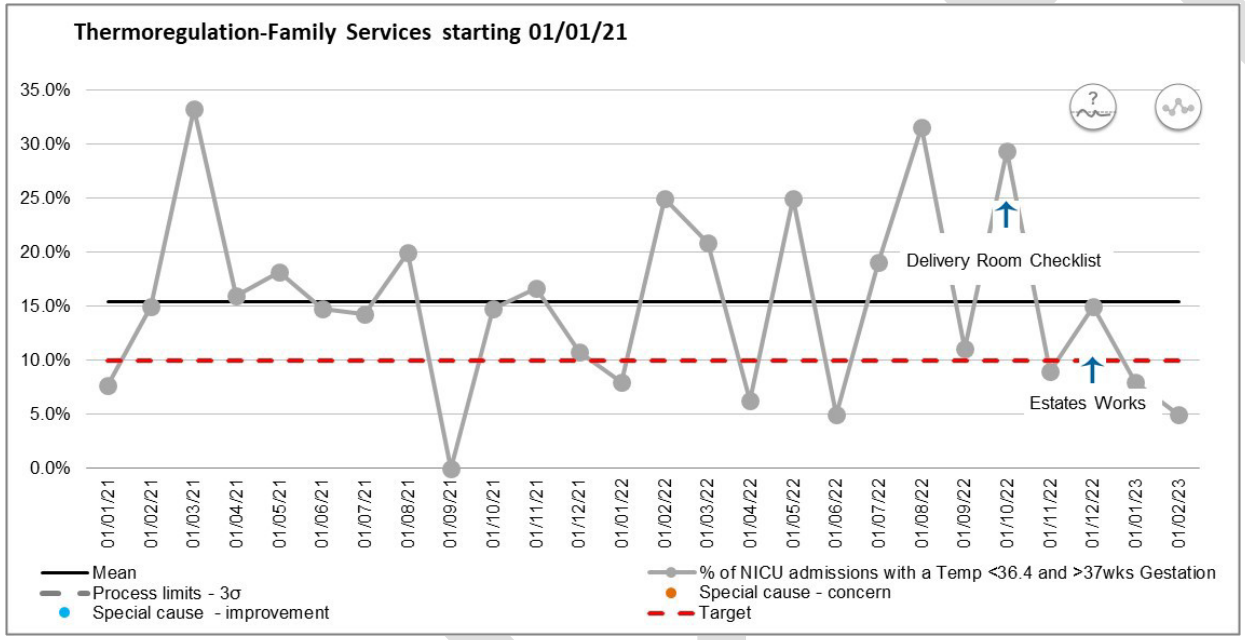
This Quality Improvement Project aim is to Implement a fully operational maternity Triage Service across the whole of the Maternity Service in NLAG, that utilises a Nationally recognised Triage Model by March 2023. In order to enhance the patient experience and care.

To date Phase 1 and 2 have been completed which focused on the implementation of a telephone triage single point of access which follows the BSOTS model. This went live in October 2022 and have answered 3557 calls to date using the BSOTS model for triage thereby centralising and standardising the advice given to patients. Having consolidated various phone lines into one single points of access this has also benefitted our wards, Antenatal Day Units (ADU) and community teams in reduced phone calls by 20hrs per week on average releasing time to care back to frontline teams. The service has also been able to utilise experienced midwives who were unable to carry out patient facing roles in a new way bringing to bear their years of experience to benefit patients making these staff members feel valued. 100% of patients using this new services have rated it either “excellent” or “very good”.

Focus has now moved to Phase 3 for full implementation of the BSOTS model which following the above telephone triage of a patient, if it is deemed they need to be assessed face to face. This extensive service redesign, including changes to staff roles and the physical footprint of our wards and areas, although fundamentally the service will be doing the same amount of work but in a different way.
The project is currently working with HR and Estates colleagues to assess requirements and agree timescales to progress Phase 3.

Reducing Thermoregulation

New-born babies following birth are at risk of thermoregulation (loss of body temperature) which can lead to other health related issues requiring admission to NICU. This Quality Improvement project's aim is to have no more than 10% of NICU admissions as a result of babies with a temperature outside of the optimal limits (<36.4) for babies >37 week gestation by 31st March 2023 (based on a baseline mean of 16% Jan 2021 – Jan 2023 equating to 97 babies). Whilst the baseline position is 16% the SPC chart below shows the larger variation and impact from 0% up to 33% of babies > 37 weeks gestation been admitted to NICU with thermoregulation.

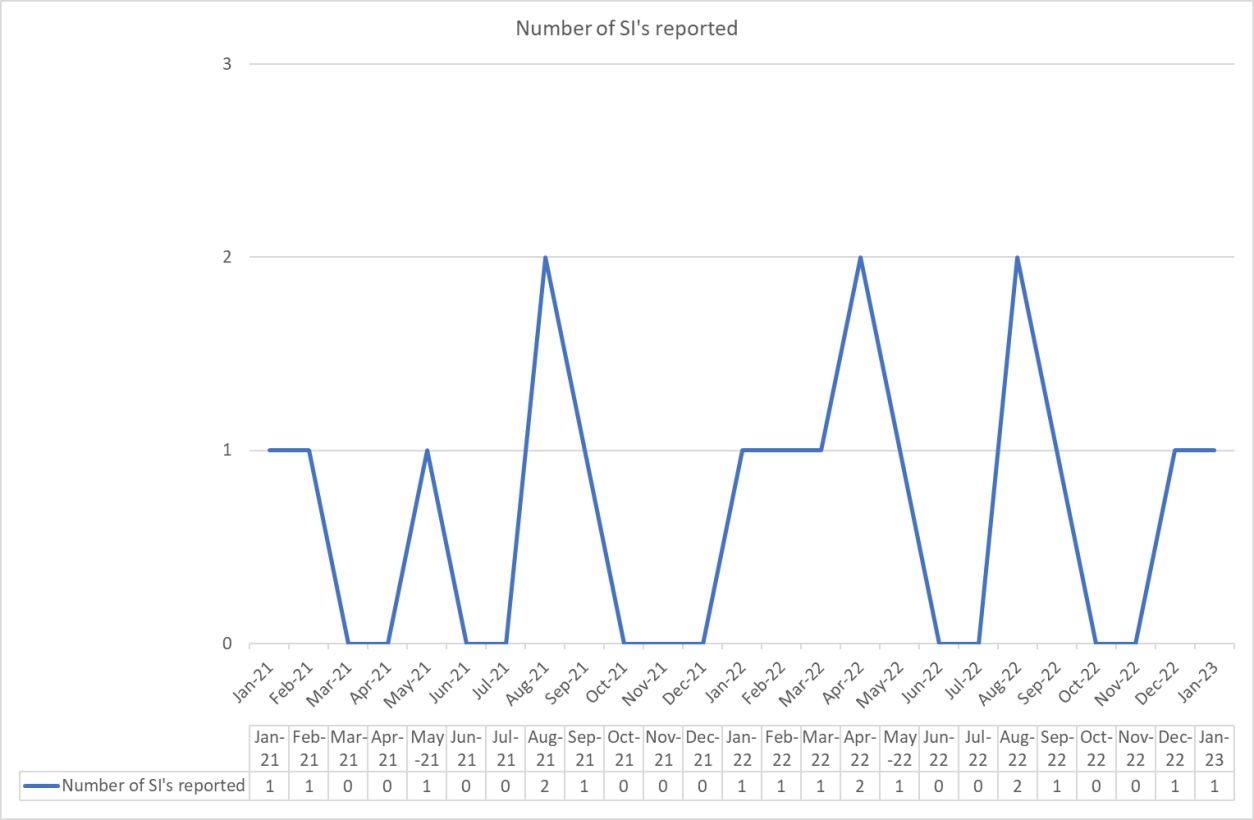


PDSA cycles commenced in October 2022 with focus on the room environments ensuring that the rooms were adequately heated, windows shut, fans off etc. This was followed up with estates working December 2022 to fix broken / draughty windows and adjust heating settings in delivery rooms at DPOW. On the 14th February an educational / communication campaign was launched aimed at both staff and new parents and care givers to explain the importance of post birth temperature and what everyone can do to support correct thermoregulation.

Since commencement of the PDSA cycles we can see from the above SPC chart that there are 4 data points below the mean with 3 data points below the 10% target. Showing potential signs of improvement. This data will continue to be monitored and reported to understand the effects of the PDSA cycles in particular the most recent educational / communication campaign which we are yet to see in this data.

6. Serious Incident reporting

The number of incidents that have been determined to be Serious Incidents (SI), in line with national SI framework is illustrated, with a monthly rate chart.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Number of SI's reported	1	1	0	0	1	0	0	2	1	0	0	0	1	1	1	2	1	0	0	2	1	0	0	1	1

Open Maternity Serious Incident Investigations as at 02.03.23

There are currently 6 Maternity Serious Incidents open in the Trust. For 2, the investigation is being undertaken by HSIB.

STEIS Ref	Site	Description	Stage	Immediate Actions	Deadline date
2022 2522	SGH	Maternal Cardiac Arrest	Approval Process	Hot debrief performed for all staff involved following incident.	07.03.2023
2022 10750	DPOW	Birth injury	Approval Process	Consultant was to be called for all forceps delivery at DPoW; this is now being extended to both sites. The batch number of the forceps is to be recorded in the labour notes, and further consent training is to be given by the Consultant.	13.03.2023
2022 18557	DPOW	Birth injury – fractured skull	Report Writing	To add to safety huddle re: use of fetal pillow for full dilatation LSCS and not to manually disimpact fetal head.	27.03.2023
2022 20796	DPOW	Unexpected baby death	Investigation	The neonatal resus pro forma is being reviewed as it is not user-friendly for an emergency situation.	HSIB investigation

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2022 26951	SGH	IUD Delayed Induction	Investigation	Familiarisation of Fetal Growth policy re timing of inductions. Doctors reminded of availability of the Consultant on Call if there is Consultant present in the clinic.	14.03.2023
2023 398	DPOW	HSIB - IUD	Investigation	Call screening to be completed by a registered midwife on WebV. Laminated cards for CTG interpretation placed on the CTG monitors Review of appropriate escalation completed by Senior Midwifery Team (outcome reported to SI Panel that escalation was compliant with policy requirements).	HSIB investigation

Maternity Serious Incident Completed Reports (January 2023) – None

Risks, learning points and themes

- PMRT – poor documentation of the assessment of domestic abuse
- Perinatal – thermoregulation of babies. This is fed into a QI project on thermoregulation
- System wide issue of in-utero transfer challenges due to staffing shortages, with regional OPEL status approach being introduced.
- Inaccuracy in the assessment of risks which may lead to incorrect care pathways or interventions.
- Birth injuries to babies from instrumental deliveries, which is being monitored through instrumental delivery audits.

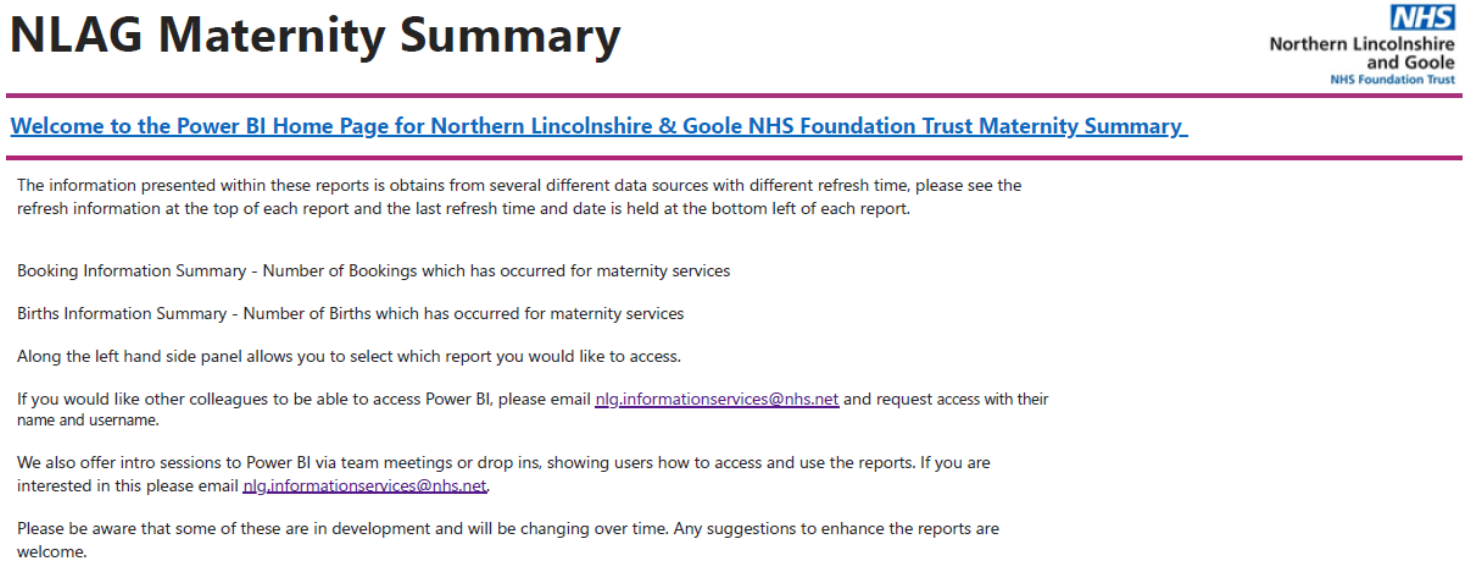
7. Operational framework compliance – Q3 data

MATERNAL CLINICAL INDICATORS											
Normal births	Number of women with a vaginal birth	614	535	398.4	1	to	761	226	to	614.5	
Normal births	% of women - normal births	62.4%	59.4%	54.4%	48.2%	to	100.0%	53.4%	to	57.6%	
Assisted vaginal births	Number of women with an instrumental birth	56	64	74.7	0	to	178	46	to	99	
Assisted vaginal births	% of women - assisted vaginal births	5.7%	7.1%	10.2%	0.0%	to	14.8%	8.2%	to	12.0%	
Elective C/S births	Number of women - El C/S	140	132	109.8	0	to	220	61.5	to	160	
Elective C/S births	% of women - El C/S	14.2%	14.7%	15.0%	0.0%	to	17.3%	14.1%	to	16.2%	
Emergency C/S births	Number of women - Em C/S	174	170	153.9	0	to	335	73.5	to	220	
Emergency C/S births	% of women - Em C/S	17.7%	18.9%	21.0%	0.0%	to	33.3%	18.0%	to	23.1%	
Number of C/S births	No. of women - Total all C/S	314	302	263.7	0	to	548	139.5	to	381	
C/S deliveries	% of women - Total all C/S	31.9%	33.5%	36.0%	0.0%	to	43.0%	33.3%	to	37.7%	
3rd/4th degree tear - normal birth	Number of women with 3rd and 4th degree tear following a normal birth	8	7	8.1	0	to	27	4	to	10	
3rd/4th degree tear - normal birth	% women with 3rd and 4th degree tear following a normal birth	1.3%	1.3%	2.0%	0.0%	to	4.0%	1.1%	to	2.6%	
3rd/4th degree tear - assisted birth	Number of women with 3rd and 4th degree tear following an assisted birth	4	2	3.2	0	to	12	1	to	4	
3rd/4th degree tear - assisted birth	% women with 3rd and 4th degree tear following an assisted birth	7.1%	3.1%	4.3%	0.0%	to	8.5%	3.0%	to	5.3%	
Induction of Labour	Number of women commenced induction of labour	371	352	269.9	0	to	471	158.5	to	399.5	
Induction of Labour	% women commenced induction of labour	37.7%	39.1%	36.8%	0.0%	to	56.1%	32.9%	to	40.0%	
PPH ≥ 1500ml	Number of women who have birthed with PPH ≥ 1500ml	21	33	28.9	0	to	61	15.5	to	43.5	
PPH ≥ 1500ml	% women who have birthed with PPH ≥ 1500ml	2.1%	3.7%	3.9%	0.0%	to	8.2%	3.2%	to	4.2%	
NEONATAL CLINICAL INDICATORS											

STILLBIRTHS											
Stillbirths - Rolling annual total	Annual number of ALL stillborn babies	7	7	11.6	0	to	33	5	to	17	
Stillbirth rate - Total	Annual rate for ALL stillborn babies / 1000 births	1.8	1.9	4.0	0.0	to	6.6	2.2	to	4.6	
Stillbirths	Number of all babies stillborn	2	3	2.8	0	to	10	1	to	3	
Stillbirths - antenatal	Rolling annual number of babies stillborn, diagnosed during antenatal period	7	6	9.9	0	to	27	5	to	15	
Stillbirth rate - Antenatal	Annual rate for antenatal stillborn babies / 1000 births	1.8	1.6	3.4	0.0	to	5.4	2.1	to	4.1	
Stillbirths - intrapartum	Rolling annual number of babies stillborn, diagnosed during intrapartum period	0	1	1.7	0	to	6	1	to	3	
Stillbirth rate - Intrapartum	Annual rate for intrapartum stillborn babies / 1000 births	0.0	0.3	0.6	0.0	to	1.4	0.1	to	0.6	
HSIB reportable births	Rolling annual number of reportable births	0	0	2.2	0	to	5	0	to	4	
HSIB reportable births	Rolling annual % reportable births	0.0%	0.0%	0.1%	0.0%	to	0.3%	0.0%	to	0.1%	
Stillbirths - excluding those with lethal abnormalities	Rolling annual number of babies stillborn, excluding those with lethal abnormalities	2	7	9.2	0	to	25	4	to	12.5	
Stillbirth rate - adjusted to exclude lethal abnormalities	Annual stillborn babies / 1000 births excluding babies with lethal abnormality	0.5	1.9	3.2	0.0	to	5.0	1.7	to	4.2	
Stillbirths at term	Rolling annual number of babies stillborn at term	2	4	3.6	0	to	8	1	to	6	
Stillbirths at term with low birth weight	Rolling annual number of babies stillborn at term < 2200g	0	1	0.3	0	to	3	0	to	0	
Stillbirths at term with low birth weight	Annual % of stillborn babies < 2200g	0.0%	25.0%	8.7%	0.0%	to	100.0%	0.0%	to	0.0%	
All losses under 24+0 weeks gestation	Number of all losses under 24+0 weeks gestation	300.0%	1	27	0	to	241	0	to	18	
Hold for %		0.0%	0.0%	0	0	to	0	0	to	0	

8. Maternity Dashboard

Front page of maternity dashboard developed by the Informatinon Team.



NLAG Maternity Summary

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Welcome to the Power BI Home Page for Northern Lincolnshire & Goole NHS Foundation Trust Maternity Summary

The information presented within these reports is obtains from several different data sources with different refresh time, please see the refresh information at the top of each report and the last refresh time and date is held at the bottom left of each report.

Booking Information Summary - Number of Bookings which has occurred for maternity services

Births Information Summary - Number of Births which has occurred for maternity services

Along the left hand side panel allows you to select which report you would like to access.

If you would like other colleagues to be able to access Power BI, please email nlg.informationservices@nhs.net and request access with their name and username.

We also offer intro sessions to Power BI via team meetings or drop ins, showing users how to access and use the reports. If you are interested in this please email nlg.informationservices@nhs.net.

Please be aware that some of these are in development and will be changing over time. Any suggestions to enhance the reports are welcome.

9. Maternity Self-Assessment Tool

The maternity self-assessment tool forms the basis for the organisation exiting from the Maternity Safety Support Programme hosted by NHSEI and was initially presented to the Trust Management Board on 6 March 2023. The self-assessment outcomes provide assurance of good self-assessed compliance with the majority of descriptors used to benchmark organisations in the core principles of good safety standards and offers assurance that the Trust's maternity operational service delivery meets national standards, guidance and regulatory requirements. Opportunities for improvement have been identified and translated into an action plan (see below) which will be progressed by the Family Services Division with Trust wide/corporate support. These actions will be monitored through divisional governance with board assurance provided via the Division's regular report to the Quality and Safety Committee, through to Trust Board. The self-assessment tool (Appendix I) will be monitored through the Maternity Improvement and Transformation Board.

ACTION LOG & TRACKER

Executive Sponsor: Ellie Monkhouse, Chief Nurse

MATERNITY SELF-ASSESSMENT TOOL

Northern Lincolnshire and Goole NHS Foundation Trust

Feb-23

Description	Evidence	Action Ref	Lead Officer	Due Date	Progress / Evidence of Completion	Status	Evidence Stored? (if required)
Leadership development opportunities	Leadership and development programme for potential future talent (talent pipeline programme)	1	Tori Horden	Mar-23	Evidence required. Leadership Development Strategy		
Maternity strategy, vision and values	Maternity strategy in place for minimum 3-5 years	2	Division Tri	Apr-23	In progress		
	Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	3	Division Tri	Apr-23	In progress		
	Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	4	Division Tri	Apr-23	In progress		
	Maternity strategy aligned with trust board LMNS and MVP's strategies	5	Division Tri	Apr-23	In progress		
Non-executive maternity safety champion	NED appointed as one of the board level maternity safety champions and working to national role descriptor	6	CNO	Apr-23	in progress		
Multiprofessional engagement workshops	Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans	7	Division Tri	Mar-23	Evidence required		
Multiprofessional inclusion for recruitment and HR processes	Organisational values-based recruitment in place	8	Dave Sprawka	Feb-23	Evidence required		Evidence\VBR
Multiprofessional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	9	Rick Dickinson	Apr-23	Evidence required		
Clearly defined behavioural standards	Schedule of focus for behavioural standards framework across the organisation	10	HRBP	TBC	Evidence required. Divisional framework in development.		
	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	11	HRBP	TBC	Evidence required. In progress at divisional level.		
Maternity governance structure	Maternity governance and leadership team roles review	12	Division Tri	Apr-23	Review underway supported by MIA. Recruitment in progress for additional leadership roles		
Proactive shared learning	Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	13	Rick Dickinson	Jun-23	Evidence required		
Safety huddles	Audit of compliance against safety huddle guideline/SOP	14	Division Tri	Apr-23	Evidence required		
Trust wide Swartz rounds	Annual schedule for Swartz rounds in place	15	Cate Neal	Feb-23	Launched Jan 23. Evidence required		Evidence\Swartz
	Multiprofessional attendance recorded and supported as part of working time	16	Cate Neal	Feb-23	Launched Jan 23. Evidence required		Evidence\Swartz
	Broad range of specialties leading sessions	17	Cate Neal	Feb-23	Launched Jan 23. Evidence required		Evidence\Swartz

Key:

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

10. CNST Evidence

Maternity Incentive Scheme (CNST) - year four

Following a robust confirm and challenge process both internally and with the ICB/LMNS, full compliance has been reported to NHS Resolution prior to the 2 February 2023 submission date.

Safety Action	Compliance met
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

Maternity Incentive Scheme, year five, is awaited.

11. Conclusion

The oversight report highlights all the work being undertaken within the maternity services and shows that the midwifery vacancies are reducing month on month. Four internationally educated midwives arrived at the trust in early March 2023 and are currently undertaking the regional course to be successful with the necessary midwifery OSCE. The pastoral and retention midwife is working with both the international midwives and the early career midwives and the additional support is being well received. The fill rates show a good position and anecdotally the trust incentives have been welcomed by midwives eager to gain the additional payment. The midwife: birth ratios remain within acceptable limits each month with it typically being around 1:25 with the national expectation being less than 1:28.

Complaints and PALS remain in low figures, and these are investigated and resolved within the expected time limits. The Friends and Family show excellent feedback with an average score of 4.78 and an 88.3% positive experience.

There was a 15 Steps Challenge Visit during January 2023 which was to the Pregnancy Assessment Centre. There had not been a previous visit and although it showed that there were some areas of improvement needed, the staff feedback was outstanding. The team are currently working through the actions, and it is anticipated that the next visit will show an improvement.

The Maternity Safety Champions have an embedded walk round programme visiting different areas each time and it provides assurance of a 'floor to board' communication. There is currently no MVP chair however we continue to work closely with the service users, gaining feedback from many forums and seeking opinions on a variety of current projects including the Maternity Strategy and partners staying overnight.

There are a number of on-going Quality Improvement projects including maternity triage services and reducing thermoregulation issues for new-born babies. Both projects have full support from all the team and feedback from staff and service users is excellent. The triage service is currently providing consistent advice to women who ring with concerns and are signposted to the most appropriate area. The next stage of the project is the opening of an area at each unit which is specifically for women who ring with concerns and need to be seen.

Serious incidents and HSIB cases remain low with 1 newly reported in January 2023. As with complaints and PALS, due to the limited number there are no themes however all learning is widely shared across all areas and reported into the regional meeting.

The maternity self-assessment tool forms a basis for the organisation to exit from the Maternity Safety Support Programme and the action plan within the report shows the outstanding issues which are being worked through. The maternity strategy is due to be completed by the end of April which will greatly support the exit plan.

Classification: Official

Publication approval reference: PAR807

Maternity services system learning
Maternity self-assessment tool

Northern Lincolnshire & Goole NHS Foundation Trust

February 2023

Where updates have been made to the content of this document since the previous version was published (version 5, February 2020), they have been highlighted in yellow.

Introduction

This Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

Please use this tool to as a benchmark for your organisation in the core principles of good safety standards within Maternity services.

The tool

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups	G	
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes	G	
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined	R	Associate Chief Nurse (B8D) – Midwifery, Gynaecology and Breast E: Job description
		Agenda for change banded at 8D or 9	G	AfC Band 8D
		In post	R	Associate Chief Nurse – Midwifery, Gynaecology and Breast
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate	G	
		Clinical director to executive medical director	G	
		DoM to executive director of nursing	G	Associate Chief Nurse (HoM) reports to Chief Nurse
		General manager to executive chief operating officer	G	Associate COO reports to COO

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity services standing item on trust board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions	**G**	Maternity services update standing agenda item at Trust Board. E: Trust Board update paper last 3 months
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	G	Via Quality & Safety Committee and Quality Governance Group E: Last 3 months QGG and QSC papers
		~~Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]~~	Duplicate of above	
		There should be a minimum of three PAs allocated to clinical director to execute their role	G	5 PA's within DMD job plan E: DMD job plan
	Collaborative leadership at all levels	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team	G	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	in the directorate/ care group	Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave	G	HR Business Partner allocated to division supported by HR Advisor E: Workforce SMT papers last 3 months, matron/ward leader meeting notes
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate	G	DFM allocated to division
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area	G	Financial monitoring systems in place at all levels within division E: Finance SMT papers last 3 months
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways	G	Adequate operational infrastructure and systems to support service delivery E: Divisional management and accountability organogram, governance meeting structure, Audit Yorkshire report
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups	G	E: Papers from last 3 months O&G Operational Group, O&G Governance, SMT, Divisional Board

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly	G	
		Leadership culture reflects the principles of the '7 Features of Safety'.	A	
	Leadership development opportunities	Trust-wide leadership and development team in place	G	
		Inhouse or externally supported clinical leadership development programme in place	G	E: People Strategy
		Leadership and development programme for potential future talent (talent pipeline programme)	A	E: People Strategy
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship	G	Bespoke leadership development with external organisation for all HoN/HoM, Aspiring HoM course
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy	G	E: Divisional and organisational accountability organograms
		Organisational vision and values in place and known by all staff	G	E: Annual Report and Accounts 21/22
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]	G	E: HR policies
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years	A	Maternity strategy in development. E: Nursing, midwifery and AHP strategy

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	A	As above
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	A	In progress
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]	G	Excellent mechanisms in place E: Examples of MVP work
		Maternity strategy aligned with trust board LMNS and MVP's strategies	A	In progress
		Strategy shared with wider community, LMNS and all key stakeholders	A	In progress
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor	A	Role description under review
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor	A	Embedded bi-monthly walkarounds by Safety Champions, close links to Maternity E: Safety champions walkaround feedback documentation
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)	G	In place E: 15 Steps Challenge example

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services	G	Maternity services update on Trust Board and minutes reflect check and challenge E: Trust Board meeting minutes
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]	G	To QSC quarterly
Multiprofessional team dynamics	**Multiprofessional engagement workshops**	Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans	A	Ockenden review events, require 23/24 workplan of scheduled events E: 23/24 workplan of multiprofessional engagement events
		Record of attendance by professional group and individual	G	Attendance recorded
		Recorded in every staff member's electronic learning and development record	G	ESR
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see	G	E; TNA with Core Competency framework
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority	G	As above
		All staff given time to undertake mandatory and job essential training as part of working hours	G	
		Full record of staff attendance for last three years	G	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Record of planned staff attendance in current year	G	
		Clear policy for training needs analysis in place and in date for all staff groups	G	E: TNA policy
		Compliance monitored against training needs policy and recorded on roster system or equivalent	G	
		Education and training compliance a standing agenda item of divisional governance and management meetings	G	E: Papers from Workforce SMT, Divisional Board, PRIM
	Clearly defined appraisal and professional revalidation plan for staff	Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]	G	PROMPT MDT training, MDT simulation based events
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal	G	
		All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation	G	
		Compliance with annual appraisal for every individual	G	Compliance monitored through O&G Operational Group, SMT, Divisional Board, and PRIM
		Professional validation of all relevant staff supported by internal system and email alerts	G	
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities	G	
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings	G	Annual workplan in place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Multiprofessional clinical forums	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups	G	
	Multiprofessional inclusion for recruitment and HR processes	Organisational values-based recruitment in place	A	Working towards E: People Strategy
		Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures	G	
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints	G	E: SOP
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy	G	Hot debrief following event, arranged debrief few days later
		Schedule of attendance from multiprofessional group members available	G	Not for debrief sessions as not recorded anywhere as emphasis on support However captured within training events including PROMPT etc
	Multiprofessional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multiprofessional attendance.	G	
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design	G	
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users	G	
	Collaborative multiprofessional	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility	G	Clear roles and responsibilities

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	input to service development and improvement	Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP	G	Several QIP on-going with clear measurables.
		Identification of the source of evidence to enable provision of assurance to all key stakeholders	G	
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access	G	E: H drive link
		Clear communication and engagement strategy for sharing with key staff groups	G	In place
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements	G	
		Weekly/monthly scheduled multiprofessional safety incident review meetings	G	Weekly incident review mtgs
	Multiprofessional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	R	Schedule required
		Positive and constructive feedback communication in varying forms	G	E: Maternity services update, blog update
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach	G	
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]	G	All staff groups involved in an incident are invited to debrief, on-going support offered to all
		Schedule of focus for behavioural standards framework across the organisation	R	External de-brief training undertaken by HoM

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	R	POE
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]	G	
		All policies and procedures align with the trust's board assurance framework (BAF)	G	E: BAF
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance	G	
		Staff across services can articulate the key principles (golden thread) of learning and safety	G	
		Staff describe a positive, supportive, safe learning culture	G	
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams	G	
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC)✓ Consultant Obstetrician governance lead (Min 2PA's) ✓ Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife X Practice development midwife ✓ Clinical educators to include leading preceptorship programme ✓ Appropriate Governance facilitator and admin support ✓	A	Trust structure does not include an Audit Midwife Review of maternity governance structure to be undertaken with MIA
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member	G	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales	G	
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF	G	E: DCP163
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF	G	E: BAF
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board	G	
		Mechanism in place for trust-wide learning to improve communications	G	
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication	G	
		Governance communication boards	G	
		Publicly visible quality and safety board's outside each clinical area	G	
		Learning shared across local maternity system and regional networks	G	
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups	G	
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	R	
		Multi-agency input evident in the development of the maternity specification	G	E: Maternity specification
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process	G	
		In date and reflective of local maternity system plan	G	
		Full compliance with all current 10 standards submitted	G	E: CNST Board submission

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.	n/a	CNST achieved 20/21 and 22/23
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance	G	
		Clear process for multiprofessional, development, review and ratification of all clinical guidelines	G	
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme.	G	
		All guidance NICE complaint where appropriate for commissioned services	G	
		All clinical guidance and quality standards reviewed and updated in compliance with NICE	G	
		All five elements implemented in line with most updated version	G	
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.	G	
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan	G	Achieved
		All four key actions in place and consistently embedded	G	
	Application of the four key action points to reduce inequality for BAME women and families	Application of equity strategy recommendations and identified within local equity strategy	G	LMNS equity strategy ratified
		All actions implemented, embedded and sustainable	G	Incl CoC prioritised for those most in need
	Implementation of 7 essential learning	Fetal Surveillance midwife appointed as a minimum 0.4 WTE	G	0.8wtein place E: Job description

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	actions from the Ockendon first report	Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs	G	One consultant at each site
		Plan in place for implementation and roll out of A-EQUIP	G	Roll out complete
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team	G	
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered	G	
		Service provision and guidance aligned to national bereavement pathway and standards	G	
	Maternity bereavement services and support available	Bereavement midwife in post	G	E: Job description
		Information and support available 24/7	G	
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities	G	
		Quality improvement leads in place	G	
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation	G	E: Maternity QI plan
		Recognised and approved quality improvement tools and frameworks widely used to support services	G	
		Established quality improvement hub, virtual or otherwise	G	
		Listening into action or similar concept implemented across the trust	G	
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.	G	Plan to re-survey in 23/24
	MatNeoSip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan	G	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)	G	
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees	G	
		FTSU guardian in post, with time dedicated to the role	G	E: FTSU Guardian job description
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post	G	
	Human factors training available	Human factors training part of trust essential training requirements	G	Part of mandatory study
		Human factors training a key component of clinical skills drills	G	
		Human factors a key area of focus in clinical investigations and formal complaint responses	G	
		Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.	G	Audited regularly

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern	G	Audited
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's	G	
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date s	G	E: Safety huddle SOP/guideline
		Audit of compliance against above	A	In progress
		Annual schedule for Swartz rounds in place	A	Launched Jan 23
	Trust wide Swartz rounds	Multiprofessional attendance recorded and supported as part of working time	A	As above
		Broad range of specialties leading sessions	A	As above
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse	G	In place
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit	G	Shared amongst all relevant divisions
		Annual or biannual trust-wide learning to improve events or patient safety conference forum	A	2022 QI conference
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes	G	E: Trust Board papers
		In date business plan in place	G	E: Divisional Business Plan

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Comprehension of business/ contingency plans impact on quality. **(ie Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively**	Meets annual planning guidance	G	
		Business plan supports and drives quality improvement and safety as key priority	G	
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups	G	
		Consultant job plans in place and meet service needs in relation to capacity and demand	G	E: Job Planning Committee papers
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans	G	E: Job plans
		Business plans ensures all developments and improvements meet national standards and guidance	G	
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.	G	
		Business plans include dedicated time for clinicians leading on innovation, QI and Research	G	
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.	G	
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidance meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.	G	
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.	G	

Key lines of enquiry	Kirkup recommendation number
Leadership and development	2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18
Governance: Covers all pillars of Good governance	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Quality Improvement: application of methodology and tools	5, 6, 9, 12, 13, 15, 16, 17, 18
National standards and Guidance: service delivery	2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Safety Culture: no blame, proactive, open and honest approach, Psychological safety	2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Patient Voice: Service user involvement and engagement through co-production and co-design. MVP and wider	6, 9, 11, 12, 13, 15, 17, 18
Staff Engagement: Harvard System two leadership approach, feedback and good communication tools	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Business Planning: aligned with LMNS plans and the National Maternity Transformation agenda, Maternity safety strategy and the Long term plan	8, 9, 10, 14, 15, 16, 17, 18

Key supporting documents and reading list

1. NHS England National Maternity review: Better Births. February 2016; https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

2. Royal College of Obstetricians and Gynaecologists Maternity Standards 2016; https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf

3. NHS England NHS Long Term Plan: January 2019; https://www.longtermplan.nhs.uk/

4. Report of the Investigation into Morecambe Bay March 2015; https://www.gov.uk/government/publications/morecambe-bay-investigation-report

5. Royal College of Midwives. Birth-rate plus tools; https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf

6. Royal College of Midwives State of Maternity Services 2018; https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf

7. NHS England. Spotlight on Maternity: Safer Maternity care. 2016; https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf

8. Department of Health Safer Maternity care. The National Ambition. November 2017; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf

9. NHS Resolution. Maternity Incentivisation Scheme 2019/20; https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

10. NHS staff survey. (2018); https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/

11. Maternity Picker Survey. 2019; https://www.picker.org/wp-content/uploads/2014/10/Maternity-4-pager-for-website-ARe-V2-18122018.pdf

12. National Maternity Perinatal Audit. (NMPA) report; https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-nmpa-clinical-report-2019/#.XdUiX2pLFPY

13. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. (MBRACE) report; https://www.npeu.ox.ac.uk/mbrrace-uk

14. Organisations Monthly Maternity Dashboards; https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard

15. Organisational Maternity and Neonatal Cultural Score Survey; https://improvement.nhs.uk/documents/5039/Measuring_safety_culture_in_matneo_services_qi_1apr.pdf

16. NHS England Saving babies lives Care bundle. V2 March 2019; https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

17. 7 Features of safety in maternity services framework; https://for-us-framework.carrd.co/

18. Ockendon Report: investigation into maternity services at Shrewsbury and |Telford NHS hospitals 2020; https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

19. Perinatal Surveillance Model; https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

20. Maternity Incentive Scheme; https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf

Appendix II

Non-Executive Director | Maternity Board Safety Champion

The role of the trust board safety champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, LMNS leads, the Regional Chief Midwife and Lead Obstetrician and the Trust board to understand, communicate and champion learning, challenges, and successes.

The role is discharged through attendance at a range of assurance committees and is supplemented by regular onsite visits.

Board Assurance Committees

- Quality & Patient Safety Committee
- Workforce Committee

Additional Committees

When not in conflict with Board Assurance committees attend:

- Maternity Transformation & Improvement Board
- Local Maternity and Neonatal System (LMNS)

Key responsibilities:

- Bring a degree of independent, supportive challenge to the oversight of maternity & neonatal services.
- Utilise the NLaG maternity services assurance framework to ensure the provision of board level oversight and assurance.
- Adopt a curious approach to understanding and supporting the quality and safety of maternity & neonatal services.
- Ensure the views and experiences of patients and staff are heard.

NLG(23)052

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	4th April 2023	
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. • Emergency Care performance and ambulance handovers remain a concern • Some improvement in Cancer performance is starting to be seen • The Trust now had zero high level water risks at DPOW	
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:	4th April 2023
Report From:	Finance & Performance Committee – 22-02-23 and 22-03-23

Highlight Report:

Unplanned Care Month 10 – Patient Flow Improvement Group

There continued to be poor performance in A&E due to the increase in numbers and acuity of patients. Ambulance handovers were still an issue but there had been some improvement in this metric. The Urgent Care Service (UCS) and Same Day Emergency Care (SDEC) were still performing well within their working hours. The Committee asked about the right to reside performance and were informed that the data came from a point in time and could fluctuate. The Trust was in the top 10 in the country and were second in the region. The Committee questioned the opening hours of the UCS and asked what the performance would increase to if we could keep the service open 24 hours, the Committee were informed that this could potentially increase performance to c70%. The Committee requested that future iterations of the paper included the Urgent Care plan and high-level progress against the improvement milestones.

Planned Care Month 10

The Committee was informed that the urgent care bed demand was hampering planned care currently, although the Referral to Treatment (RTT) waiting list and Diagnostic performance had stabilised. There remained a shortage of MRI capacity. There had been a growth in two week wait demand but the Cancer performance was showing some improvement and was being monitored weekly. The Committee were informed that the Trust would not be entering Tier 2 for Cancer, but the national reviews would continue. The Committee queried the confidence level for hitting zero RTT 78-week waiters at the end of March and were assured that the Trust were on track, albeit with some risk of additional waiters arising from the validation process before the end of March.

Unplanned Care Month 11

Urgent Care continued to have poor performance within A&E as boarding of patients was a regular occurrence, and the ambulance handovers position was variable day by day. The UCS was still performing at 99% within 4 hours and SDEC was performing at 43%, above the national 28% performance. The 7-, 14- and 21-day lengths of stay for the Trust were still positive. The Committee questioned whether the new ED at SGH would improve the ambulance handover position and were informed that it should help if the flow of patients out of ED improved.

Planned Care Month 11

The Committee were pleased to note that Cancer performance was showing early signs of improvement, although the 62-day position was still a work in progress as the numbers included referrals where diagnostics had been completed and cancer had been ruled out. The Diagnostic performance had improved on the January position, but further progress still needed to be made. The Committee questioned the RTT 78-week March ‘23 projected month end position and were informed that there were likely to be some breaches as the Trust had just taken on further Gynaecology mutual aid from HUTH. The Committee were notified that Theatres 7 and 8 as well as Theatre A at Scunthorpe were now closed for refurbishment, which would affect RTT Treatment until they reopened in July ‘23. Performance had also improved in the sending of summary letters to General Practitioners.

Water
The Committee was presented with a comprehensive paper which detailed the improvements made in the Trusts water systems. The Trust now had zero high level water risks at DPOW which was a big improvement on the 2018 assessment; the 2023 assessment was nearing completion. The Committee were made aware that the Health and Safety Executive (HSE) had made a request to review the water system in Scunthorpe A&E due to a previous incident. The Committee queried the report wording around increased positive sample returns since the introduction of the new silver copper treatment plant at SGH and were assured there had been a significant reduction in the quantity of positive water samples.

Deep Dive into the Electrical Cable Failure at SGH
The Committee was presented with the deep dive into the Electrical cable failure on the 14th of December 2022 which resulted in a loss of power and the servers going down. The Committee was not assured by the paper and questioned the awareness of and ability to quickly implement the Business Continuity plans, as they were aware that some plans were not implemented immediately. The Committee were informed that further investigations into that example would take place and would be brought back to the March meeting. The Committee also asked about the investigation into the faulty fuel gauge, as that had not been included in the report, and were told that that was a separate incident that would be included in the updated March paper.

Deep Dive Update in March
The Committee reviewed the additional Appendices C and D to the report produced in February, which provided assurance on the review and learning from the Communications issues during the electrical failure and the Fuel Gauge incident. Action plans had been provided and the Committee would obtain assurance that all the identified actions had been completed at a future meeting.

Lifts
The Committee were assured by a paper on lifts which gave a positive picture and stated the lifts were all in good working order. The Committee were informed that an investment of around £1.25m would be required in the future to maintain them.

Highlight Report Oxygen Assurance
The Oxygen Assurance Highlight Report was received by the Committee but was lacking the details on how regularly the system was tested. The Committee were informed verbally that the system was tested every 3 years and that oxygen usage was monitored 4 times a day on all sites. The Committee were assured and agreed that annual assurance on testing would be left to the Audit, Risk and Governance Committee as agreed by the Board.

Confirm or Challenge of the Board Assurance Framework:

The Strategic Objective SO1-1.2 was reviewed by the Committee and it was agreed that with the current gaps in controls and assurance that the current risk score of 20 was the correct score for the level of risk to the achievement of the strategic objective.

Action Required by the Trust Board:

The Trust Board is asked to note the key points made and the conclusion of the deep dive into the electrical cable failure incident.
Gill Ponder
Non-Executive Director / Chair of Finance and Performance Committee

NLG(23)053

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	04 April 2023
Director Lead	Simon Nearney, Interim Director of People
Contact Officer/Author	Simon Nearney, Interim Director of People
Title of the Report	**Staff Survey**
Purpose of the Report and Executive Summary (to include recommendations)	To inform the Board of the National Staff Survey (NSS) results
Background Information and/or Supporting Document(s) (if applicable)	The NSS results have been discussed / debated at the Workforce Committee on 21 March 2023
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)	There is no request for investment as a result of this report, although it underpins the need to invest in our people priorities and culture.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	The report includes Equality, Diversity and Inclusion and specifically refers to WRES and the WDES findings.
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

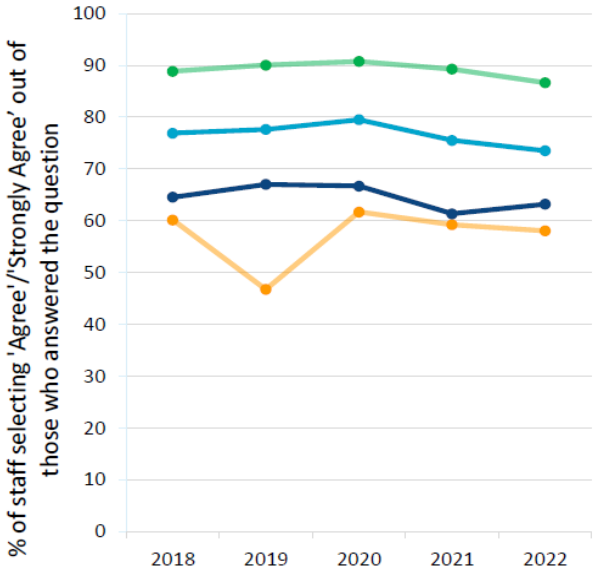
NHS Staff Survey

We each have
a voice that counts

National Staff Survey 2022

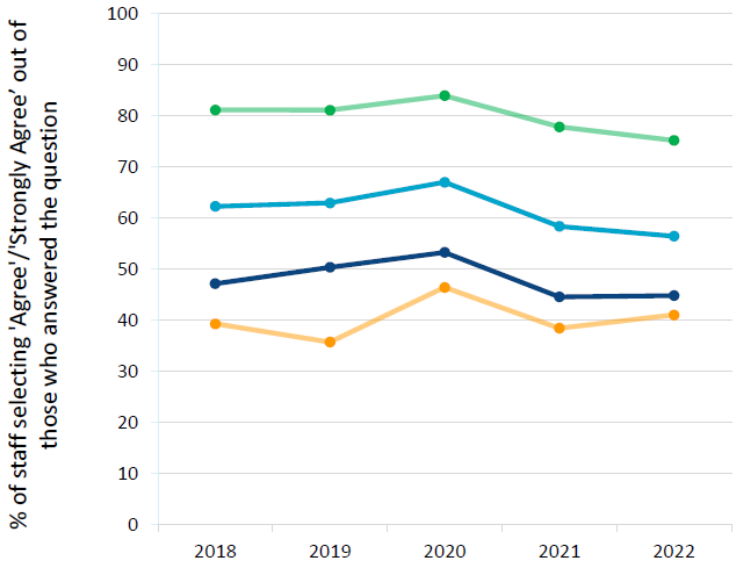
Northern Lincolnshire and Goole NHS Foundation Trust

Q23a Care of patients / service users is my organisation's top priority.



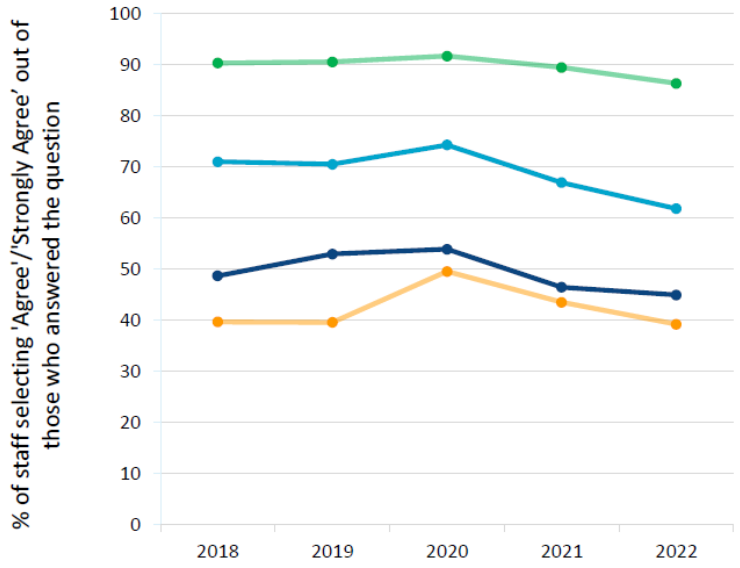
	2018	2019	2020	2021	2022
Your org	64.5%	67.0%	66.7%	61.3%	63.2%
Best	88.8%	90.0%	90.8%	89.3%	86.6%
Average	76.9%	77.6%	79.5%	75.5%	73.5%
Worst	60.1%	46.7%	61.7%	59.2%	58.0%
Responses	1943	2497	2358	2432	2349

Q23c I would recommend my organisation as a place to work.



	2018	2019	2020	2021	2022
Your org	47.2%	50.4%	53.3%	44.6%	44.8%
Best	81.2%	81.2%	84.0%	77.9%	75.2%
Average	62.3%	63.0%	67.1%	58.4%	56.5%
Worst	39.3%	35.7%	46.5%	38.5%	41.0%
Responses	1941	2478	2360	2436	2352

Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2018	2019	2020	2021	2022
Your org	48.7%	53.0%	53.9%	46.5%	45.0%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	1931	2488	2363	2433	2349

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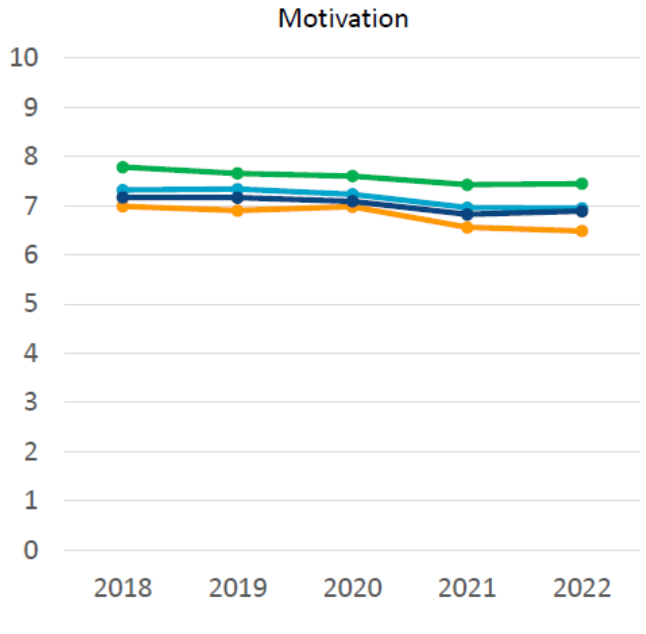
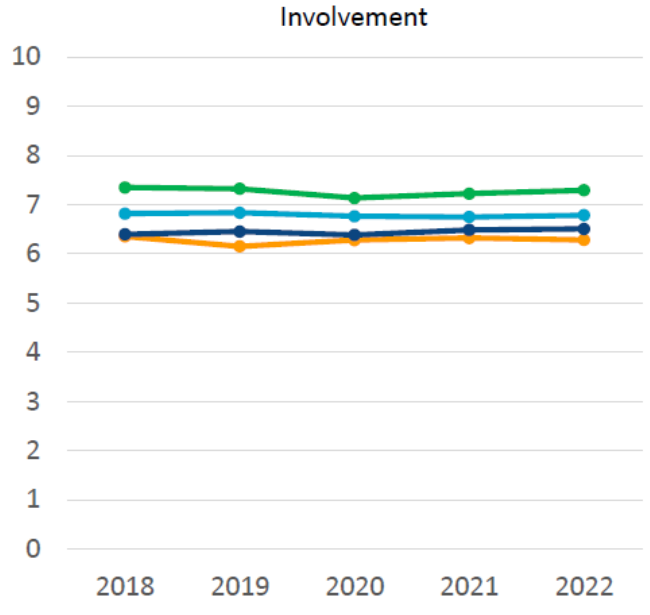
National Staff Survey 2022

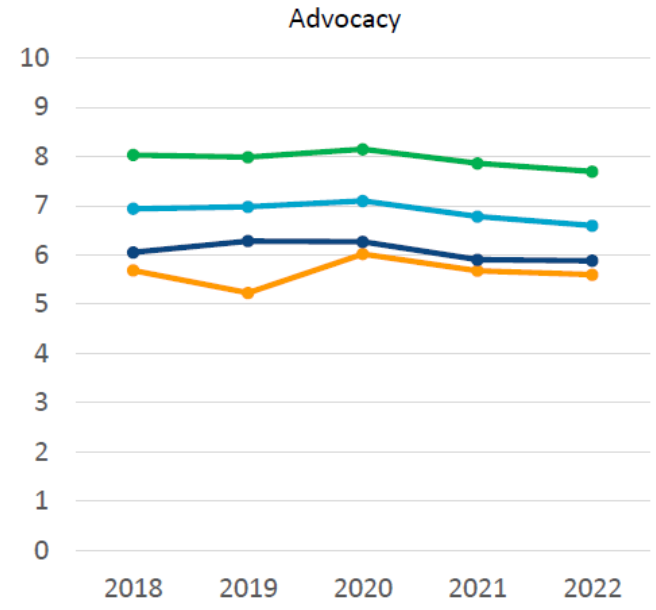
Northern Lincolnshire and Goole NHS Foundation Trust



	2018	2019	2020	2021	2022
Your org	7.2	7.2	7.1	6.8	6.9
Best	7.8	7.7	7.6	7.4	7.4
Average	7.3	7.3	7.2	7.0	7.0
Worst	7.0	6.9	7.0	6.6	6.5
Responses	1965	2531	2391	2473	2336



	2018	2019	2020	2021	2022
Your org	6.4	6.5	6.4	6.5	6.5
Best	7.3	7.3	7.1	7.2	7.3
Average	6.8	6.8	6.8	6.7	6.8
Worst	6.4	6.2	6.3	6.3	6.3
Responses	1995	2560	2394	2480	2359



	2018	2019	2020	2021	2022
Your org	6.1	6.3	6.3	5.9	5.9
Best	8.0	8.0	8.2	7.9	7.7
Average	6.9	7.0	7.1	6.8	6.6
Worst	5.7	5.2	6.0	5.7	5.6
Responses	1944	2493	2364	2437	2352

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Timeline

Survey Window: 4th October- 26th November 2022

Embargoed Findings: 24th February 2023

NHSEI Publication: 30th March 2023 5pm

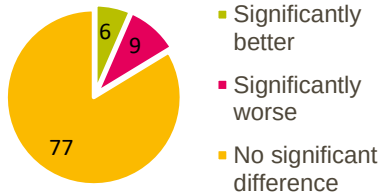
Key Facts	
Benchmark Comparators:	65 Acute & Acute Community Trusts
Benchmark Response Rate	46% (NLaG -11%)
NLaG Response Rate:	35% (-3% on 2021 survey)
NLaG Survey Mode:	online (2,415 completed / -138 on 2021)
Eligibility:	Now includes Long Term Sickness 90+ days Secondees of longer than 12mths+ Separate survey for Bank staff issued
Staff Engagement Score	6.4

Since last year, reporting is based on the 7 People Promise elements:

This report summarises the findings from the core NHS Staff Survey 2022* carried out by Picker, on behalf of NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST. Picker was commissioned by 65 Acute and Acute Community Trusts organisations to run their survey – this report presents your results in comparison to those organisations.

A total of 117 questions were asked in the 2022 survey, of these, 112 can be compared to 2021 and 97 can be positively scored. Your results include every question where your organisation received at least 11 responses (the minimum required).

6945	6848	**35%**	46%	38%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (2415)	Average response rate for similar organisations	Your previous response rate

		Comparison to 2021**	Comparison with average**
46%	q23c. Would recommend organisation as place to work		
46%	q23d. If friend/relative needed treatment would be happy with standard of care provided by organisation		
63%	q23a. Care of patients/service users is organisation's top priority		

*Bank worker survey results are presented via separate reports for those organisations who took part
**Chart shows the number of questions that are better, worse, or show no significant difference

Top 5 scores vs Organisation Average	Org	Picker Avg
q21a. Received appraisal in the past 12 months	85%	80%
q4c. Satisfied with level of pay	28%	26%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	75%	73%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	94%	92%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	46%	44%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q23d. If friend/relative needed treatment would be happy with standard of care provided by organisation	46%	61%
q23c. Would recommend organisation as place to work	46%	57%
q20. Feel organisation respects individual differences	60%	70%
q11a. Organisation takes positive action on health and well-being	46%	56%
q19b. Would feel confident that organisation would address concerns about unsafe clinical practice	45%	56%

Most improved scores	Org 2022	Org 2021
q11e. Not felt pressure from manager to come to work when not feeling well enough	76%	71%
q14d. Last experience of harassment/bullying/abuse reported	46%	43%
q21c. Appraisal helped me agree clear objectives for my work	28%	25%
q22d. Feel supported to develop my potential	47%	44%
q22a. Organisation offers me challenging work	66%	63%

Most declined scores	Org 2022	Org 2021
q4c. Satisfied with level of pay	28%	36%
q19b. Would feel confident that organisation would address concerns about unsafe clinical practice	45%	49%
q19a. Would feel secure raising concerns about unsafe clinical practice	66%	70%
q11a. Organisation takes positive action on health and well-being	46%	49%
q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public	86%	90%

Tables are based on absolute % differences, not statistical significance

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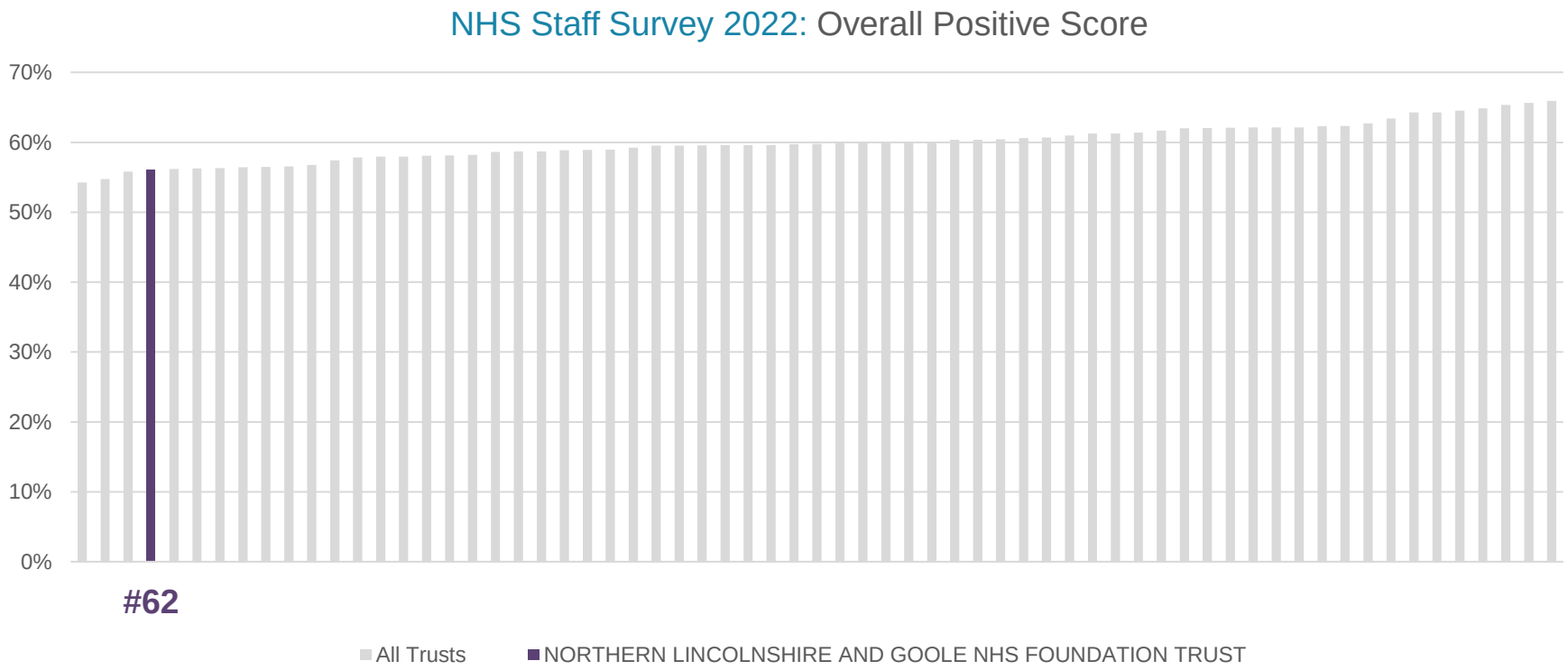
League table: overall positive score

Northern Lincolnshire and Goole NHS Foundation Trust

The league table shows how your overall positive score is ranked in comparison to the overall positive score of every other Acute and Acute Community Trusts organisation that ran the NHS Staff Survey 2022 with Picker. The overall positive score is the average positive score for all positively scored questions in the survey.



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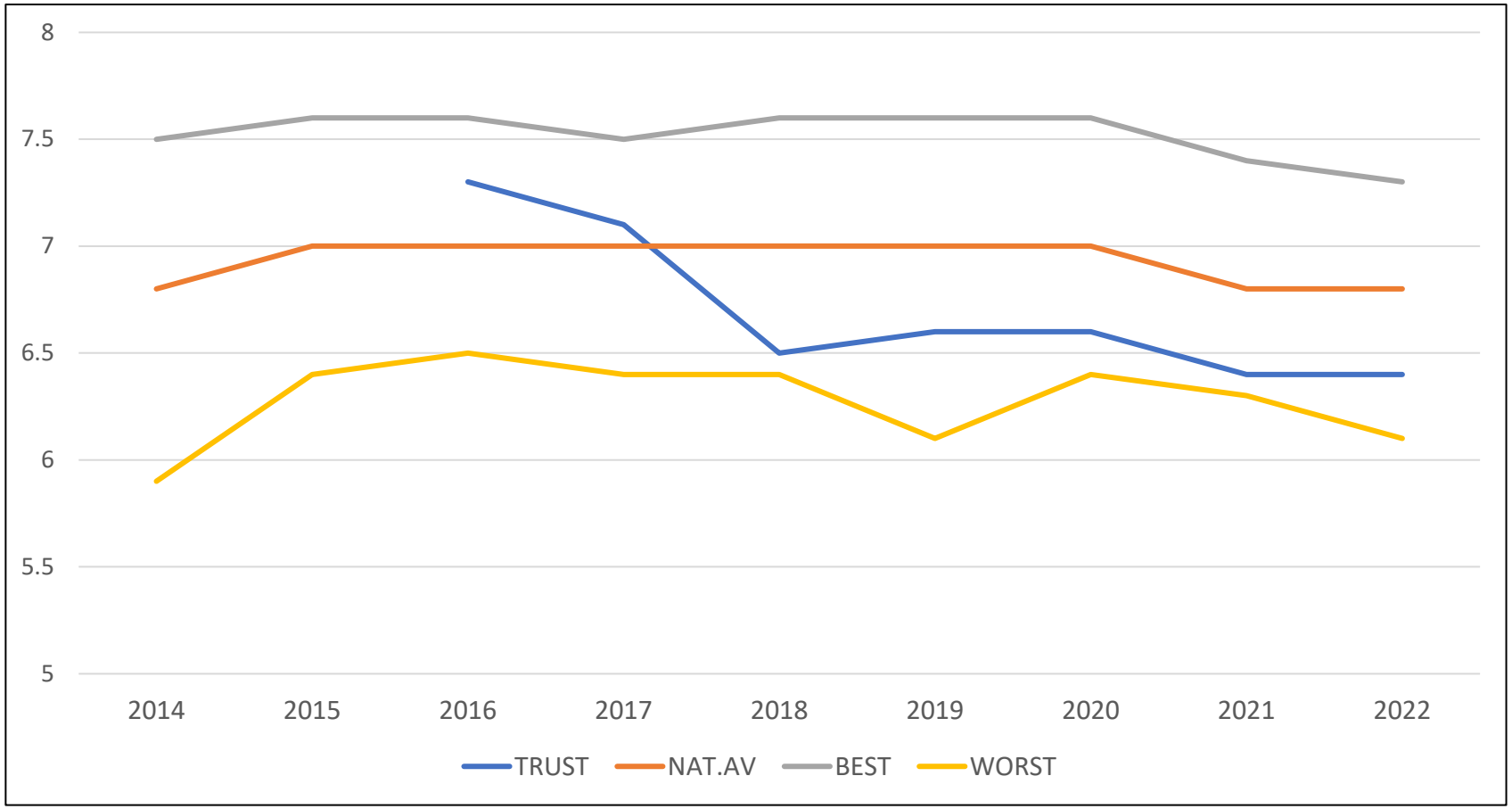
National Staff Survey staff engagement score

Northern Lincolnshire and Goole NHS Foundation Trust



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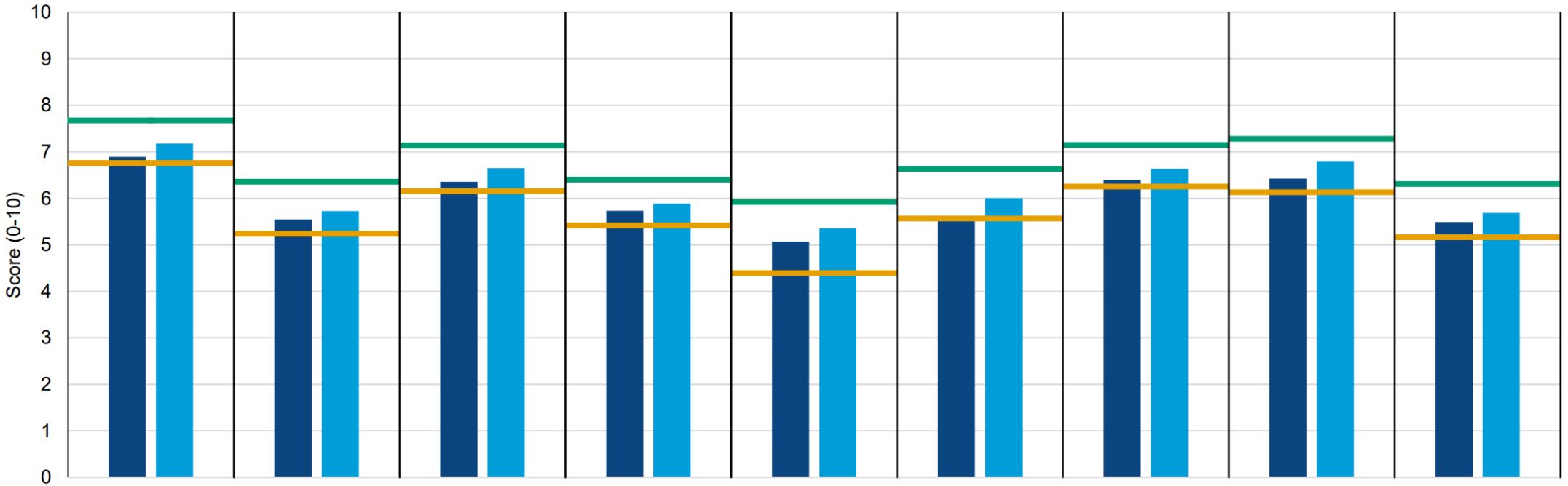
People Promise Themes

Northern Lincolnshire



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	6.9	5.5	6.4	5.7	5.1	5.6	6.4	6.4	5.5
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	2359	2359	2345	2355	2283	2352	2357	2359	2358

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WRES

Northern Lincolnshire and Goole NHS Foundation Trust

Question	NLAG	White	BME 2022	BME 2021
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from…Patients / service users, their relatives or other members of the public	24.8%	23.4%	33.2%	31.90%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	29.5%	28.1%	37.9%	38.10%
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	53.3%	54.6%	46.7%	40.10%
In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues	9.7%	7.7%	22.3%	21.40%

WDES

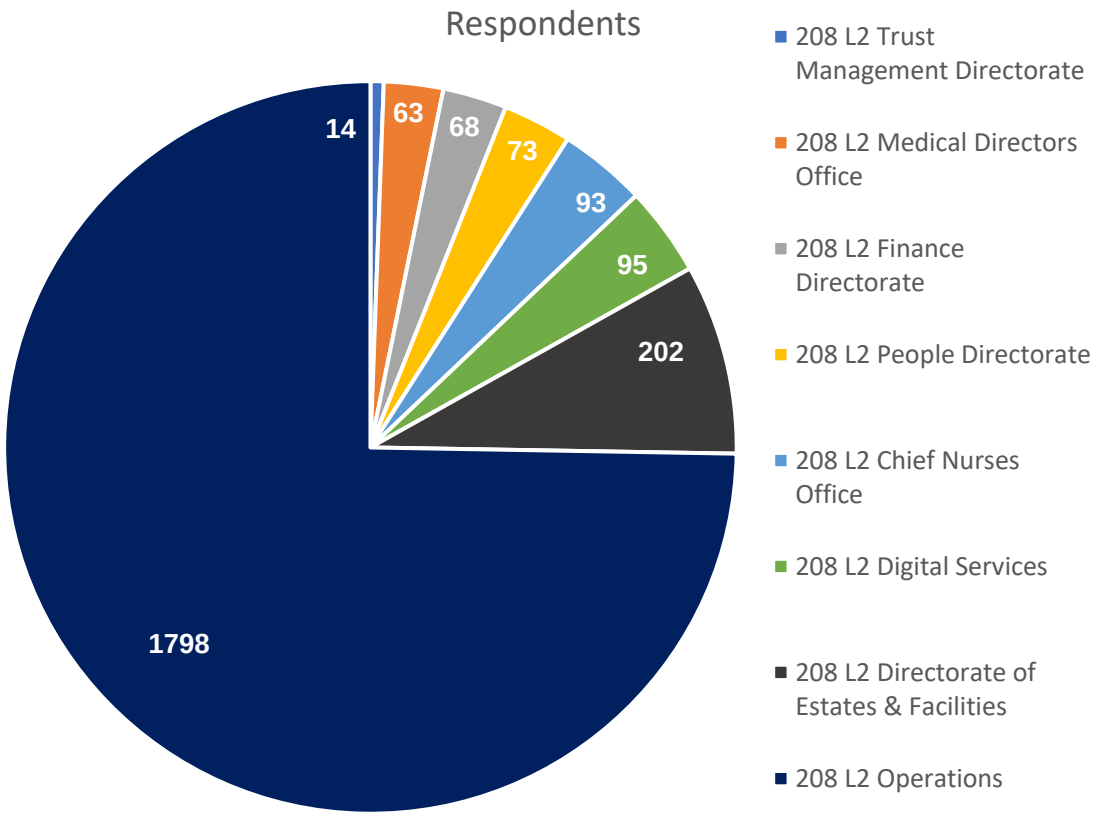
Northern Lincolnshire and Goole NHS Foundation Trust

Question	NLAG	No disability	Disability 2022	Disability 2021
Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients, Managers or Colleagues	40.5%	36.6%	**53.6%**	25.2%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from…The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	46.3%	45.0%	49.4%	42.9%
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	53.3%	56.3%	**43.8%**	47.2%
Have you felt pressure from your manager to come to work?	24.4%	21.7%	30.8%	35.8%
The extent to which my organisation values my work.	34.9%	36.9%	28.1%	26.7%
Has your employer made adequate adjustment(s) to enable you to carry out your work?	68.4%	*	**68.4%**	70.5%
Staff Engagement Score	6.4	6.6	**5.9**	6.0

NSS22
Divisional Breakdown

Divisional Response rates

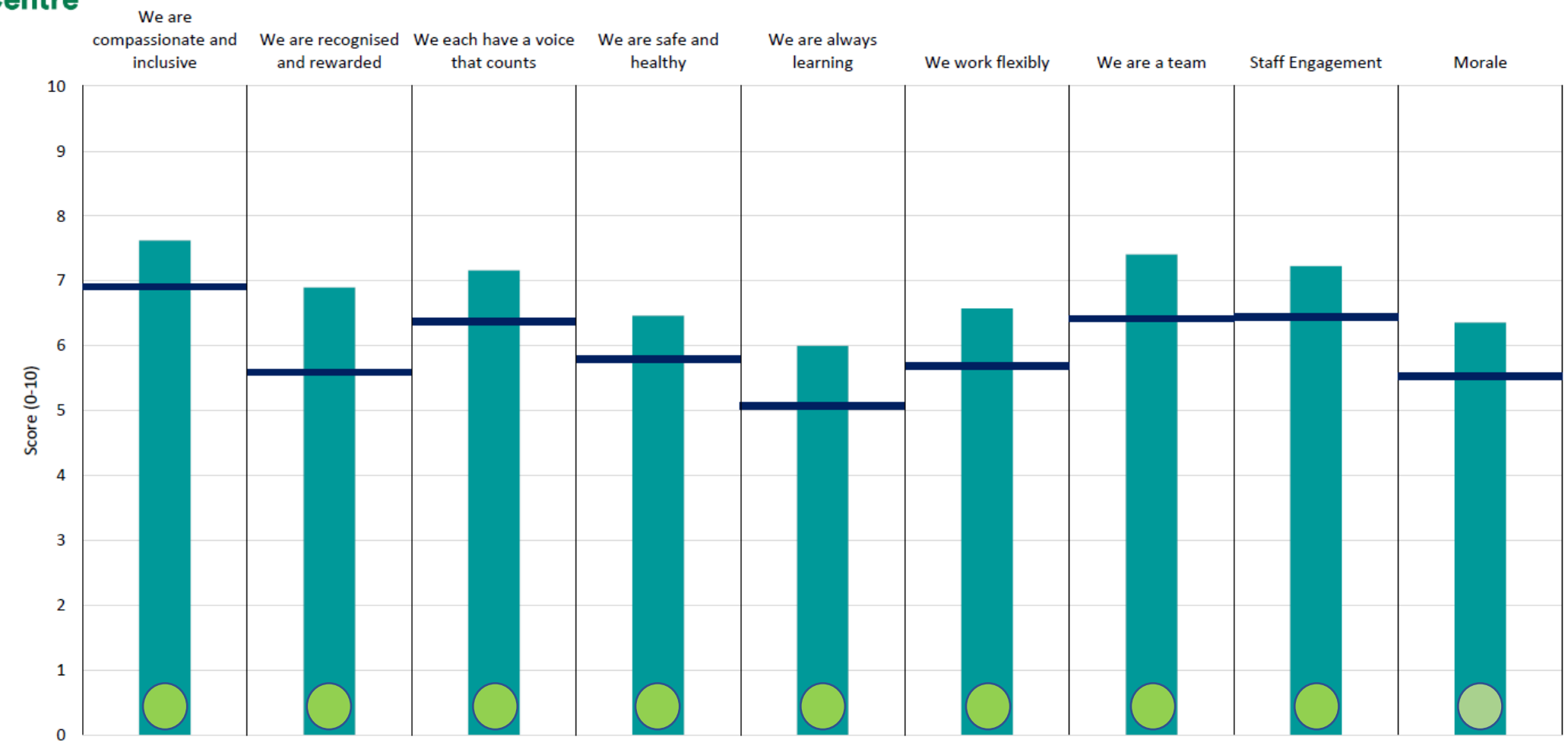
Locality	Respondents	Response Rate
Your Organisation	**2415**	**35.3%**
208 L2 Chief Nurses Office	93	72.1%
208 L2 Digital Services	95	64.2%
208 L2 Directorate of Estates & Facilities	202	29.7%
208 L2 Finance Directorate	68	79.1%
208 L2 Medical Directors Office	63	46.0%
208 L2 Operations	1798	32.4%
208 L2 People Directorate	73	80.2%
208 L2 Trust Management Directorate	14	82.4%



Survey Coordination Centre

208 L2 Chief Nurses Office

NHS

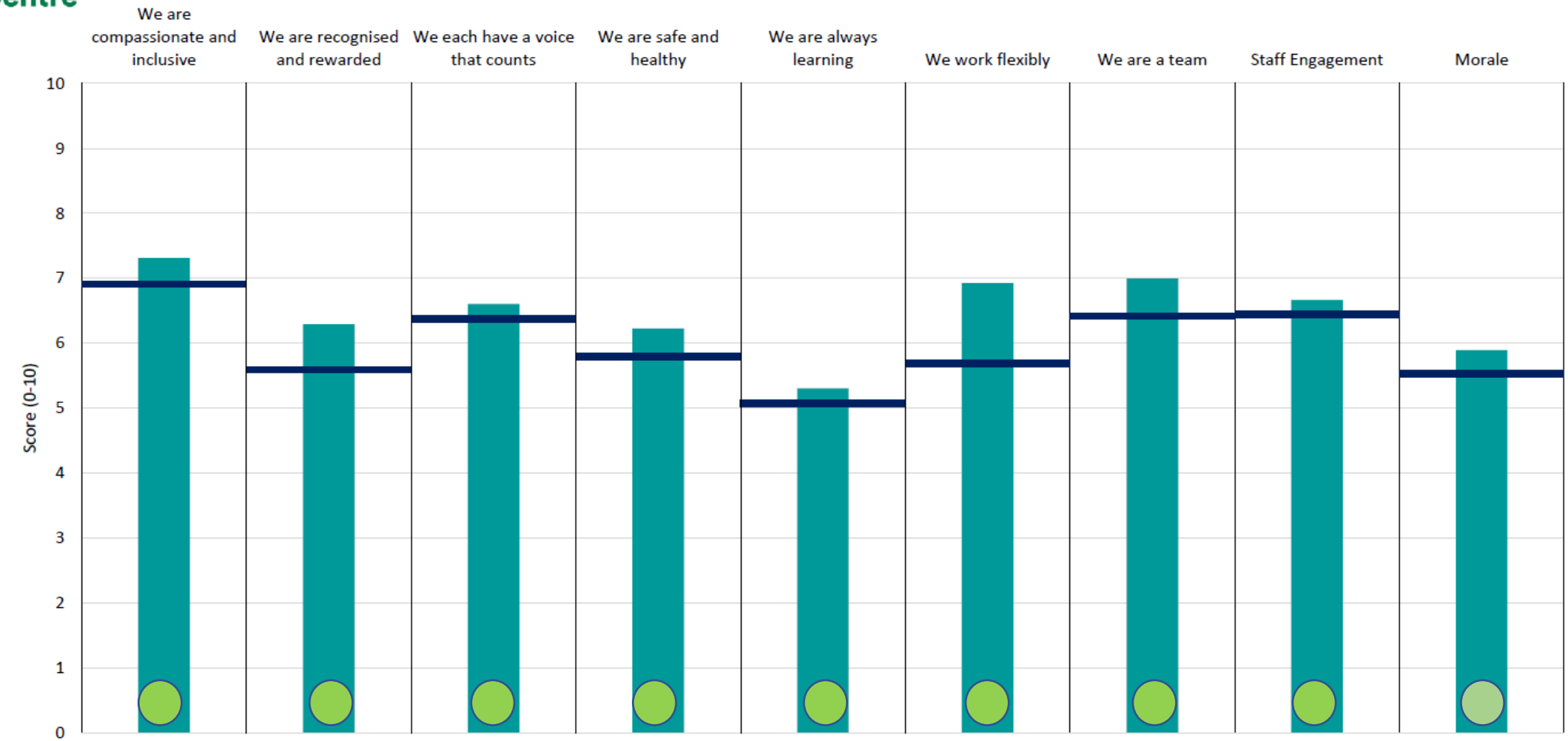


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.6	6.9	7.2	6.5	6.0	6.6	7.4	7.2	6.4
Your org	6.9	5.6	6.4	5.8	5.1	5.7	6.4	6.4	5.5
Responses	91	91	90	91	91	91	91	91	91

Survey Coordination Centre

208 L2 Digital Services

NHS

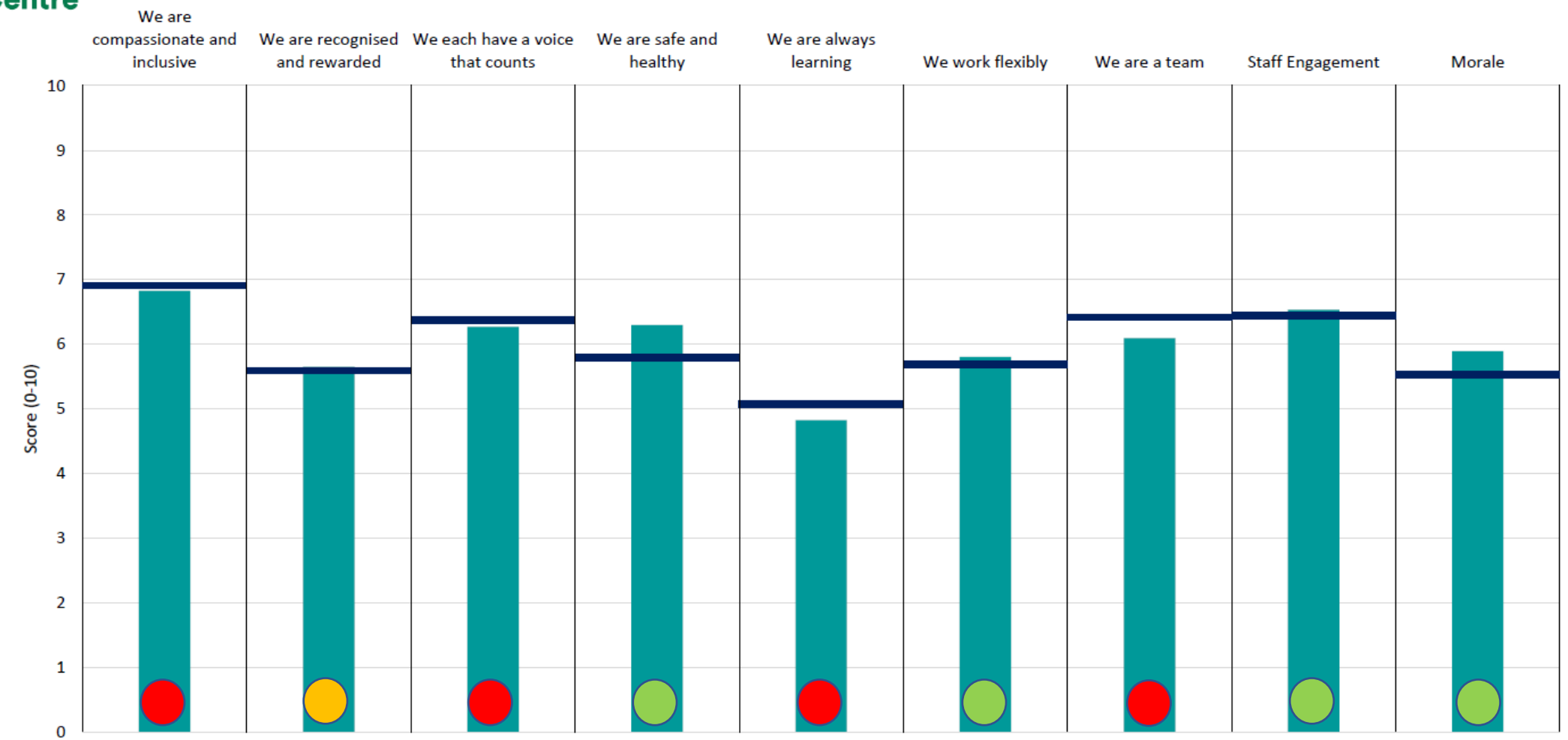


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.3	6.3	6.6	6.2	5.3	6.9	7.0	6.7	5.9
Your org	6.9	5.6	6.4	5.8	5.1	5.7	6.4	6.4	5.5
Responses	91	91	91	91	88	91	91	91	91

Survey Coordination Centre

208 L2 Directorate of Estates & Facilities

NHS

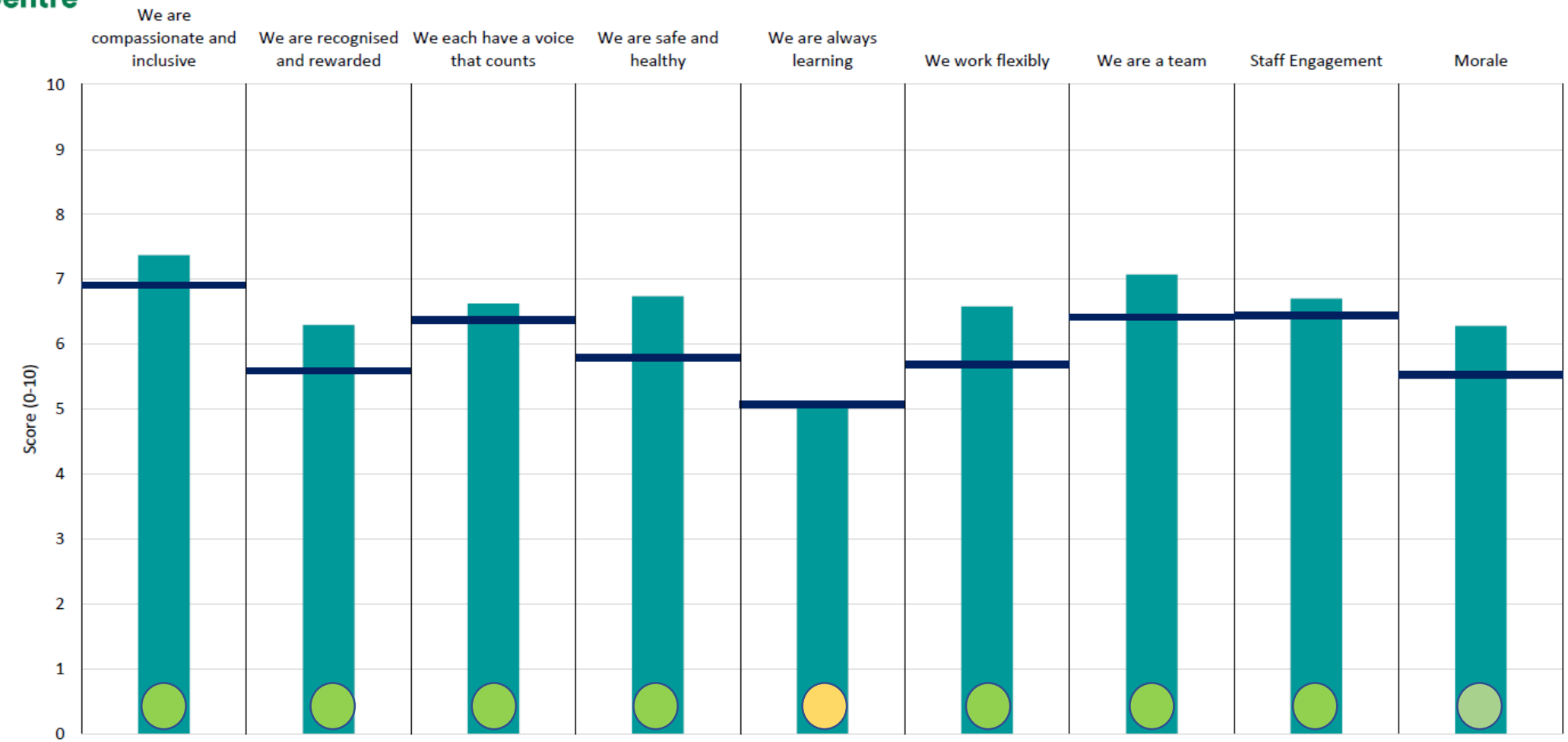


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	6.8	5.6	6.3	6.3	4.8	5.8	6.1	6.5	5.9
Your org	6.9	5.6	6.4	5.8	5.1	5.7	6.4	6.4	5.5
Responses	199	200	194	198	182	197	200	200	200

Survey Coordination Centre

208 L2 Finance Directorate

NHS

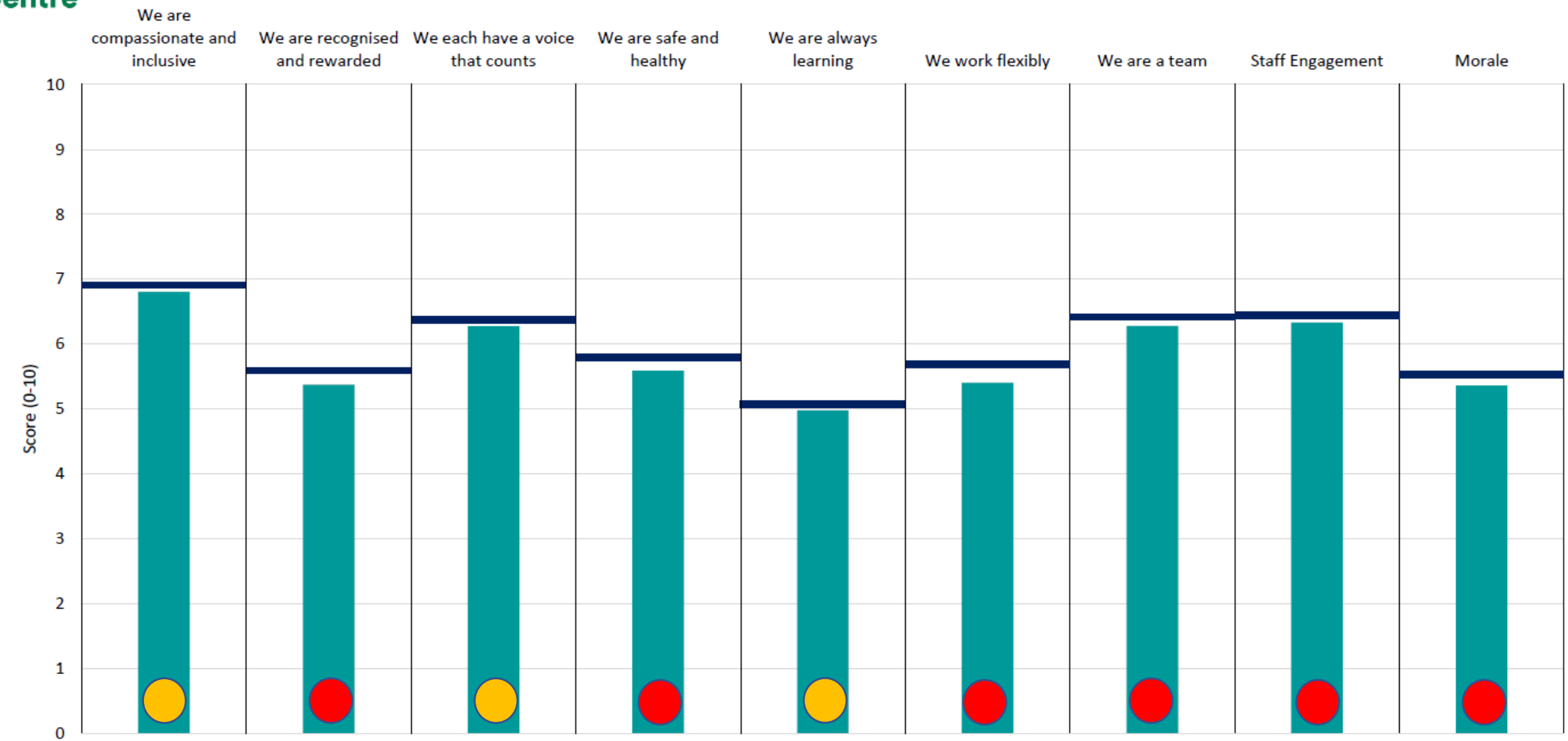


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.4	6.3	6.6	6.7	5.0	6.6	7.1	6.7	6.3
Your org	6.9	5.6	6.4	5.8	5.1	5.7	6.4	6.4	5.5
Responses	65	65	65	64	64	65	65	65	65

Survey Coordination Centre

208 L2 Operations

NHS

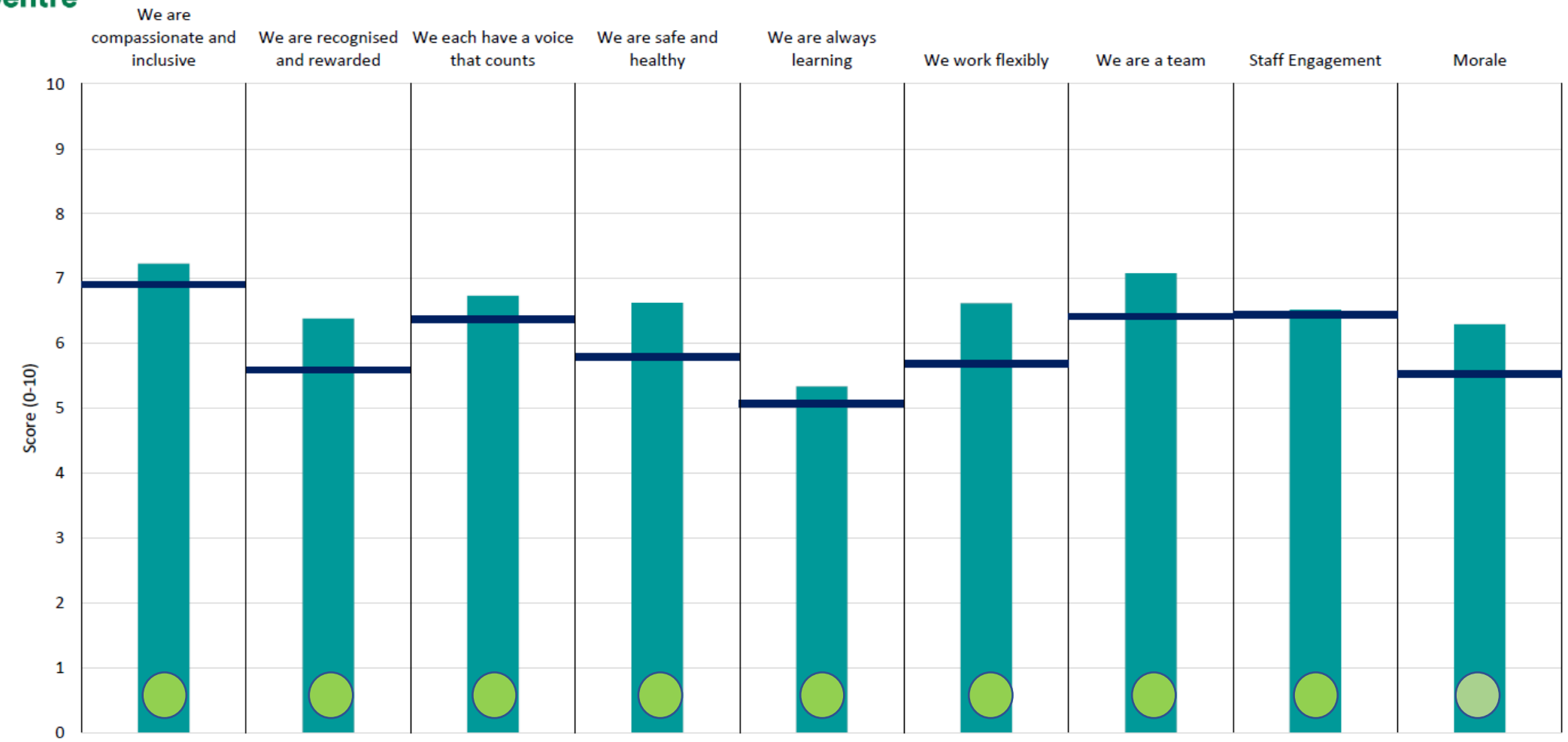


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	6.8	5.4	6.3	5.6	5.0	5.4	6.3	6.3	5.4
Your org	6.9	5.6	6.4	5.8	5.1	5.7	6.4	6.4	5.5
Responses	1758	1757	1750	1756	1706	1753	1755	1757	1756

Survey Coordination Centre

208 L2 Medical Directors Office

NHS

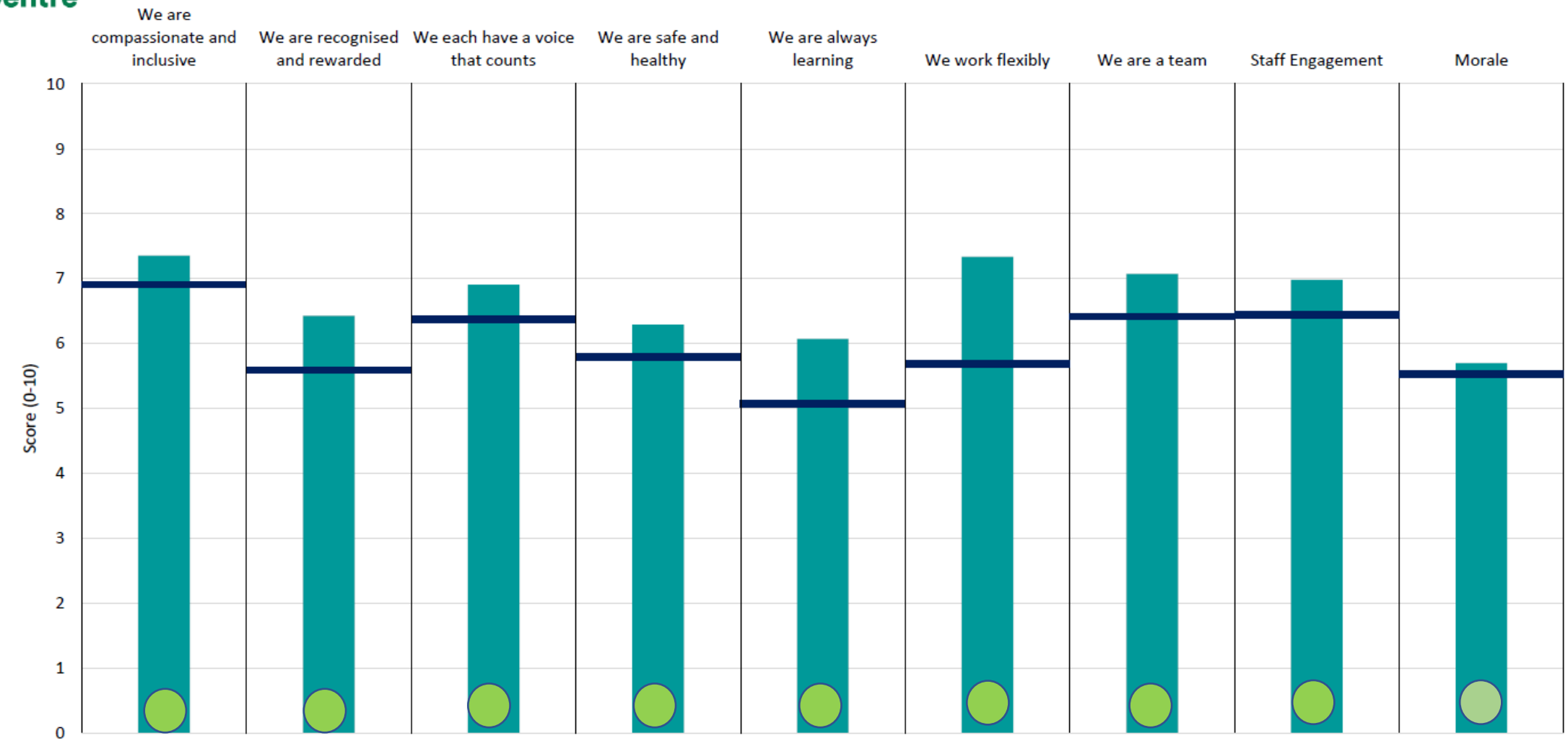


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.2	6.4	6.7	6.6	5.3	6.6	7.1	6.5	6.3
Your org	6.9	5.6	6.4	5.8	5.1	5.7	6.4	6.4	5.5
Responses	60	60	60	60	58	60	60	60	60

Survey Coordination Centre

208 L2 People Directorate

NHS

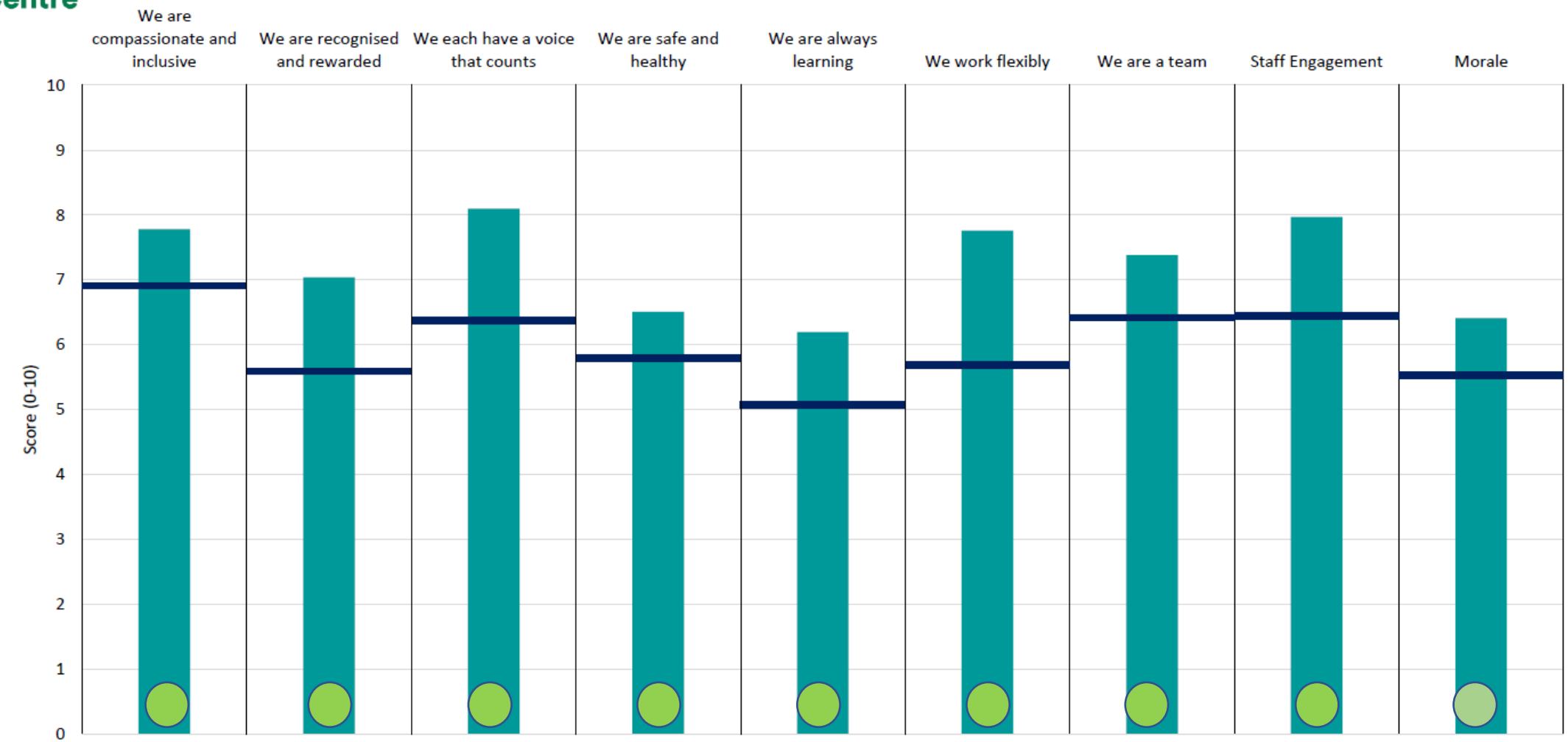


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.4	6.4	6.9	6.3	6.1	7.3	7.1	7.0	5.7
Your org	6.9	5.6	6.4	5.8	5.1	5.7	6.4	6.4	5.5
Responses	73	73	73	73	72	73	73	73	73

Survey Coordination Centre

208 L2 Trust Management Directorate

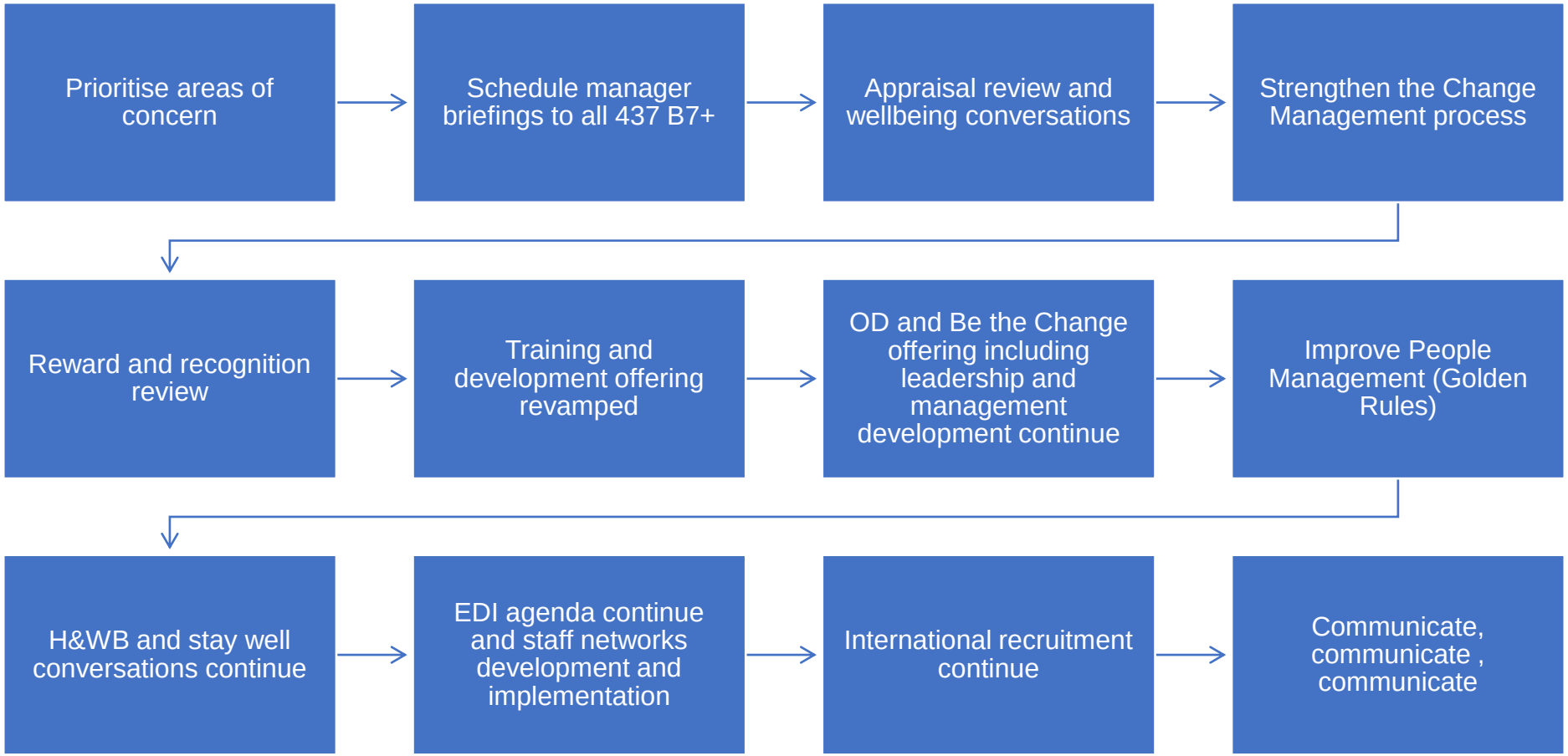
NHS



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Breakdown	7.8	7.0	8.1	6.5	6.2	7.8	7.4	8.0	6.4
Your org	6.9	5.6	6.4	5.8	5.1	5.7	6.4	6.4	5.5
Responses	13	13	13	13	13	13	13	13	13

Key actions to take

Northern Lincolnshire and Goole NHS Foundation Trust



Kindness · Courage · Respect

Cultural Transformation

Northern Lincolnshire and Goole NHS Foundation Trust

"**Be The Change Academy**" supports the Trust's cultural transformation programme at individual, team, leader and organisation's level through workshops, face to face and online sessions to support staff development and team interventions for specific needs with tailored solutions.

Our aim is to build a network of change agents aka our **Be The Change Agents** and **Cultural Ambassadors** who can develop skills and knowledge in the field of change, transformation and organisational development and advocate for our values in action and building an environment where our staff thrive.

We link the Be the Change Culture transformation programme and development solutions to our engagement strategy and NSS yearly and quarterly to track and monitor our culture transformation journey.

Training courses/sessions	Team interventions	Individual development	Leadership & Management development	Cultural ambassadors / Be The Change Agents
• Working with Kindness, Courage and Respect • Civility & Cultural sensitivity	• High performing teams : Insights • Building respectful teams : Teams charters • Team away days : building a vision and team engagement activities	• Personal Coaching sessions • 360 feedback • High performer Insights Profile & Coaching • Mentoring programmes • Personal and professional development sessions	• 360 feedback • Leading with Kindness Courage & Respect • People Leader Core Skills • People Leader Induction	• Change management • Coaching skills • Facilitation skills • OD expertise

Kindness · Courage · Respect

NLG(23)054

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	04 April 2023
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. Q3 Freedom to Speak Up Guardian Report. 2. CQC Report. 3. Criminal record checks for temporary and agency workers. 4. Occupational Health update. 5. Workforce turnover. 6. National Staff Survey Results for 2022. The Board is asked to receive and note the content of this highlight report.
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

BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	04 April 2023
Report From:	Susan Liburd, Non-Executive Director, and Chair of Workforce Committee

Highlight Report: Workforce Committee – 21 March 2023

1. **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.

2. **Q3 Freedom to Speak Up Guardian (FTSUG) Report**
   There were 71 concerns raised in Q3. This is a significant increase in the number of concerns raised in the current reporting year. The increase may be attributable to the Speak Up campaign in October and a change in how concerns are calculated. For example, group concerns are no longer counted as one concern, they are recorded as individual concerns. The main themes of concern were attributed to worker safety, behaviour, and processes. 40% of concerns related to worker safety. Staffing levels and the perception that staff were not able to provide the care they would want to provide were the notable themes in this category. Some reasonable adjustments around neurodiversity conditions were being made to address several concerns and support worker safety and wellbeing. Most of the 71 concerns were managed and closed within 10 weeks. It was noted that the FTSUG has a unique insight into NLaG leadership behavioural trends. The Committee confirmed the importance of her insights being fed into leadership development and cultural transformation initiatives.

3. **CQC Progress Report**
   There were several actions to note in relation to this report since the last update to workforce committee in January 2023. There is a change in the ratings language providing greater clarity and allowing better reviewing of actions for Committee and Board assurance. There was an increase in the total number of actions due to several actions being split to provide more accurate reporting and assurance. In addition, progress reporting and risks to delivery of CQC improvement planning were better articulated. There were seven actions rated as providing limited assurance and limited evidence of improvement. Action plans were on track to deliver outcomes or under close scrutiny if a deadline or deterioration in performance was approaching. The seven actions related to ensuring:
   - All medical staff receive training to ensure they have the skills and knowledge to recognise and identify those patients approaching end of life.
   - National standards for medical staffing are being met.
   - Bank and agency staff receive a full, formal induction, so they are familiar with equipment, policies, and emergency escalation procedures.
   - All staff receive appropriate support, training, professional development, supervision, and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform.
   - Sufficient qualified, competent, skilled, and experienced staff to meet the needs of patients using NLaG services.
   - Safeguarding leads complete Safeguarding Children Level 3 training.

- The division's overall core, mandatory, and role specific training compliance meets trust targets.

4. Criminal Record Checks

An assurance report was requested following an incident in East Kent, where a Trust missed opportunities to identify a locum doctor who was under caution for indecent exposure. He also been previously arrested on hospital premises for two sexual offences. The criminal records check was undertaken 2 months after the locum had commenced work.

Individuals undertaking work at NLaG may be categorised as either employees or agency workers. The process for criminal records checks for these staff groups are different. Checks of employees, volunteers, students, clinical attachments, visiting professionals, and work experience students are undertaken by a Disclosure and Barring Service (DBS) application and/or overseas police certificates for international hires at the point of recruitment. In addition, checks are carried out if an existing member of staff who has never had a DBS check before is moving to a position that requires a check or the new position significantly changes the individual's role, responsibilities, or level of contact with vulnerable groups.

Temporary employees and agency workers are considered under separate policies/procedures. Agency staff deployed at the Trust fall into three main groups: Medical, Nursing & Midwifery and AHP staff. The Trust has separate procedures for each of these group for DBS checks. These include a set of requirements NLaG places on agencies to evidence DBS records when they are supplying the Trust with staff. Information that is out of date or incomplete stops the engagement of that member of staff. There are currently no Medical, Nursing & Midwifery and AHP staff with outstanding or non-valid DBS certificates.

5. Occupational Health

With financial investment and focus, the delays of more than three months waiting for occupational health clearance for new hires has seen significant improvement. Backlogs have been reduced and recruitment waiting lists are down to approximately 6 weeks. A new appointment has been made to the Head of Occupational Health. The Workforce Committee will continue to monitor progress.

6. Workforce Turnover

Staff turnover remains high although it is decreasing. It continues to be above the 10% target, the latest turnover data point is 11.7%. There is a continued focus on both recruitment and retention. Registered Nursing vacancy positions continues to be high at 12.8% against a target of 8%. Unregistered Nursing vacancy positions are13.3% although decreasing, this is still above target of 8%. The Medical vacancies position is 14.5% this continues to be below the target of 15%.

There remain several recruitment hotspots notably in pharmacy. This continues to be a challenged position there currently remains 8 WTE vacancies from a 9.6 WTE establishment. There is pressing and immediate local, regional, and international focus and action being taken to address this challenge. This matter will continue to be a focus of attention for both Workforce and Quality Patient Safety Committees.

7. National Staff Survey Results for 2022

The committee took a deep dive into the findings of the NHS Staff Survey report 2022 where NLaG was benchmarked against 65 Acute and Acute Community Trusts. There was a low response rate of 35% compared to an average of 46% response for similar organisations and this was a lower response rate than 2021 (38%). The board has been sighted on the content of the report.

The Director of People is putting in place a series of actions to address the findings. These include accelerating and bolstering some planned activity, prioritisation, and retargeting of resources as well as better marketing of the importance of the survey to the workforce. The importance of leadership development and organisational culture as being key levers for change and transformation was supported by committee members.

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.

Sue Liburd
Non-Executive Director and Chair of Workforce Committee

NLG(23)055

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	4 April 2023	
Director Lead	Lee Bond, Chief Financial Officer	
Contact Officer/Author	Brian Shipley, Deputy Director of Finance	
Title of the Report	**Finance Report – M11**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights the reported financial position of Month 11 of the 2022/23 reporting period. The Trust Board are asked to note: • The Finance Report, Month 11 • The £1.3m 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.

Northern Lincolnshire and Goole NHS Foundation Trust

Finance Report Month 11

February – 2022/23

Finance Overview

YTD I&E Performance – pages 4 to 6

(£1.3m) The month 11 surplus was £0.5m which brings the YTD deficit to £1.3m. This is £2.2m adverse to plan.

YTD CIP Delivery – page 7

£5.2m The Trust has delivered £25.6m CIP against a YTD target of £20.4m. Non-recurrent technical reserves are £5.2m above plan, with the core programme £0.9m behind plan at the YTD.

Capital Expenditure – page 13

(£14.1m) Year to date capital expenditure is £25.9m against the £40.0m YTD plan - a £14.1m adverse variance.

Underlying I&E – page 9

(£38.1m) After adjustments for non-recurrent income and expenditure in 2022/23, the Trust underlying deficit is £38.1m.

I&E Forecast Outturn – page 8

(£2.5m) The Trust is forecasting an unmitigated £2.5m deficit based on current run rates but has £2.5m non-recurrent flexibility remaining and is therefore reporting a breakeven FOT position.

System Financial Performance – page 11

(£11.5m) The ICS reported a £11.5m deficit for the year to date at month 10, £12.1m adverse to plan. However, it is reporting a FOT break-even position.

Balance Sheet & Cash – page 14

£35.8m The Trust cash balance at 28th February 2023 was £35.8m.

Temporary Staffing – page 18

(£4.8m) The Trust has spent £62.0m on agency, bank and locum pay. This is £4.8m more than the same period in 2021/22.

Key Risks

[Key risks to achieving financial plan/targets in 2022/23:]

- ❑ Minimising premium agency spend, particularly within Nursing despite increased Bank capacity.
- ❑ Non Pay Activity related pressures on Clinical Supplies and Drugs

Key Actions

[Key actions to achieve financial plan/targets in 2022/23:]

- ❑ Reducing cost pressures - reliance on premium agency, minimising escalation beds and greater control of non-pay consumables.
- ❑ Maximising planned care activity, reducing reliance on IS and WLI premium costs.
- ❑ Delivering a challenging stretch CIP programme - conversion of non-recurrent savings into recurrent delivery schemes and identifying new schemes]

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NHS Foundation Trust

Income and Expenditure Performance

Financial Performance Summary

The Trust ended February with a YTD deficit of £1.3m, £2.2m adverse to plan.

- The Trust achieved a £0.5m surplus in February 2023, £0.3m ahead of plan. This brings the year to date deficit to £1.3m. The year-to-date position is supported by £11.4m non-recurrent technical CIP, which is £5.2m above plan.
- Additional sources of income have been received in 2022/23 and these are offset by increased costs – for example the Trust has received £8.6m additional income to fund pay awards, and this is substantially offset by higher pay costs. **The Trust has also received £5.5m in additional surge funding (2.75m in month) reducing its reliance on technical savings in order to achieve a balanced end of year position.**
- Increased reliance on premium temporary staffing covering vacancies, sickness, increased demand from non-elective pathways, premium waiting list capacity and additional escalation beds are the key factors contributing to the clinical pay overspends. Bank Incentives have increased supply but at a cost of £0.72m year-to-date, with no corresponding reduction in nurse agency spend.
- Additional activity, inflation and some clinical practice changes are driving higher than planned clinical non-pay costs. Slippage on planned IS contracts partly offset the additional WLI capacity in Medical Staffing.
- The Trust is forecasting an unmitigated £2.5m year-end deficit based on the current run rate. The Trust has £2.5m non-recurrent flexibility remaining to address this risk.

£million	In Month			Year to Date			Full Year		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Income									
Clinical Income	37.2	40.6	3.5	408.7	421.8	13.2	445.8	462.9	17.1
Other Income	3.3	5.1	1.8	36.0	41.8	5.7	39.3	45.8	6.5
Total Operating Income	**40.5**	**45.7**	**5.3**	**444.7**	**463.6**	**18.9**	**485.2**	**508.7**	**23.6**
Pay Costs									
Clinical Pay	(21.4)	(24.0)	(2.6)	(235.2)	(255.1)	(19.9)	(256.5)	(278.8)	(22.3)
Other Pay	(5.5)	(7.1)	(1.6)	(60.2)	(60.2)	0.1	(65.7)	(66.3)	(0.6)
Total Pay Costs	**(26.8)**	**(31.1)**	**(4.3)**	**(295.4)**	**(315.2)**	**(19.8)**	**(322.2)**	**(345.1)**	**(22.9)**
Clinical Non Pay	(5.6)	(6.5)	(0.9)	(63.8)	(68.7)	(4.9)	(70.2)	(75.6)	(5.4)
Other Non Pay	(5.9)	(6.0)	(0.1)	(65.2)	(62.6)	2.6	(71.4)	(67.9)	3.5
Total Non Pay Costs	**(11.5)**	**(12.4)**	**(1.0)**	**(129.0)**	**(131.3)**	**(2.3)**	**(141.6)**	**(143.5)**	**(1.9)**
Total Operating Expenditure	**(38.3)**	**(43.6)**	**(5.2)**	**(424.5)**	**(446.5)**	**(22.1)**	**(463.8)**	**(488.6)**	**(24.8)**
EBITDA	**2.1**	**2.2**	**0.0**	**20.2**	**17.0**	**(3.2)**	**21.4**	**20.1**	**(1.2)**
Depreciation	(1.5)	(1.4)	0.1	(14.6)	(14.4)	0.2	(16.2)	(15.8)	0.4
Non Operating Items	(0.4)	(0.3)	0.1	(4.8)	(3.9)	0.8	(5.2)	(4.3)	0.9
Surplus/(Deficit)	**0.2**	**0.5**	**0.3**	**0.9**	**(1.3)**	**(2.2)**	**0.0**	**0.0**	**0.0**

Financial Performance – Divisions

See Appendix A on page 16 for a summary of the in month and YTD positions for all Divisions and Corporate Directorates.

Divisions	YTD Performance	Key Actions
Operations Directorate **(£0.1m)** In-month Variance **(£0.6m)** YTD Variance **£0.1m** YTD CIP Variance	• £0.69m Pathology overspends (note circa 50% CCG activity on block) • £0.30m Operations Centre overspends covering Site are partially offset with Pharmacy vacancy underspends of £0.24m.	• Conclude Site Management Consultation • Quantify Pathlinks Over-performance to aid in 23/24 planning negotiations.
Family Services **(£0.0m)** In-month Variance **£0.6m** YTD Variance **(£0.1m)** YTD CIP Variance	• £2.0m year-to-date nursing vacancy underspends across Maternity and NICU. • Partly offset by overspend on clinical supplies (£0.5m), mainly on high cost insulin pumps, and Medical Staff (£0.2m) due to Gynae over-establishments / additional sessions / exempt on-call.	• Deep dive into medical staff for Obstetrics/Gynae/Paediatrics, over-establishment/split between Obstetrics/Gynae - job plan alignment, sickness and rota cover Obstetrics/Gynae/Paediatrics and use of additional sessions.
Surgery & Critical Care **(£0.9m)** In-month Variance **(£8.6m)** YTD Variance **(£0.5m)** YTD CIP Variance	• £4.3m overspent on Medical Staff mainly due to pay premiums covering vacancies alongside restricted duties and on-call cover. • £2.7m overspent on Clinical Supplies mainly due activity in Orthopaedics, Urology, Ophthalmology and Audiology and Theatres. • £0.9m overspent on Theatre ODP and Imaging vacancies.	• Non-pay deep dives to continue – they have so far identified unbudgeted changes in clinical practice in Urology and General Theatres for energy sealing devices and heating devices. • Restricted duties of medical staff – HR/Workforce assisting in addressing these restrictions. • Continued focus on recruitment to medical staffing and nursing vacancies.

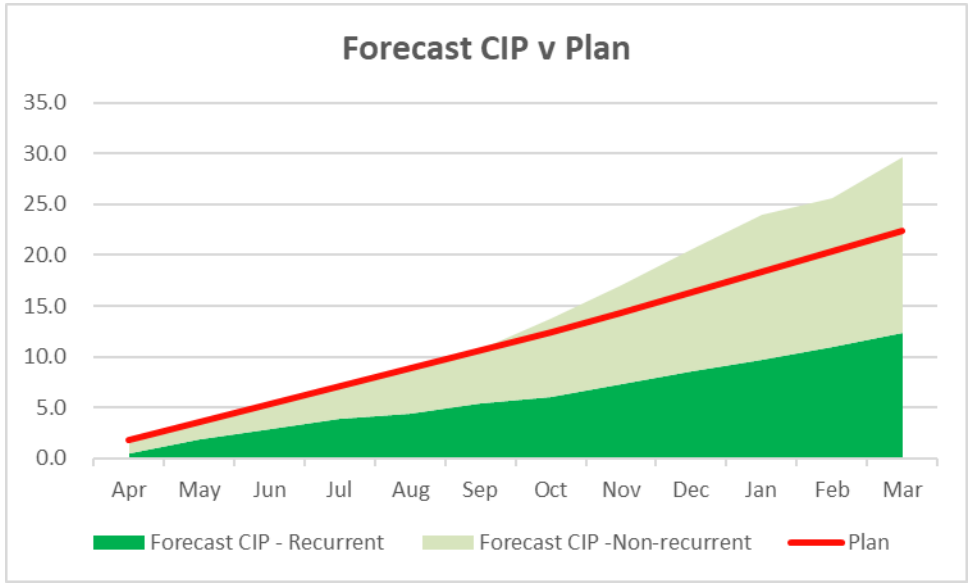
Financial Performance – Divisions continued

Divisions	YTD Performance	Key Actions
Medicine **(£1.0m)** In-month Variance **(£6.3m)** YTD Variance **(£1.9m)** YTD CIP Variance	• £2.3m Medical Staff overspend mainly due to additional shift bookings in Acute Care and ED. • £2.8m Nursing Staff overspend due to £1.4m escalation beds and £1.5m due to additional duties in ED and SDEC agency premiums. • £0.5m Drugs and £0.5m Clinical Supplies mainly due to high cost insulin pumps and pacemakers, £0.4m Healthcare Services from HUTH for Haematology and Cardiology.	• Continue with roster/rota reviews and medical staff deep dives. • Collaborate and assist with Community virtual ward capacity embedding OPAT and Homefirst services to relieve bed pressures.
Therapy & Community Services **£0.3m** In-month Variance **£0.2m** YTD Variance **£0.0m** YTD CIP Variance	• £1.7m vacancy underspends across many areas including district nursing, neuro rehab and community dental services. • £0.4m Goole Medicine overspends due to escalation beds and premium pay covering vacancies. • £0.3m overspends due to unallocated CIP and £0.5m overspends across Community equipment / orthotics and wheelchairs.	• £0.34m overspends across Community equipment / orthotics and wheelchairs are awaiting detailed prescription and activity data analysis since 2019-20. • Reduce unallocated CIP through review of large underspends.
Corporate Directorates **£2.5m** In-month Variance **£13.1m** YTD Variance **£1.3m** YTD CIP Variance	• With the exception of Estates & Facilities all Corporate Directorates are in surplus mainly due to non-recurrent CIP over-delivery. • The position is further supported by slippage on reserves of £2.0m. • Other corporate areas £11.1m underspent mainly due to non-recurrent release of technical reserves and non-recurrent corporate CIP.	• Deep dive into non-pay – postage cost drivers and overspending areas including electricity, water, sewerage and building/engineering maintenance and materials

Financial Performance – CIP delivery

The Trust has delivered £25.6m CIP against a YTD target of £20.4m. This has been achieved through higher non-recurrent technical reserves (£5.2m above plan) with the core programme £0.9m behind plan at February.

£million	Current Month			Year to Date			Forecast Year-end		
	Plan	Actual	Varianc	Plan	Actual	Varianc	Plan	Actual	Varianc
CLINICAL WORKFORCE									
Medical Staff	0.2	0.2	(0.0)	2.4	1.0	(1.3)	2.6	1.2	(1.3)
Nursing and Midwifery	0.5	0.3	(0.2)	3.2	2.1	(1.0)	3.6	2.4	(1.2)
AHP Staff	0.0	0.1	0.1	0.5	1.0	0.5	0.5	1.1	0.6
TOTAL CLINICAL WORKFORCE	**0.7**	**0.6**	**(0.2)**	**6.0**	**4.1**	**(1.8)**	**6.7**	**4.7**	**(2.0)**
Corporate and Non-Clinical	0.1	0.1	0.1	0.8	2.0	1.2	0.9	2.2	1.3
Non-Pay and Procurement	0.2	0.1	(0.1)	2.0	1.7	(0.3)	2.2	1.8	(0.4)
Other CIP	0.2	0.3	0.1	2.0	2.1	0.1	2.2	2.3	0.1
TOTAL CORE PROGRAMME	**1.2**	**1.1**	**(0.1)**	**10.8**	**9.9**	**(0.9)**	**12.0**	**11.0**	**(1.0)**
COVID Expenditure Reduction	0.3	0.4	0.1	3.3	4.2	0.9	3.6	4.7	1.1
Non-recurrent Technical Efficiency	0.6	0.2	(0.4)	6.2	11.4	5.2	6.8	13.9	7.1
TRUST TOTAL EFFICIENCY PLAN	**2.1**	**1.6**	**(0.4)**	**20.4**	**25.6**	**5.2**	**22.4**	**29.7**	**7.3**



- The Trust is £0.9m behind its £10.8m core CIP programme at the end of February 2023. The shortfall is driven by a £1.8m under delivery against the clinical workforce schemes.
- The £0.9m shortfall has been covered by an over recovery of £0.9m on COVID spend reduction targets, but is primarily supported by the use of its non-recurrent technical reserves of £11.4m compared to a plan of £6.2m.
- The Trust is forecasting to deliver £11.0m savings against a core programme of £12m by the year end. Non-recurrent savings from technical adjustments are forecast to total £13.9m, nearly half of the forecast £29.7m savings in year.

Financial Performance – Forecast Outturn

The Trust is forecasting an unmitigated £2.5m deficit based on current run rates but has £2.5m non-recurrent flexibility remaining and is therefore reporting a breakeven FOT position.

	M10 £m	M11 £m	Change £m
Clinical Income (Lincs CCG)	(0.05)	(0.05)	0.00
Other Income	2.63	8.01	5.38
Pay Award Funding Shortfall	0.02	0.02	0.00
Medical Staffing	(9.90)	(9.02)	0.87
Nursing – Escalation Beds (M1-6)	(1.29)	(1.29)	0.00
Other Nursing	(1.60)	(1.51)	0.09
Other Pay	0.60	0.35	(0.25)
Drugs & Clinical Supplies & Other Non-Pay	(7.20)	(7.96)	(0.75)
IS Capacity Slippage	2.51	2.68	0.16
Post EBITDA Slippage	1.26	1.46	0.20
Technical Reserve Release	5.59	4.63	(0.96)
CIP Non-Delivery (excl Technical)	(0.00)	0.18	0.19
Forecast Deficit	**(7.43)**	**(2.50)**	4.93

The Trust is currently £2.2m behind plan at the end of month 11 with a year to deficit of £1.3m and is marginally behind its improvement trajectory by £0.01m.

The Trust has received additional funding of £5.5m and improved its Medical staff run rates in month but these have been offset by the increase Nursing spend linked to incentives with no corresponding reduction in agency expenditure.

If no mitigating actions are taken, the forecast projects a potential £2.50m end of year deficit risk.

The Trust has non-recurrent flexibility of £2.5m remaining and is therefore reporting a breakeven FOT position.

Underlying Position

After adjustments for non-recurrent income and costs in 2022/23, the Trust underlying deficit is £38.1m.

£million	
2022/23 - Planned Surplus/(Deficit)	**0.0**
Non-recurrent Adjustments	
Non Recurrent Income	(25.8)
Non Recurrent Expenditure	17.1
Non Recurrent Technical B/S Release	(19.3)
Non Recurrent Underspends (Midwifery / Community Nursing)	(2.9)
Non Recurrent Savings Delivery	(3.1)
FYE Investment Programme	(4.0)
Underlying Deficit	**(38.1)**

- The Trust continues to assess the recurrent impacts on its underlying financial position bridging from its 2022/23 break-even forecast.
- The table opposite shows the non-recurrent income and cost adjustments identified in 2022/23 resulting in a revised estimated underlying deficit of £38.1m.
- The underlying position is constantly evolving as 2023/24 planning round confirms assumptions on recurrency of specific funding and expenditure schemes.

Northern Lincolnshire and Goole NHS Foundation Trust

System Financial Performance

System Financial Performance – January 2023

The Humber and North Yorkshire ICS has delivered a YTD deficit of £11.5m at the end of January 2023 which is £12.1m adverse to plan. The system is forecasting to deliver a breakeven position at year end.

Humber and North Yorkshire ICS
Summary Surplus / (Deficit) Position - 2022/23 Month 10

Organisation	2022/23 Plan	Surplus / (Deficit) YTD Budget	Surplus / (Deficit) YTD Actual	Surplus / (Deficit) YTD Variance	Surplus / (Deficit) FOT	Surplus / (Deficit) FOT Variance
	£'000	£'000	£'000	£'000	£'000	£'000
East Riding Of Yorkshire Place	0	0	(1,809)	(1,809)	3,760	(3,760)
Hull Place	0	0	(1,282)	(1,282)	2,824	(2,824)
Hull University Teaching Hospitals NHS Trust	0	259	51	(208)	0	(0)
Humber Teaching NHS FT	0	(95)	(95)	0	0	0
Hull and East Riding	**0**	**164**	**(3,134)**	**(3,298)**	**6,584**	**(6,584)**
North East Lincolnshire Place	0	0	(49)	(49)	636	(636)
North Lincolnshire Place	0	0	(537)	(537)	1,242	(1,242)
Northern Lincolnshire and Goole NHS FT	0	674	(1,773)	(2,447)	0	0
North and North East Lincolnshire	**0**	**674**	**(2,358)**	**(3,032)**	**1,878**	**(1,878)**
North Yorkshire Place	0	(0)	(2,582)	(2,582)	5,029	(5,904)
York Place	0	0	(2,463)	(2,463)	4,660	(4,660)
York and Scarborough Teaching Hospitals NHS FT	0	(253)	(5,102)	(4,849)	0	0
Harrogate and District NHS FT	0	0	(4,467)	(4,467)	(0)	(0)
North Yorkshire and York	**0**	**(253)**	**(14,614)**	**(14,361)**	**9,688**	**(10,564)**
ICB-Wide Expenditure	0	0	8,588	8,588	(18,149)	18,149
TOTAL ICS SURPLUS/(DEFICIT)	**0**	**585**	**(11,519)**	**(12,104)**	**0**	**(876)**
ICB Total	0	(0)	(8,721)	(8,721)	18,149	(18,149)
ICB-Wide Expenditure	0	0	8,588	8,588	(18,149)	18,149
ICS Provider Total	0	585	(11,385)	(11,970)	0	(0)
TOTAL ICS SURPLUS/(DEFICIT)	**0**	**585**	**(11,519)**	**(12,104)**	**0**	**(0)**

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Capital and Cash

Capital Expenditure

Year-to-date capital expenditure is £25.9m against a £40.0m YTD plan. The Trust is forecasting to marginally overspend the full year £44.6m programme by £0.6m to offset slippage within the ICB overall programme.

£million	Year to Date			Full Year		
	Plan	Actual	Var.	Plan	Forecast	Var.
Estates Major Schemes						
Emergency Department/AAU	20.8	16.8	(4.0)	18.0	18.7	0.8
DPOW & SGH Theatres TIF	4.2	0.4	(3.8)	6.1	6.1	0.0
SGH Fire Alarm	1.5	2.0	0.6	2.5	2.5	0.0
DPOW & SGH Reconfiguration Programme	2.7	1.2	(1.5)	2.6	2.6	0.0
Total Estates Major Schemes	**29.2**	**20.4**	**(8.8)**	**29.1**	**29.9**	**0.8**
Other Estates Schemes	1.4	0.6	(0.8)	2.6	1.5	(1.1)
IM&T Programme	2.3	2.2	(0.1)	4.8	5.2	0.4
Equipment Renewal	3.6	0.7	(2.9)	3.9	4.7	0.8
Facilities Maintenance	2.7	1.1	(1.6)	3.3	3.0	(0.2)
Other Capital Expenditure	0.8	0.9	0.1	0.9	0.9	(0.0)
Total Capital Programme	**40.0**	**25.9**	**(14.1)**	**44.6**	**45.2**	**0.6**
Funded By:						
Internally Generated	12.9	9.7	(3.3)	13.4	14.0	0.6
PDC Funded	26.2	15.3	(10.9)	30.3	30.3	0.0
Donated	0.2	0.2	0.0	0.2	0.2	0.0
IFRS16	0.6	0.7	0.1	0.7	0.7	0.0
Total Funding	**40.0**	**25.9**	**(14.1)**	**44.6**	**45.2**	**0.6**

The Trust capital funding for 2022/23 is £44.59m. The additional funding for discharge lounge has slightly increased to £0.11m.

The actual spend to 28th February was £25.89m, £25.66m relating to Trust funded schemes and £0.23m for donated and grant funded. Key variances are detailed below:

- The DPOW Gamma Camera is progressing, the Trust have been chasing payment certificates, the actual gamma camera is due to be delivered 27th March and the scheme is still on plan to finish by 31st March 2023.
- The ED/AAU schemes are still forecast to slip spend from 22/23 into 23/24. The Trust is continuing to manage this by bringing forward priorities from 23/24. The spend for this year is being closely monitor to ensure delivery. The handover of SGH ED did not happen at the end of February due to a water defect and is now planned for 8th March. The schemes are currently forecasting additional costs and risks of **£3.06m**. These additional costs have been included in the 2023/24 draft capital plan.
- Facilities maintenance – the water improvements will now span 2 years (22/23 & 23/24). The electrical infrastructure and theatre scheme are progressing, they are slightly behind plan with £0.2m slipping into 23/24. The Trust is managing this across the financial years. The funding of £0.35m for fire doors at SGH will be spent by 31st March.
- All Equipment orders have now been placed, equipment totally £1.3m has been delivered in the first week of March.

Balance Sheet

£ million	Actual 31-Mar-22	Actual 31-Jan-23	Actual 28-Feb-23	In month movement
Fixed Assets	268.9	271.1	272.8	1.6
Current Assets				
Inventories	3.3	4.0	4.0	(0.1)
Trade and Other Debtors	20.0	20.8	20.7	(0.1)
Cash	31.9	33.8	35.8	2.0
Total Current Assets	**55.2**	**58.7**	**60.5**	**1.8**
Current Liabilities				
Trade and Other Creditors	37.1	38.8	40.7	2.0
Accruals	20.1	20.2	18.9	(1.3)
Other Current Liabilities	6.9	5.8	7.9	2.1
Total Current Liabilities	**64.1**	**64.8**	**67.6**	**2.8**
Net Current Liabilities	**(8.9)**	**(6.1)**	**(7.1)**	**(1.0)**
Debtors Due > 1 Year	1.25	1.25	1.25	0.00
Creditors Due > 1 Year	0.00	0.00	0.00	0.00
Loans > 1 Year	6.88	6.88	6.88	0.00
Finance Lease Obligations > 1 Year	14.86	14.91	14.96	0.05
Provisions - Non Current	5.44	5.44	5.44	0.00
Total Assets/(Liabilities)	**234.1**	**239.1**	**239.6**	**0.6**
TOTAL CAPITAL & RESERVES	**234.1**	**239.1**	**239.6**	**0.6**

Key Movements:

Current Assets

- Stock balances have remained stable in month.
- Debtors have also remained stable overall, however NHS have increased following the release of surge funding. Prepayments have reduced.
- The Trust cash balance has increased in month, payment runs have been lower than January, the Trust received £0.18m of PDC funding for capital schemes. The cash balance at 28th February was £35.8m a increase of £2.0m.

Current Liabilities

- The deferred income increased in month, this relates to the March Health Education Income received in advance.
- Revenue creditors have increased in month, this relates to invoices authorised but not yet due for payment and Lloyds invoices for two months again not due for payment.

The total BPPC figures for the Trust continue to be above 90% at 92.2% for number and 92.6% for value paid within 30 days. We are seeing a continued improvement each month in both NHS and Non NHS. Monitoring of BPPC and communication to staff of the importance of authorising invoices will continue.

Northern Lincolnshire and Goole NHS Foundation Trust

Appendices

Appendix A – Divisional Financial & Reserves Summary

£million	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Operations						
Operations Directorate	(3.7)	(3.8)	(0.1)	(36.5)	(37.2)	(0.6)
Family Services	(3.9)	(4.0)	(0.0)	(43.6)	(43.0)	0.6
Surgery & Critical Care	(10.2)	(11.1)	(0.9)	(111.9)	(120.5)	(8.6)
Medicine	(9.6)	(10.5)	(1.0)	(112.7)	(119.0)	(6.3)
Therapy & Community Services	(3.0)	(3.3)	(0.3)	(32.9)	(32.7)	0.2
Total Operations	**(30.4)**	**(32.7)**	**(2.2)**	**(337.7)**	**(352.4)**	**(14.7)**
Corporate Directorates						
Trust Management	(0.1)	(0.1)	0.0	(1.4)	(1.3)	0.1
Medical Director's Office	(2.0)	(1.9)	0.1	(21.4)	(21.0)	0.4
Chief Nurses Office	(0.4)	(0.4)	(0.0)	(4.8)	(4.6)	0.1
Finance	(0.4)	(0.4)	0.0	(4.6)	(4.2)	0.4
People & Organisational Effectiveness	(0.4)	(0.4)	0.0	(4.9)	(4.8)	0.1
Estates & Facilities	(2.9)	(3.1)	(0.2)	(30.5)	(31.1)	(0.6)
Strategic Development	(0.1)	(0.1)	0.0	(1.2)	(1.1)	0.1
Digital Services	(0.9)	(0.9)	0.0	(9.7)	(9.5)	0.2
Central & Capital Charges	(1.4)	(1.5)	(0.1)	(14.0)	(6.9)	7.1
Central Income	39.3	42.2	2.9	432.4	435.5	3.1
Trust Reserves	(0.1)	(0.2)	(0.2)	(2.5)	(0.4)	2.0
Total Corporate Directorates	**30.5**	**33.0**	2.5	**337.4**	**350.5**	13.1
Other Items	0.1	0.1	(0.0)	1.2	0.7	(0.5)
Trust Total	**0.2**	**0.5**	**0.3**	**0.9**	**(1.3)**	**(2.2)**

£million	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance
Investment Reserves				
2022/23 SDF NL	0.23	0.21	0	**(0.23)**
ED / UCS Expansion	0.91	0.64		**0.64**
Nursing Apprenticeships	0.32	0.30		**0.30**
Overseas Recruitment	(0.19)	(0.23)		**(0.23)**
HOBS Beds	(0.38)	(0.32)		**(0.32)**
End of Life (Acute)	(0.15)	(0.14)		**(0.14)**
Winter Ward / Virtual Bed Capacity	0.43	(0.01)		**(0.01)**
Training ACP's	0.52	0.47		**0.47**
Leadership Development	0.15	0.14		**0.14**
Cancer Alliance	0.25	0.23		**0.23**
Total Investment Reserve	**2.10**	**1.28**	**0**	**0.85**
Inflation Reserves				
Pay Inflation incl Incentives	(0.77)	(0.75)		**(0.75)**
Non Pay Inflation	0.54	0.76		**0.76**
Digital Aspirant	0.24	(0.05)		**(0.05)**
Total Inflation Reserve	**0.01**	**(0.04)**	**-**	**(0.04)**
COVID-19	**2.15**	**1.83**	**-**	**1.83**
ERF	**- 0.02**	**(0.63)**	**-**	**(0.63)**
TOTAL	**4.24**	**2.45**	**0.44**	**2.01**

Appendix B – Elective Recovery

Elective Recovery Funding was again recognised as fully achieved, per system requirements. The Trust did not achieve the 104% activity target in month; performance was 93% in month and remains at 96% year-to-date. However, core activity is supported by IS capacity of 3% both in month and year-to-date. £4.70m of Elective Recovery Funding received year-to-date would have been at risk if penalties had been enforced.

Elective Recovery by POD v 2019/20	Medicine	Surgery and Critical Care	Womens and Childrens	Surgery Endoscopy	Community and Therapies	Trust Total
Elective	45%	94%	75%		2%	86%
Daycase	106%	93%	82%	104%	68%	97%
OPD New	120%	118%	110%			116%
OPD New Procedures	68%	85%	107%			97%
OPD Follow Up	97%	96%	111%			99%
OPD Follow Up Procedures	66%	118%	118%			106%
Total	**97%**	**97%**	**93%**	**104%**	**45%**	**96%**

Spells/ Attendances	2019/20	2020/21	2021/22	2022/23	Variance to 2019/20
Elective	6136	3318	4510	4499	(1,637)
Daycase	48993	32371	44781	49306	313
OPD New	86335	70582	92896	100785	14,450
OPD New Procedures	25542	12136	20547	21069	(4,473)
OPD Follow Up	185098	187300	197523	199366	14,268
OPD Follow Up Procedures	49359	26251	40534	47781	(1,578)
Total	**401463**	**331958**	**400791**	**422806**	**21343**

Spells/ Attendances	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Elective	345	400	353	399	417	426	482	476	357	389	455
Daycase	3990	4747	4248	4538	4633	4356	4456	4897	4338	4668	4435
OPD New	9064	10146	9682	9304	9048	9847	9491	9538	7949	8951	7765
OPD New Procedures	1718	1978	1702	1795	1806	2081	2022	2139	1762	2140	1926
OPD Follow Up	16546	18993	18350	16929	17418	18173	18737	20669	16334	19776	17441
OPD Follow Up Procedures	3804	4374	3790	3865	3980	4419	4563	5243	3808	5263	4672
Total	**35467**	**40638**	**38125**	**36830**	**37302**	**39302**	**39751**	**42962**	**34548**	**41187**	**36694**

Appendix C – Temporary Staffing Summary

	2021/22			2022/23			Variance		
Subjective Sub catergory	Non-COVID	COVID	Total	Non-COVID	COVID	Total	Non-COVID	COVID	Total
Medical Staff	24,756	2,824	27,580	28,903	285	29,188	(4,147)	2,539	(1,608)
Nursing Staff	18,774	4,945	23,720	25,576	287	25,862	(6,801)	4,659	(2,143)
Scientific, Therapeutic & Technical Staff	1,867	44	1,911	2,544	0	2,544	(677)	44	(634)
Admin & Clerical Staff	1,723	295	2,018	2,367	8	2,375	(643)	287	(357)
Maintenance Staff	-	-	-	5	-	5	(5)	0	(5)
Other Staff	3	-	3	3	-	3	0	0	0
Support Staff	1,668	365	2,033	2,037	25	2,062	(369)	340	(29)
Grand Total	**48,792**	**8,472**	**57,265**	**61,435**	**604**	**62,039**	**(12,642)**	**7,868**	**(4,774)**

		2021/22			2022/23			Variance		
Type	Subjective Sub catergory	Non-COVID	COVID	Total	Non-COVID	COVID	Total	Non-COVID	COVID	Total
Agency	Medical Staff	10,293	1,350	11,643	11,650	31	11,681	(1,357)	1,319	(38)
	Nursing Staff	9,248	2,621	11,870	13,713	127	13,841	(4,465)	2,494	(1,971)
	Scientific, Therapeutic & Technical Staff	1,401		1,401	1,616		1,616	(215)	0	(215)
	Admin & Clerical Staff	183		183	348		348	(164)	0	(164)
	Maintenance Staff	-		-	5		5	(5)	0	(5)
	Other Staff	3		3	3		3	0	0	0
	Support Staff	1		1	1		1	(0)	0	(0)
Agency Total		**21,129**	**3,972**	**25,101**	**27,335**	**159**	**27,494**	**(6,206)**	**3,813**	**(2,393)**
Bank / Locum	Medical Staff	14,463	1,474	15,937	17,253	254	17,507	(2,790)	1,220	(1,570)
	Nursing Staff	9,526	2,324	11,850	11,862	159	12,022	(2,336)	2,165	(172)
	Scientific, Therapeutic & Technical Staff	466	44	510	928	0	929	(463)	44	(419)
	Admin & Clerical Staff	1,540	295	1,835	2,019	8	2,027	(479)	287	(192)
	Support Staff	1,668	365	2,033	2,036	25	2,061	(369)	340	(28)
Bank / Locum Total		**27,663**	**4,501**	**32,164**	**34,099**	**445**	**34,545**	**(6,436)**	**4,055**	**(2,381)**
Grand Total		**48,792**	**8,472**	**57,265**	**61,435**	**604**	**62,039**	**(12,642)**	**7,868**	**(4,774)**

NLG(23)056

Name of the Meeting	**Trust Board of Directors (public)**
Date of the Meeting	Tuesday, 4 April 2023
Director Lead	Jug Johal – Director of Estates and Facilities/Health Inequalities Lead
Contact Officer/Author	Jug Johal – Director of Estates and Facilities/Health Inequalities Lead
Title of the Report	**Estates and Facilities Executive Report**
Purpose of the Report and Executive Summary (to include recommendations)	The report provides a brief overview of the highlights, lowlights and risks within the services in the Estates and Facilities Directorate. Updating the board of key successes and outcomes and current/future projects. The Trust Board is asked to: a) Note the Estates and Facilities Report b) Note the Key highlights, low lights and risks across all Estates & Facilities functions
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

FACILITIES SERVICES

Highlights	Lowlights	Risks
• National Standards of Healthcare Cleaning – Audit Officers in post and commenced annual Audit Programme		• Star Rating based on overall environment • Resource to support Star Rating within "Handyman" Team
	• No additional Porter Resource approved for DPoW & SGH Eds	• ED Porter Resource unable to support timely Patient flow requests, requiring Nursing support to move patients
• Facilities team support in mobilising SGH & DPoW ED Departments with equipment, consumables, cleaning, and staffing		
• National Standards for Healthcare Nutrition & Hydration Nov 2022		• Capital Investment for Cooking Equipment to support traditional cook
	• T&C's now only competitive with minimum wage roles	• Recruitment process takes time, recruits withdraw when delays occur
• Recruitment of staff into Facilities roles		• Agenda for Change (AFC) T&Cs no longer competitive, lengthy recruitment process often fails to secure appointment
• Trust Wide CCTV System Install, Impact on Evidence gathering, quality of evidence		
• Inflation impacting costs of Fuel, food and plastic consumables pricing and availability		• Sourcing consumables, supplier drift for price, impact on revenue
• Security & Car Parking Operational and contract Costs		
• Car Parking Variable Message Signage Review to improve communication of site spaces post ED works	• Parking Income below Operating costs	• Costly to replace

COMMERCIAL SERVICES

Highlights	Lowlights	Risks
• Accommodation configuration adjusted at SGH to support the increase in HYMS Students. Students now occupy most of the single rooms across the Trust. This limits flexibility to support other staff groups, at SGH in particular. DPoW benefits from a significant number of flats in addition to rooms. • Overall Trust activity is at 77% against the Minimum Services (MSP) adjustment target of 80%. This is in line with activity levels in prior contract years. • Utilisation of Decontamination Services Agreement (DSA) to facilitate instrument repair and purchases through Services Provider realised additional vat recoverable of £4k via invoicing process YTD and is forecast to be circa £22k within the Financial Year in addition to refunds of £76k YTD. • Significant increase in Private Patient demand. Opportunity to target waiting lists if theatre slots are available. • Trust has re-occupied children's centre's for Maternity Services, specifically Barton. • Monarch House disposal and relocation of services to New Beacon House reducing property rental costs and improving utilisation of leased assets.	• Still unable to secure a regular weekly/ monthly theatre session which would allow for better planning and performance of Private Patients function. • Demand for accommodation at SGH exceeds supply. • Unable to implement Hybrid working paper. • Minimum Services adjustment payments of £62k for DSA. • Progress on lease arrangements with NLC for the Community Equipment Store remains challenging with NLC seeking to apply additional cost pressures to the Trust. • Awaiting consultation process for the children's centres in NEL to enable services to resume. • IFRS 16 making lease arrangements less attractive. 2021 Rate Review.	• Ability to provide surgery slots to meet demand for Private Patients. • If the Trust is unable to provide accommodation this can impact workforce and patient care. • Severe potential that we will not be able to offer admin space to teams (especially at DPOW) or adhere to Space utilisation policy. • Trust highly unlikely to achieve Minimum Services Level with DSA creating a financial pressure. • Underutilisation of DSA instrument purchase managed service will not yield potential VAT savings.

SAFETY & STATUTORY COMPLIANCE

Highlights	Lowlights	Risks
• Fire alarm replacement project at SGH ahead of programme currently and on target to be completed within 24/25. • Estates Return Information Collection (ERIC) submission data gathering commenced. Preparing sections required for early submission at end of April 23 and final submission later in 23/23. • Residual involvement in ED projects during defect periods as units not open. Work on SDEC projects underway. • PAM workshop 22/23 programme nearing and report compiled. PAM portal due to open soon for submissions into DHSC centrally. • Reporting on fire training attendance being further developed to give more information to areas in regard to those not attending. • Upgraded community lone worker devices now upgraded with unallocated units returned to avoid incurring additional charges. Greater working relationship with provider developed to take forward initiatives to increase usage. • Compliance training for 22/23 fully committed and budget for 23/24 being finalised • Acting a competent H&S advisor to HUTH and management of safety team	• Community lone workers alarm usage very poor – working with providers on a number of initiatives to increase usage. • Project work impacting on work programme. Whilst statutory compliance performance monitoring is being maintained some development of the processes is restricted. • Time to recruit – the overall process from getting the job description to appointing and then starting date can act as a discouragement to some candidates	• Single vacancy left to recruit delayed due to delay in getting band evaluation completed . • No dedicated training venue for E&F (currently used for Practice Development Nurses) so may affect ability to “catchup” delayed training

ESTATES & ENGINEERING

Highlights	Lowlights	Risks
• Continued drive to modernise and create a culture with the right skills and abilities developing a more proactive, forward leaning team in an era of constant change. Transformational, instilling a culture of continuous learning and development. • The NHS long-term plan focuses on digitalization. Continued drive to implement wider digitalization of the estate; Building Management System (BMS) role, asset tagging, energy metering, laser scanning & Building Information Modelling (BIM).. This will result in strategic and operational management improvement via enhanced Computer Aided Facilities Management (CAFM) system. • Enhanced information gathering and appreciation which has enabled a more defined, understood picture of the estate to be escalated, to ensure accurate data Estates Return Information Collection (ERIC) and Premise Assurance Model, and thus creating a detailed backlog maintenance programme. • The pandemic, and on-going support to projects, has put pressures on all teams, however, it has developed closer collaboration with clinical counterparts as we strive for environmental betterment for staff and patients alike. • The enhanced new energy centre and associated	• Lack of resource support to new EDs, MRIs (pay and non-pay) which are additional m2 to the estate. Continued budgetary pressure due to inflation and ageing infrastructure, 117m Back Log Maintenance (BLM). • Unable to achieve full compliance requirements due to pressure to deliver Trust strategic projects. • Positive Trust drive to improve NLaG: Ask Peter, Patient Led Assessment of Care Environment (PLACE), Patient Advice and Liaison Service PALS, 15 Steps, generating lists of reactive work which compounds budgetary pressures, creating a negative perception of the estate. • Due to Trusts financial position, it was unable to support 2021/22 & 22/23 business case for specific resource to manage water risk at SGH, which leads to increase risk of enforcement action, thus doing reputational damage. Team has been set up regardless from existing resource, but at the potential risk of inability to complete other works.	• Resource impact due to influenza/Covid combined with continual business as usual pressure, compounds risk to patient environment delivery due to lack of additional resource provision, supported by accepted risk on risk register. • Mismatch between finance, staffing and operational requirements, results in increased risk to patients & staff. • Continued operational pressures (Moving from COVID to Capital Projects) resulting in dwindling good will of maintenance team impacting compliance work. • Financial position under pressure driven by aging estate and economic climate. • So what… Combined, impacts ability to support operational delivery as risk factors are all elements considered external.

CAPITAL PROJECTS

Highlights	Lowlights	Risks
• The new Emergency Departments and enabling schemes at both DPoW & SGH are now operational, offering significant improvements to the urgent and emergency care facilities at both sites. Work is now ongoing to convert the old A&E areas into AAU/SDECs [c.£63m overall] • Completion of the replacement of the failing Fire Alarm System at DPoW, providing a safer environment for patients and staff throughout the entire hospital [c.£4.5m] • Full refurbishment of Ward 25 at SGH, creating a fully modernised single room ward environment improving the patient experience whilst having medical treatment, in line with improved infection control guidance [c.£2.7m]. • New Gamma Camera for DPoW, improving the diagnostic capabilities available at the Grimsby site [c.£1.7m incl. equipment]. • Refurbishment of Theatres 7, 8 at DPoW and Theatre A at SGH, enabled by TIF funding, and upgrades to the electrical critical infrastructure serving the SGH Theatres, enabling increased capacity to address the backlog in elective surgery [c.£6.8m overall incl. the electrical works]. • Critical Water Infrastructure Works to address the concerns over the condition of the fresh water reservoir at the Scunthorpe site [c.£730k overall]. • Fire Door Surveys and the commencement of fire door replacement work at SGH, improving the fire safety of the site [c.£350k]. • Changing Places facility and improvement to pedestrian and disabled access routes at SGH [c.£240k incl. £90k from NLC]. • Refurbishment of the Maxillo Facial Rooms at SGH [c.£300k]; • Refurbishment and installation of new equipment into the Fluoroscopy facility at SGH [c.£630k incl. equipment]. • Improvements to the Mammography facilities at DPoW [c.£800k incl. HTF funding] • Replacement of the Fire Alarm system at the Scunthorpe site has also commenced, a £5.5m project which is due to continue into 24/25 Financial Year.	• Difficulties and delays in recruiting sufficient staff to deliver projects effectively and sustainably • Project delays due to supply chain and material shortages	• Supply chain and material resource availability impacting on ability to deliver projects • Ongoing inflationary pressures within the supply chain impacting on ability to deliver projects within budget constraints. • Difficulty in recruiting staff to both permanent and fixed-term roles

NHS Northern Lincolnshire and Goole NHS Foundation Trust

NLG(23)057

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	4th April 2023	
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. • Recommendation for a Board discussion to be arranged on Workforce • To highlight to the Board the importance of hitting month 11 and 12 activity plans to hit the financial plan and start 2023/24 on plan • The Operational and Finance Plan was going through several iterations	
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 TRUST BOARD

Report for Trust Board Meeting on:	4th April 2023
Report From:	Finance & Performance Committee – 22-02-23 and 22-03-23

Highlight Report:

Review of NLaG monthly Financial position (Finance Report) (SO3.1/SO3.2b)
Finance Report Month 10

The Trust had an in-month surplus of £0.7m, £1.3m better than plan which resulted in a £1.8m year-to-date (YTD) deficit, £2.4m worse than plan. The YTD position was supported by a £11.3m non-recurrent technical CIP. The Trust was forecasting an unmitigated £7.4m year-end deficit, however, non-recurrent mitigations of £4.6m reduced that to £2.8m; the Trust was formally reporting a breakeven forecast outturn position. The Committee queried the assurance level of the breakeven forecast outturn position and were informed that if the month 11 and 12 activity figures hit plan, then the Trust should make the breakeven position.

Pay was £2.1m adverse in month, which equated to a £15.5m adverse year-to-date position. The Bank incentive payments had not resulted in a reduced spend on Agency staffing, which reminded the Committee of the request for a Board level discussion on a range of Workforce issues which were critical enablers to achievement of the 2023/24 operational and financial plans.

The Committee were informed that a settlement of £1.5m had been agreed with Greater Lincolnshire PLACE which the Trust believed was a reasonable position.

The Committee were informed that Estates and Facilities were contesting several energy invoices, although this would not amount to big sums of money it should bring some funds back in the Trust.

The Committee had a discussion around increasing food costs, due to inflation and the number of patients spending long periods in the Emergency Department (ED) or in escalation beds. Costs had increased by the equivalent of 5 wards.

Review of NLaG monthly Financial position (Finance Report) (SO3.1/SO3.2b)
Finance Report Month 11

The Trust had an in-month surplus of £0.5m, £0.3m ahead of plan which resulted in a YTD deficit of £1.3m, £2.2m adverse to plan. That position was supported by the Trust receiving £5.5m in additional surge funding (£2.75m in month) reducing its reliance on technical savings. The Trust is still confident of reaching the year end in a balanced position.

The Committee were informed that spending on bank and agency staff this year had hit £62m, which was £5m above last year's cost. The Committee asked about the bank incentive scheme and whether it had been a success, they were informed that uptake in month 10 was good but it had dropped off in month 11. It was mentioned that the Committee had requested a Board level workforce session to discuss recruitment and retention for the forthcoming year.

The Trust had delivered Cost Improvements of £30m, but £14m of that had come from technical adjustments which were non-recurrent. The Committee queried the mitigation plans for the non-recurrent savings and were told that the savings would need to be found in the next financial year.

The Committee questioned the Capital position as it appeared to be behind plan but were assured that there was little risk that the Trust would not hit the target level of spend for the year.

ED & IAAU Update Report

The Committee were presented with a paper that gave an update on the ED and IAAU upgrade Business Case. The paper detailed the extra costs which the scheme had incurred, which included £11.2m (£5.7m at OBC) on enabling schemes including roads, four additional car parks and Doctor's accommodation, £268k for asbestos removal, 500K for screed and other unplanned scope changes.

The Committee were not assured about the realism of the contingency fund allocated at the start of the project £1.5m for a £60m scheme, as that appeared to be the root cause of the overspend and felt that learning needed to be taken from these projects when future projects were planned.

Based on the forecast overspend and assessment of residual Trust Risk on the project, it is estimated than an addition funding allocation of £4.1m inc VAT would be required to offset the current overspend and allow sufficient contingency to manage the remaining costed risks.
The Committee queried the extra £1m and asked if that had been factored into 2023/24 plans and were told that that was the current worst-case scenario and that it was hoped that the overspend would be less than that. The Committee were told that it was not in the 2023/24 plans and that some other projects may have to be delayed enabling these projects to be completed.

Recovery Support Program for finance (RSPf)
There were several meetings happening to progress the Trust's position and a decision was expected within a few weeks.

Business Case Assurance
No Business Cases that fell under the remit of the Committee were presented.

Draft Operational and Finance Plan Month 10
A paper was presented, but the plan was still a work in progress until closer to the submission deadline. Currently the plan stood at 104% of the 2019/20 activity level, but the requirement was 107%, so more work was required. The Committee were informed that in 19/20 the Trust had more operational theatres and were able to carry out more Waiting List Initiatives (WLI's) which would have increased activity that year. The Committee queried the baseline assumption on staffing levels for next year and were informed that it was a known risk as assumptions had been made on the pipeline and retention levels. The Committee also queried the reduction in average length of stay given the difficulties with discharges and was informed that the money made available to the Home First, Virtual Ward, Outpatient Parenteral Antibiotic Therapy (OPAT) and Paediatric Hospital at Home projects was now confirmed as recurrent which would aid the reduction.
The Committee were informed that the financial plan was still very fluid, and the current planned income/expenditure deficit had just been reduced from £51.7m to £44.1m based upon further planned efficiencies. There was a possibility of a further £4/5m from the ICS to be included but this was likely to have to be used to reduce the deficit only. The Finance plan had the Trust at the highest-level efficiency target at 3.2%, but the deficit was like that of other ICS Trusts. The Committee queried whether the £20m from the balance sheet to cover the 2022/23 deficit would also be available in 2023/24 to cover any deficit and were informed that this would not be an option. If that had not been available in 2022/23, the likely outturn would have been £20m below plan, so it remained critical for elective capacity to be recovered within available funding.

Draft Operational and Finance Plan 2023/24 Month 11 Update
The Committee were informed that a version of the plan had been submitted last week which had the Trust at 107% of 2019/20 activity, which matched the ICB request. The increase from the previous 104% submitted had been achieved by using ERF funding to pay for independent sector and additional waiting list initiatives. The plan would allow the Trust to realise zero 65-week RTT waits and decrease the number of 52-week waiters, however further work was still required to reduce outpatient follow ups and increase the use of Patient Initiated Follow Ups. The refurbishments of the theatres had been factored into the plan and would show increased efficiency and productivity once open. The Committee were informed that another submission of the plan was due on 24th March. The Committee stated that several of the risks to achievement of the plan were like last year and asked if there was ongoing work with the ICS and PLACE organisations to reduce unnecessary hospital admission and treatment. The Committee were informed that the Trust were working closely with ICS and PLACE colleagues to develop a joined-up plan. The Committee questioned the waiting list trajectories as they were looking optimistic but were advised that work was ongoing across the ICS to mitigate the risks by utilising funding to increase community service provision. The Committee were not assured by planned agency and bank reductions in the plan, given the level of spend in 2022/23 and reiterated its view that a Board level discussion on workforce issues would be beneficial in ensuring that the risks were fully understood and mitigated to the greatest extent possible.

The plan was now showing a financial deficit of £20m from the previous draft version of £44m. The largest risk in the financial plan was the amount of savings required, as the target was £36m for the year because the ICB had requested the Trust to make an additional £10m of savings on top of what was already in the original plan. The plan included investment in the discharge lounge to lengthen the opening hours and investment in pathology which should help to speed up Cancer diagnostics, as well as investments in onboarding international nurses and a medical recruitment team. The Committee expressed concern at the amount of savings required and the potential impact on exit from the Recovery Support Programme for finance if the Trust and the ICB do not make a strong start to the year.
Confirm or Challenge of the Board Assurance Framework:
No Financial BAF Risk was assessed.
Action Required by the Trust Board:
The Trust Board is asked to note the key points made and consider the Committee's recommendations for a Board level discussion on ways of reducing spend on temporary staffing and other Workforce issues underpinning the operational and financial plans for 2023/24. Gill Ponder Non-Executive Director / Chair of Finance and Performance Committee

NLG(23)058

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 4 April 2023
Director Lead	Ivan McConnell, Director of Strategic Development / HAS
Contact Officer/Author	Kerry Carroll, Deputy Director of Strategic Development Claire Hansen, Programme Director, HAS
Title of the Report	**Strategic & Transformation Report – Key Issues**
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 and the completion of the final Clinical Senate. Continued engagement in the enabling programmes of 'Out of Hospital', Digital, and Planned Care. 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 • 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 • Leadership of South Bank Community Diagnostic Centres Programme and progress made with approval of the Scunthorpe Hub submission 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 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)	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 – April 2023

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)
    - Collaborative of Acute Providers (CAP)
    - 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, workforce 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 monthly assurance reviews continue with positive challenge and support
• NHSE review for capital finance on HAS models
• Final Clinical Senate review completed and draft report received
• Ongoing briefings of individual ICS Executive Team members, Place Directors and Primary/Secondary Care interface Groups
• Continuation of 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
• The Consultation Institute Assurance report on the HAS pre-consultation engagement
• Planning and co-ordination of the wider ICS planned care strategy for future service option opportunities
	• 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 – challenging to implement within the wider ICS consultation
	• 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 HAS/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): • Final Clinical Senate review and draft report received on the potential models for consultation • H&NY ICB briefings x 2 • Timeline reset against consultation change to summer 2023 • Timeline approval gateway/ICB dates mapped • Finalisation of PCBC contents - finance and economic chapters in train • Continuation of consultation and engagement planning for pre-consultation. • Staff engagement events to continue based around Integrated Impact Assessment • 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. • Positive assurance report received from the Consultation Institute on the pre-consultation engagement • Alignment of PCBC activity, workforce, capital and finances • Risk workshop scheduled with Executive team – April 23	• Capital funding sources not yet agreed – raised issue with Regional Finance Director – funding sources and capital gaps	• Potential for developments in ICB Strategy, Place Strategies and Collaborative Acute Providers Strategies to change prioritisation and focus of effort

Programme 3 (P3)
• Joint Trust Board scheduled – April 23 for strategic capital review
• Awaiting announcements on final 8 Trusts selected to become part of New Hospitals Programme (NHP)
  • 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
• Capital options developed to implement HAS potential models within own capital resources over a phased 5 year approach if not successful with NHP
	• 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	

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 (HNY) 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, and the wider ICS 180 days workforce planning - leading on Retention) • 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	• Multiple and competing priorities for resourcing	• Management of conflicting priorities: o ICS, Sub System, Collaboratives, Place, Organisation • System pressures create a change of focus from long to short term action • Resource implications of servicing multiple and often duplicate meetings • Ensuring that NLaG retains a voice in all discussions • Availability of system wide resource to support design and implementation of initiatives

Collaboration of Acute Providers (CAP) • The Trust is an active member of the Acute Collaborative and has a number of leadership roles within that group, including: • Director of Strategic Development, Chairs CAP Strategy Group • COO Chairs, COO Group • NLaG is providing leadership of the CAP Planned Care Strategy noting approach of development of the strategy engaged with Place Boards, HNY Clinical & Professional Groups, Clinical Networks and Public Health • NLaG is providing leadership of the CDC programme on the South Bank noting submission of the Scunthorpe Hub business case approved. Development of the Grimsby business case is train. **Place Based Partnership Boards** • Trust Chair, CEO, Director of Strategic Development are members of both the North and North East Lincolnshire Place Boards • Members of Trust Executive and Leadership teams provide support to multiple Place based working groups **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		

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	4 April 2023
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 2 March 2023
Background Information and/or Supporting Document(s) (if applicable)	**The Strategic Development Committee met on 26 August where members considered** : • HASR Programme 2 • Community Diagnostic Centres • External Demands PLACE • Strategic Capital Investment • Out of Hospital support **The Trust board is asked to consider** : • The Trust Board is asked to consider the external demands placed on the Trust by the 3 different Place based Quality committees and consider a way this could be simplified **The Trust Board is asked to note :** • Progress made on the CDC project • Progress made on HASR Programme 2 • Position regarding the strategic capital incestment concerns and next steps
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:	4 April 2023
Report From:	Strategic Development Committee – 2 March 2023

Highlight Report:

External demands - Place Partnerships

The committee were concerned that the Trust is still servicing the different Quality Boards for NEL, NL and ERY after this issue being discussed in the SDC meeting in December 2022. There was a suggestion that NLaG should take control of this and create a Quality Board that all Place representatives where they can all receive their assurance in one meeting

HASR Programme 2

The committee were given an update on progress from the clinical senate meeting which had just been held where the clinical proposal for change was reviewed. The clinical models were reviewed along with consideration being given to sustainability and the credibility of assumptions made .The senate gave reasonable assurance on the current models (other gradings available are limited or no assurance). Substantive assurance was also given to the level of pre consultation work that had been undertaken

The next steps involve an NHSEI Gateway review end March/early April prior to the ICB approving the consultation narrative. A joint Trust Board briefing with HUTH is planned 4th April to review the latest HASR position and capital options

Community Diagnostics Centre

The committee received an update on the progress made in developing the business case for the SDC in Scunthorpe. The site has been specified and sized and the demand modelling has been rebased. NHSEI will be reviewing the workforce modelling and the national team are reviewing the business case on 30th March. There is a national requirement that the unit be open for business on 01.04.2024 on a phased basis. The committee thanked Ivan McConnell and his team for all their hard work and diligence on supporting this project .

Strategic Capital Investment

The committee were informed that the Trust's internal capital position was significantly challenged and the Trust would need to think differently. Over the last two years NLaG has generated internally £26.2mil of capital funding. This has only provided a small contribution to the overall capital investment requirements.

The Six Facet Survey 22/23 highlighted an infrastructure issue of £117.5m gap, it was noted that within this figure there was a Backlog Maintenance estimated cost of £107.5m of this £80m relates to critical infrastructure risk.

With the identified capital priorities of c£57m over the next 5 years and the real time 9-10% increase on the BLM risk (based on historical increases) this would mean in 5 years the Trust would still have a BLM issue of circa £113m . The conclusion of the presentation was that we could no longer continue as it and needed to do something differently now. The Trust board will debate this issue further in the capital infrastructure session on the 4th April

Confirm or Challenge of the Board Assurance Framework:
The BAF risks 1.3 transforming care over time with partners, 1.5 digital risks, 3.2 failure to secure adequate capital were reviewed and the risk ratings approved. With SO 4.0 risk that the trust is not a good partner or collaborator had a risk score of 12 against a target risk score of 8 and it was felt the trust were performing better that portrayed and would revisit the current risk score as a result
Action Required by the Trust Board:
The Trust Board is asked to discuss the external demands placed on the Trust by the 3 different Place based Quality committees and consider a way this could be simplified **Linda Jackson** **Vice Chair / Chair of Strategic Development Committee**

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	4 April 2023
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 –** 9 March 2023
Purpose of the Report and Executive Summary (to include recommendations)	The attached highlight report summarises key issues presented to and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 9 March 2023. The following were worthy of highlighting to the Public Trust Board: • HTF Trustees' Committee Terms of Reference • HTF 'Wish' 102/22 – Siemens Healthineers SGH MRI Innovision • Appeals • HTF Fundraising Strategy
Background Information and/or Supporting Document(s) (if applicable)	HTF Trustees' Committee Terms of Reference
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)	Only on Health Tree Foundation Charitable Funds
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
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:	4 April 2023
Report From:	Health Tree Foundation Trustees' Committee held on 9 March 2023

Highlight Report:

HTF Trustees' Committee Terms of Reference

- Trustees reviewed the Committee's ToRs. In addition to some minor changes, which the Committee approved, it was noted that current ToRs call for 3 Non-Executive Directors in the Committee core membership. Only 2 are currently nominated by Trust Board, namely Gill Ponder and Sue Liburd. Trustees ask that Trust Board decides whether it requires 2 or 3 Non-Executive Directors to be appointed and will amend ToRs accordingly prior to submission to Trust Board for their final ratification.

HTF 'Wish' 102/22 – Siemens Healthineers SGH MRI Innovision

- Trustees were advised that the original quotation for the above 'Wish' of £57,800 had expired before the order could be placed. The revised quotation is now £111,000. Trustees discussed the ways in which the 'Wish' process could be improved to obviate such delays and decided that:
    - Unless further informal approaches to Siemens were successful, then the latest quotation would be met to secure the MRI Ambience enhancement. This would also respect the specific wishes of several individual donors for this improvement.
    - A revised pre-approval step would be added into the 'Wish' process.
    - A Trustee would be sought in future to monitor and facilitate progress of 'Wishes' costing more than £25k.

Appeals

- Trustees agreed the need to continually be on the lookout for new appeals that HTF could adopt and publicise for broad fundraising. This decision reflected the success of specific, named appeals, such as the two new EDs at SGH & DPOW, compared with general fundraising successes. Trustees wished the Trust Board to be aware of this and to note the need for such appeals to align with the Trust's strategic priorities.

HTF Fundraising Strategy

- To counter the reduction in income over the past year and at the request of Trustees in the November 2022 meeting, the Head of Smile Health and the HTF Charity Manager presented a robust fundraising strategy for 2023/24. This live document, containing monthly target topics and fundraising KPIs, covers all aspects of HTF's work. This includes legacies, schools engagement, corporates and partner charities

and will provide a clear, measurable focus over the coming year. Trustees welcomed such clarity and approved the strategy, whilst asking for regular updates at each Trustees' Meeting.

Confirm or Challenge of the Board Assurance Framework:

N/A

Action Required by the Trust Board:

The Trust Board is asked to decide the number of Trustees required by the HTF Meeting, note the other 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	4 April 2023
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 – February 2023**
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 23 February 2023: 1. **Internal Audit Recommendations –** Positive progress noted with the implementation of audit recommendations. **For Board to Note.** 2. **Board Assurance Framework (BAF)** – The Committee discussed how much of the Board agenda is actually focused around strategic objectives and the BAF, and whether more time should be devoted to them. **For Board to Consider.** 3. **Mortuary and Body Store Assurance** – Assurance received that mortuaries and body stores are fully compliant with NHSE instructions and will be compliant with HTA guidance once upgrades are complete in March 2023. **For Board to Note.** 4. **Salary Overpayments** – Significant reduction in Q3, lowest since Q1 of 2017/18 and a return to downward trend. **For Board to Note.** 5. **Declarations of Interest** – Low levels of compliance amongst Decision Making Staff. **For Board to Support.**
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk & Governance Committee Agenda Papers – 23 February 2023
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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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.
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Highlight Report to the Trust Board

Report for Trust Board Meeting on:	4 April 2023
Report From:	Audit, Risk & Governance Committee – 23 February 2023

Highlight Report:

1. **Internal Audit Recommendations** – The Committee noted good progress with the implementation of Internal Audit recommendations and wished to highlight this positive update to the Board.

2. **Board Assurance Framework (BAF)** – Following discussion of the Q3 BAF report and the question of how much of the Board agenda is actually focused around Trust strategic objectives and issues in the BAF, the Committee agreed to highlight to the Board that there was a strong view that more time should be given over to discussing key themes at Board meetings, such as the underlying financial position, workforce issues, etc.

3. **Mortuary and Body Store Assurance -** The Director of Pathology presented the latest update paper to the Committee and provided assurance that all mortuaries and body stores in the Trust are now in full compliance with NHSE instructions regarding standards to control and audit access to such areas. Additionally, the mortuaries at SGH and DPOWH will be in full compliance with HTA guidance following completion of facility upgrades scheduled for completion in March 2023. The Committee considers this closed.

4. **Salary Overpayments** – The Committee noted the significant reduction in salary overpayments for Q3, the lowest since Q1 of 2017/18 and a pleasing return to a down trend. The Committee expressed their thanks to the Payroll team and also to managers for their diligence in reducing overpayments. The Committee agreed that this is an area which the Board, and Executive colleagues, need to continue to pay attention to.

5. **Declarations of Interest** – The Director of Corporate Governance identified that there are low levels of compliance with declarations of interest amongst Decision Making Staff. Efforts will continue to ensure the Trust are compliant with NHSE requirements on conflicts of interest, and the issue is highlighted to the Board for Executive support in their areas.

Confirm or Challenge of the Board Assurance Framework:

See item 2 in section above.

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 of Directors**	
Date of the Meeting	4 April 2023	
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	**Annual Review of Health Tree Foundation Trustees Committee Terms of Reference**	
Purpose of the Report and Executive Summary (to include recommendations)	Proposed changes as a result of this annual review are tracked for ease of reference on the attached. **The Trust Board is asked to approve the revisions to the Health Tree Foundation Trustees Committee Terms of Reference.**	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: HTFT 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.

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Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Finance

HEALTH TREE FOUNDATION TRUSTEES COMMITTEE

Membership and Terms of Reference

Reference:	DCT041
Version:	3.3
This version issued:	16/03/22
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	03/03/22
Approving body:	Charitable Funds Trustees Committee
Date for review:	March 2023
Owner:	Lee Bond, Chief Financial Officer
Document type:	Terms of Reference
Number of pages:	9 (including front sheet)
Author / Contact:	Lee Bond, Chief Financial Officer

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 Purpose

1.1 The Trustees' Committee is tasked with overseeing and managing the affairs of the Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds. The working name of the Charity is The Health Tree Foundation.

1.2 The Trustees' Committee must ensure that the Charity acts within the terms of its declaration of trust, and all appropriate legislation, on behalf of the Trust Board as Corporate Trustee.

2.0 Authority

2.1 The Trust Board exercises its role as Corporate Trustee through its review and control over the Terms of Reference of the Trustees' Committee, and through its powers to appoint to the Trustees' Committee.

2.2 The Trust Board delegates authority to receive, manage and utilise charitable funds to the Trustees' Committee.

2.3 Expenditure commitments must be approved in line with the delegation limits set out in Appendix A. The final decision on any expenditure rests with the Trustees' Committee.

2.4 Investment and disinvestment decisions remain the preserve of the Trustees' Committee.

2.5 The Trust Board will review the working of the Trustees' Committee through the reporting arrangements set out in section 3, in order to perform its role as Corporate Trustee.

2.6 The members of the Trustees' Committee shall act independently of the Trust Board when making decisions about expenditure.

2.7 The Trustees' Committee must ensure that the expenditure decisions are granted only to further the charity's purposes for the public benefit and for no other purpose.

3.0 Accountability & Reporting Arrangements

3.1 The Trustees' Committee is established as a formal sub-committee of the Trust Board, under the Trust Constitution Part IV Section 6.8 d. These Terms of Reference shall have effect as if incorporated into the Trust's Constitution, and shall only be amended by agreement of the Board.

3.2 The minutes of the Trustees' Committee will be formally recorded and submitted to the Trust Board once agreed by the Committee.

3.3 The Trustees' Committee will supply the Trust Board with a highlight report following each meeting, outlining investment and disinvestment decisions, and material expenditure commitments, in line with limits set out in Appendix A. The

highlight report will also include key items of activity that Trustees wish the Trust Board to be aware of.

3.4 The Trust Board shall have access to all reports and papers of the Trustees' Committee. These must include regular comprehensive financial reports and progress updates.

3.5 The Trustees Committee' must ensure that accounts for Charitable Funds are completed in line with regulatory standards and deadlines, and made available to the Trust Board and Audit Risk and Governance Committee.

4.0 Responsibilities

The responsibilities of the Charitable Trustees, Committee are to:

- Manage the affairs of the Northern Lincolnshire and Goole NHS Foundation Trust Charity within the terms of its declaration of trust and appropriate legislation including that of the Charity Commissioners of England and Wales
- Implement procedures and policies ensuring that accounting systems are robust, donations are received and coded as instructed and all expenditure is reasonable, clinically and ethically appropriate
- Ensure funding decisions are appropriate and are consistent with the Trust's objectives and to ensure such funding provides added value and benefit to the patients and staff of the Trust, above those afforded by Exchequer funds
- Maintain engagement and monitoring arrangements for major projects utilising significant funding provided by the Charity
- Monitor and review fund balances, and where appropriate amend the structure of individual funds (e.g. merging, deleting, rationalising)
- To manage the investment of funds in accordance with the Trustee Act 2000 and if necessary to appoint fund managers to act on its behalf
- Maintain a proactive approach to fund raising, including charitable giving, legacies, and publicity as well as arranging appropriate communications on all matters associated with the Charity
- Review and agree audited Annual Report & Accounts
- ~~Ensure that Trustees Committee membership is refreshed and that undue reliance is not placed on particular individuals when undertaking responsibilities of the Committee~~
- Review and update these Terms of Reference annually, recommending any changes to the Trust Board
- Evaluate its own membership and performance on an annual basis

5.0 Membership

5.1 Core membership

The Trust Board acts as Corporate Trustee of the Charity. The Trustees' Committee shall be appointed by the Trust Board from amongst the Non-Executive and Executive members of the Trust Board, and the local community, and shall consist of the following voting members:

- An independent Chair
- 3 Non-Executive Directors;
- Executive Directors:
  - Chief Executive
  - Medical Director
  - Chief Nurse
  - Chief Financial Officer

5.2 In attendance:

- Health Tree Foundation Charity Manager
- Head of Smile Health - HEY Smile Foundation
- Director of Estates and Facilities
- Director of People
- Associate Director of Communications
- Chief Financial Accountant
- Assistant Director of Finance, as required
- Governor Representative
- Investment Representatives, as required
- Other Trust staff and stakeholders as required

5.3 Charitable Funds Executive Clinical Champions

The Trustees' Committee shall have two Charitable Funds Executive Clinical Champions, the Medical Director and the Chief Nurse. The role of the Clinical Champions is to provide expert clinical opinion on all HTF matters where appropriate, particularly around the question of the impact of HTF wishes on patient experience. They will also be responsible for approving expenditure between £5001 - £25,000 as per Appendix A.

6.0 Procedural issues

6.1 Frequency of Meetings

The Committee shall meet no less than four times a year, although at more regular intervals should the Committee so determine. Notice of each meeting, including an agenda and supporting papers, shall be forwarded to each member of the Charitable Trustees Committee not less than five working days before the date of the meeting.

6.2 Independent Chair and Trustees

The Independent Chair and Trustees shall be appointed by the Trust Board.

6.3 Secretarial Support

The Chief Financial Officer will ensure that appropriate administrative support is available to provide support to the Chair and members of the Charitable Trustees Funds Committee.

6.4 Attendance

6.4.1 Permission for Trustees to Nominate Deputies

In the absence of the Chair, a Non-Executive Committee member will be nominated by the Chair to perform this role. Other Trustees may ~~not~~ nominate non-voting deputies to act on their behalf.

6.4.2 Attendance by Trustees

All Committee members will be required to attend 75% of meetings. The Trustees' Committee will maintain and publish annually a register of attendance.

6.5 Quorum

6.5.1 The Committee will be quorate when:

- A minimum of four Trustees are in attendance
- At least two Independent external or Non-Executive Trustees are in attendance, and
- At least one Executive Director Trustee is in attendance

6.5.2 Where the Chief Financial Officer is unable to attend the Committee, they remain responsible for ensuring that appropriate technical advice and support is still available to the Committee in order to support effective execution of its duties.

6.6 Minutes of Meetings

The Charity Manager will agree the agenda items with the Committee Chair; produce all the necessary papers and attend the meetings. The Committee shall be supported by the Chief Financial Accountant, who will provide the financial updates and attend the meetings.

The Directorate of Finance will provide an appropriate individual to take minutes, keep a record of matters arising and issues to be carried forward. The minutes, once formally agreed at a subsequent meeting of the Trustees' Committee, will be presented to the Trust Board in order to support the Trust Board's role as Corporate Trustee. The Trustees' Committee Highlight Report will be agreed by the Committee Chair and presented to the Trust Board by one of the Non-Executive Directors.

6.7 Review

The Terms of Reference will be published on the Trust Intranet and will be reviewed annually.

7.0 Equality Act (2010)

7.1 Northern Lincolnshire and Goole NHS Foundation Trust is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

7.2 The Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

7.3 The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

7.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

Appendix A

CHARITABLE FUNDS – DELEGATION LIMITS

1.	Up to £250	Authorisation from Health Tree Foundation Charity Manager
2.	Between £251 - £5,000	As above plus further authorisation from the Fund Guardian
3.	Between £5,001 - £25,000	As above plus further authorisation from Fund Guardian and from either of the Charitable Funds Executive Clinical Champions, i.e. the Medical Director or the Chief Nurse
4.	Above £25,000	As above, plus further authorisation from the Committee

The Trustees' Committee will exercise final authority over all decisions, and will set out appropriate guidelines, as required; to support this delegated decision making process.

All investment and disinvestment decisions relating to the funds held by the Charity will require the authorisation of the Trustees Committee.

The Committee is required to approve expenditure above £25,000, but all expenditure items above £1,000 will be reported to the Committee.

Individual expenditure commitments above £50,000 in value, and all investment or disinvestment decisions, will be reported for oversight purposes to the Trust Board as Corporate Trustee, through the regular Highlight Report.

NLG(23)063

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	4 April 2023
Director Lead	Simon Parkes – Chair of Audit, Risk and Governance Committee
Contact Officer/Author	Lee Bond – Chief Financial Officer
Title of the Report	**Annual Review of ARG Committee Terms of Reference**
Purpose of the Report and Executive Summary (to include recommendations)	In line with its agreed annual work plan, the Audit, Risk and Governance (ARG) Committee performed its annual review of its formal Membership and Terms of Reference at its meeting on 23 February 2023. A limited number of changes are proposed, to reflect content within the new HFMA NHS Audit Committee Handbook Supplement (November 2022). The Supplement deals primarily with the setting up of Audit Committees in Integrated Care Boards, but also deals with the need for Audit Committee's to take a wider view when considering audit and assurance as a result of the Health and Care Act 2022 introducing new requirements for NHS bodies to work together to meet joint financial objectives and duties. It also references dealing with the management of risk across a system and what assurances an Audit Committee will need and where assurances will come from. The HFMA advise that a full updated Handbook is due to be published in 2023, and the Committee's terms of reference will be revisited once the new Handbook is published. Proposed changes as a result of this annual review are tracked for ease of reference on the attached. **The Trust Board is asked to approve the revisions to the Audit, Risk and Governance Committee's Membership and Terms of Reference.**
Background Information and/or Supporting Document(s) (if applicable)	HFMA NHS Audit Committee Handbook (2018) HFMA NHS Audit Committee Handbook Supplement (2022) ARG Committee agenda papers from 23 February 2023
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Audit, Risk and Governance 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.

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Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Finance

AUDIT, RISK AND GOVERNANCE COMMITTEE

Membership and Terms of Reference

Reference:	DCT122
Version:	1.98
This version issued:	~~07/04~~/22
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	~~05/04/22 / 24/02/22~~
Approving body:	Trust Board / Audit, Risk & Governance Committee
Date for review:	April, 2023
Owner:	Lee Bond, Chief Financial Officer
Document type:	Terms of Reference
Number of pages:	20 (including front sheet)
Author / Contact:	Sally Stevenson, Assistant Director of Finance – Compliance & Counter Fraud / Helen Harris, Director of Corporate Governance

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1.0 Constitution

1.1 The Trust has established the Audit, Risk and Governance Committee as a formal sub-committee of the Trust Board. The Committee is responsible for oversight, challenge and assurance, on behalf of the Trust Board.

2.0 Purpose

2.1 The Committee has no executive powers, other than those specifically delegated in these terms of reference.

2.2 These terms of reference have been produced in line with the guidance contained within the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2018) and the Handbook supplement (2022).

3.0 Authority

3.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

3.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3.3 The Provisions in the attached Annex to these Terms of Reference will only come into force at the explicit discretion of the Trust Board; and then only for those periods of time such as it determines to be appropriate in order for the Trust to discharge its functions under its business continuity plans during periods of potentially significant disruption to service delivery.

4.0 Accountability and Reporting Arrangements

4.1 Minutes of each meeting shall be submitted to the next meeting for formal approval ~~and signature by the Chair~~ as a true record of that meeting. The approved minutes will be submitted to the next meeting of the Board for information.

4.2 The Chair shall draw to the attention of the Board (via a highlight report) any issues that require disclosure to the Board or require executive action.

4.3 The Committee shall report to the Board annually on its work in support of the Annual Governance Statement specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence that shows the organisations is fulfilling regulatory requirements relating to its existence as a functioning business and the robustness of the processes behind the quality accounts.

4.4 The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The report will also outline its workplan for the coming year.

4.5 The Committee's annual report and workplan will also be submitted to the Council of Governors for information.

5.0 Responsibilities

5.1 General Duties

5.1.1 The Committee supports the Board by:

- Assessing the Trust's overarching framework of governance, risk and control
- Obtaining assurances about the design and operation of internal controls
- Seeking assurances about the underlying data (upon which assurances are based) to assess their reliability, security and accuracy
- Challenging poor and/or unreliable sources of assurance
- Challenging relevant managers when controls are not working, or data are unreliable

The duties / responsibilities of the Committee are categorised as the follows:

5.2 Integrated Governance, Risk Management and Internal Control

5.2.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

5.2.2 In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications

- The policies and procedures for all work related to counter fraud and corruption as required by the NHS Counter Fraud Authority

5.2.3 In carrying out this work the Committee use the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers.

5.2.4 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

5.2.5 As part of its integrated approach, the Committee will have effective relationships with other Trust Board Sub Committees (which may include reciprocal membership) to provide an understanding of processes and linkages and particularly to enable review and oversight of the other Sub Committee's governance of risk. This will include the exchange of their chair's action logs and highlight reports to the Trust Board.

5.3 Internal Audit

5.3.1 The Committee shall assure itself that there is an effective internal audit function that meets Public Sector Internal Audit Standards (PSIAS) and provides independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Reviewing and approving the internal audit strategy, the annual internal audit plan and more detailed programme of work, that is consistent with the audit needs of the Trust as identified in the Assurance Framework
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources
- Monitoring the implementation of agreed internal audit recommendations in line with agreed timescales, and where concerns exist in relation to the lack of implementation in a particular area the Committee can request the relevant operational manager to attend a meeting and give explanation
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Reviewing the Internal Auditor's annual report before its submission to the Board
- Monitoring the effectiveness of internal audit and carrying out an annual review and obtaining independent assurance that Internal Audit complies with PSIAS

5.4 External Audit

5.4.1 The Committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Assisting and advising the Council of Governors in their appointment of the External Auditors (and make recommendations to the Board when appropriate)
- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Establishing a clear policy for the engagement of external auditors to supply non-audit services, and for scrutinising and where appropriate approving uses of, or exceptions to, this policy.

5.5 Financial Reporting

5.5.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

5.5.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

5.5.3 The Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted misstatements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit

- Letters of representation
- Explanations for significant variances

5.6 Risk Management

5.6.1 The Committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks the Committee considers it is appropriate to do so. This will include:

- Reviewing the Trust's information governance and cyber security arrangements, in order to provide assurance to the Board that the organisation is properly managing its information and cyber risks and has appropriate risk mitigation strategies
- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks
- Overseeing actions plans relating to regulatory requirements in terms of the NHS ~~Single~~ Oversight Framework and Use of Resources
- Providing the Board with assurance over developing partnership arrangements (e.g., ~~accountable care organisations~~integrated care systems) and mitigation of risks which may arise at the borders between such organisations. The Health and Care Act 2022 introduced new requirements for NHS bodies to work together to meet joint financial objectives and duties, and as such the Audit Committee will need to take a wider view when considering audit and assurance. Organisations need to agree together how best to recognise and manage risk across a system, including what assurances the Audit Committee will need and where these will come from

5.6.2 The Board will however retain the responsibility for routinely reviewing specific risks.

5.7 Counter Fraud and Security

5.7.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud that meet the NHS CFA's standards and shall review the outcomes of work in these areas. The Committee shall receive the annual report and annual work plan from the Local Counter Fraud Specialist and shall also receive regular progress reports on counter fraud activities.

5.7.2 The Committee shall also receive and review the annual report and the annual work plan from the Local Security Management Specialist. It shall receive other security activity reports as appropriate.

5.8 Management

5.8.1 The Committee shall request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

5.8.2 The Committee may also request specific reports from individual functions within the organisation (e.g., clinical audit).

5.9 Other Assurance Functions

5.9.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

5.9.2 These will include, but not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g., the Care Quality Commission, NHSE/I, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g., Royal Colleges, accreditation bodies, etc.).

5.9.3 In addition, the Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular this will include any clinical governance, risk management or quality committees that are established. The Committee shall receive the action logs and highlight reports to the Trust Board of the following Board sub-committees for information:

- Finance and Performance Committee
- Quality and Safety Committee
- Workforce Committee
- HealthTree Foundation Committee
- Ethics Committee (when in operation)
- Strategic Development Committee
- Remuneration & Terms of Service Committee – Annual Summary report only

5.9.4 In reviewing the work of the Quality & Safety Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

5.9.5 The Committee will review Standing Financial Instructions, Scheme of Delegation and those elements of the Trust Constitution (Standing Orders) that provide assurances on the internal management of procurement and financial matters. It will also review the Trust's Standards of Business Conduct Policy.

5.9.6 The Committee will receive the Board Assurance Framework (BAF) and the High Level Risk Register on a quarterly basis, to gain assurance that it is operating as part of the Trust's overarching governance / control systems.

6.0 Membership

6.1 Core Membership

6.1.1 The Committee shall be appointed by the Board from among the Non-Executive Directors of the Trust and shall consist of not less than three members. One of the members shall have recent relevant financial experience.

6.1.2 The Chair of the Trust shall not be a member of the Committee.

6.1.3 The Trust Board may appoint such Associate Non-Executive Directors as it deems beneficial to add expertise to the Committee and these will be non-voting positions not forming part of the quorum.

6.2 Regular Attendees

6.2.1 The following shall normally attend meetings:

- Chief Financial Officer
- Director of Corporate Governance
- Internal Audit representative(s)
- External Audit representative(s)

6.2.2 The Local Counter Fraud Specialist will attend to report upon and discuss counter fraud matters.

6.2.3 An invitation to join the Committee as an attendee in an observer capacity will be extended to a Governor to be identified by the Lead Governor.

6.2.4 The Chair of the Trust and the Chief Executive should be invited to attend and should discuss at least annually with the Audit, Risk and Governance Committee the process for assurance that supports the Annual Governance Statement. The Chief Executive should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

6.2.5 Other Executive Directors/managers may be invited to attend, normally for their items(s) only, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director/manager.

6.2.6 Representatives from other organisations (e.g., NHS Counter Fraud Authority (NHS CFA)) and other individuals (e.g., Local Security Management Specialist) may be invited to attend on occasion.

6.2.7 At least once a year, usually at its Audited Accounts meeting, members of the Committee shall meet privately with the External and Internal Auditors. Other meetings will take place at the request of members or auditors.

7.0 Procedural Issues

7.1 Frequency of Meetings

7.1.1 The Committee should normally meet at least five times per year at appropriate times in the audit cycle to allow it to discharge all of its responsibilities in line with its annual workplan. Additional meetings, including any focus working group, may be called as required. The Committee will review this annually.

7.1.2 The Committee will maintain a twelve-month rolling workplan capturing its main items of business at each scheduled meeting. This will be updated throughout the year as the Committee sees fit.

7.1.3 The Accountable Officer, External Auditors and/or Head of Internal Audit may request a meeting if they consider that one is necessary.

7.2 Chairperson

7.3 One of the members will be appointed Chair of the Committee by the Board.

7.4 Attendance

7.4.1 Attendance is a minimum of 75% of all Committee meetings for members and regular attendees (as listed at 6.2).

7.4.2 Other regular attendees (as listed at 6.2) must ensure that in his/her absence, a nominated deputy is briefed to present required information and to respond to scrutiny on his/her behalf.

7.4.3 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 can attend up to 25% of all meetings.

7.4.4 For joint Trust roles however, such as the Chief Financial Officer or any such role, attendance is required to be 50% of Committee meetings with appointed deputies covering the remainder of meetings.

7.5 Quorum

7.5.1 A quorum shall be two of the three members.

7.5.2 A quorum must be maintained at all meetings.

7.6 Administration and Minutes of Meetings

7.6.1 Agenda items for consideration to be submitted at least twelve calendar days before the Committee meeting.

7.6.2 The agenda for the Committee shall be approved by the Chair of the Committee (or his or her nominated deputy).

7.6.3 Secretarial support (including distribution of agenda and papers to the Committee and noting of apologies) will be arranged by the Chief Financial Officer (or his or her nominated deputy).

7.6.4 The Secretary to the Committee shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

7.6.5 Agenda papers will be circulated to all members of the Committee no less than seven calendar days prior to each meeting. Late papers may only be circulated, or tabled at the meeting, with the prior approval of the Chair.

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 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 the 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 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 Standing Financial Instructions 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.

8.0 Monitoring, Compliance and Effectiveness

8.1 In accordance with the requirements of good governance and in order to ensure its ongoing effectiveness, the Audit, Risk and Governance Committee will undertake an annual evaluation of its performance and attendance levels.

8.2 The Committee will carry out an annual self-assessment (Appendix A) that is based on the good practice guide found in the HFMA's NHS Audit Committee Handbook.

8.3 As part of the annual evaluation process, the Committee will formally review performance against core duties, completion of the actions outlined in the action log and effectiveness of the work programme.

8.4 Where gaps in compliance are identified arising from this evaluation, an action plan will be developed, and implementation will be monitored by the Committee.

8.5 The results from the annual evaluation exercise, including any agreed actions, will be reported to the Trust Board.

9.0 Review

9.1 The Committee will review its Terms of Reference annually, or as necessary in the intervening period, to ensure that they remain fit for purpose and best facilitate the discharge of its duties.

9.2 It shall recommend any changes to the Trust Board for approval.

10.0 Access to the Committee Chair

The Head of Internal Audit, representatives of External Audit and the Local Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

11.0 Whistleblowing / Freedom to Speak Up Guardian

11.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensures that any such concerns are investigated proportionately and independently.

11.2 The Trust's Freedom to Speak Up Guardian, or his or her nominated deputy, shall attend the Committee at least annually to provide assurance on the design and operation of the function.

12.0 Equality Act (2010)

12.1 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.

12.2 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.

12.3 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.

12.4 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).

ANNEX

Additional Provisions under Terms of Reference Paragraph 6.3

Under the provisions of paragraph 6.3 of the Committee's Terms of Reference:

(a) The application of the provisions in this Annex is subject to the explicit written prior approval and review of the Trust Board;

(b) References to *"The Period"* in this Annex mean to such period(s) of time as the Trust Board may specify, and;

(c) The provisions in this Annex are additions to the Committee's Terms of Reference and therefore should in no way be interpreted as diminishing the overall remit of the Committee.

"3.0 Attendance at Meetings":

Additional paragraph **3.9** added:

(a) "*During The Period meetings of the Committee may be held on such basis – physical; teleconference and/or videoconference – as may be decided by the Chair of the Committee in consultation with the Chief Financial Officer.*

(b) *Subject to adhering to the requirements for quorum (section 2.0) then it will be a matter for the Chair of the Committee in consultation with the Chief Financial Officer to determine who should be a participant in any Committee meeting during The Period.*

(c) *Notes are to be made of both the attendance at the meeting and of the decisions taken on the items discussed at the meeting for subsequent formal written presentation to the Trust Board monthly.*

(d) *The Chair in consultation with the Chief Financial Officer will maintain a log of those agenda items tabled but not discussed at the meetings during The Period; this will be presented to the Trust Board monthly in writing for information with a statement on the intended action."*

"5.0 Frequency of Meetings":

Additional paragraph **5.3** added:

"During The Period the Committee shall meet with such frequency as may be determined by the Chair in consultation with the Chief Financial Officer and also in order to comply with any revised year-end or other reporting procedures required of it by NHSE/I."

"7.0 Responsibilities":

Additional bullet point added to paragraph **7.1**:

- *"Reviewing the adequacy of the Trust Board's revised arrangements for governance and assurance during The Period; including any proposal to suspend Standing Orders; and making recommendations to the Trust Board in these matters."*

"7.2 Integrated Governance, Risk Management and Internal Control":

The following text added to the final bullet point to paragraph **7.2.2**:

- *"…with a particular focus on the heightened risk for fraud and criminal activity during The Period."*

The following text added to paragraph **7.2.5**:

- *In the absence of the operation of any of the other Trust Board Sub-Committees during The Period it will fall to the Chair of the Committee to maintain regular liaison with those Sub-Committee Chairs in order to remain briefed on any issues that may be of interest to the Committee."*

"7.3 Internal Audit":

The following text added to the end of this section:

"During The Period to agree such revised arrangements with the Internal Auditors (such as the conduct of the work programme for internal audits and follow-ups; and the obtaining of audit opinions, etc.) as may be deemed necessary in the circumstances."

"7.4 External Audit":

The following text added to the end of this section:

"During The Period to agree such revised arrangements with the External Auditors (such as the conduct of annual audit plan; and the annual audit opinion, etc.) as may be deemed necessary in the circumstances."

"7.6 Risk Management":

The following text added as an additional bullet point to **paragraph 7.6.1**:

- *"During The Period any such other matters as the Committee may consider to be relevant in the prevailing circumstances, but in particular in the absence of the operation of any of the other Trust Board Sub-Committees the Committee will assume general oversight of the Sub-Committee-level of the Trust's Board Assurance Framework and report any issues or concerns to the Trust Board*

"7.7 Counter Fraud & Security":

The following text added to paragraph **7.7.2**

"…with a focus on the particular nature of the heightened risk for fraud and criminal activity during The Period."

"7.9 Other Assurance Functions":

The following text added as a new paragraph **7.9.6**:

- *"During The Period and in the absence of the operation of any of the other Trust Board Sub-Committees the Committee may, if considered relevant in the prevailing circumstances, consider such assurance reports as the other Sub-Committees may otherwise have considered and propose a course of action on each."*

The electronic master copy of this document is held by Document Control, Office of the Trust Secretary, NL&G NHS Foundation Trust.

Appendix A

HFMA NHS Audit Committee Handbook, 2018 – Extract

This checklist is designed to elicit a simple yes or no answer to each question. Where 'no' answers have been given, the issues should be debated to determine if any further action is needed.

Area/Question	Yes	No	Comments/Action
Composition, establishment and duties			
Does the audit committee have written terms of reference and have they been approved by the governing body?			
Are the terms of reference reviewed annually?			
Has the committee formally considered how it integrates with other committees that are reviewing risk?			
Are committee members independent of the management team?			
Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?			
Does the committee prepare an annual report on its work and performance for the governing body?			
Has the committee established a plan of matters to be dealt with across the year?			
Are committee papers distributed in sufficient time for members to give them due consideration?			
Has the committee been quorate for each meeting this year?			
Internal control and risk management			
Has the committee reviewed the effectiveness of the organisation's assurance framework?			

Area/Question	Yes	No	Comments/Action
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?			
Has the committee reviewed the accuracy of the draft annual governance statement?			
Has the committee reviewed key data against the data quality dimensions?			
Annual report and accounts and disclosure statements			
Does the committee receive and review a draft of the organisation's annual report and accounts?			
Does the committee specifically review: • The going concern assessment • Changes in accounting policies • Changes in accounting practice due to changes in accounting standards • Changes in estimation techniques • Significant judgements made in preparing the accounts • Significant adjustments resulting from the audit • Explanations for any significant variances?			
Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?			
Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?			
Internal audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?			
Does the committee review and approve the internal audit plan, and any changes to the plan?			

Area/Question	Yes	No	Comments/Action
Is the committee confident that the audit plan is derived from a clear risk assessment process?			
Does the committee receive periodic progress reports from the head of internal audit?			
Does the committee effectively monitor the implementation of management actions arising from internal audit reports?			
Does the head of internal audit have a right of access to the committee and its chair at any time?			
Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?			
Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*?			
Does the committee receive and review the head of internal audit's annual opinion?			
External audit			
Do the external auditors present their audit plan to the committee for agreement and approval?			
Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?			
Does the committee review the external auditor's value for money conclusion?			
Does the committee review the external auditor's opinion on the quality account when necessary? **[Note: this question is not relevant for CCGs]**			

Area/Question	Yes	No	Comments/Action
Does the committee hold periodic private discussions with the external auditors?			
Does the committee assess the performance of external audit?			
Does the committee require assurance from external audit about its policies for ensuring independence?			
Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?			
Clinical audit **[Note: this section is only relevant for providers]**			
If the committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?			
If the committee is responsible for monitoring clinical audit has it: • Reviewed an annual clinical audit plan? • Received regular progress reports? • Monitored the implementation of management actions? • Received a report over the quality assurance processes covered by clinical audit activity?			
Counter fraud			
Does the committee review and approve the counter fraud work plans, and any changes to the plans?			
Is the committee satisfied that the work plan is derived an appropriate risk assessment and that coverage is adequate?			
Does the audit committee receive periodic reports about counter fraud activity?			

Area/Question	Yes	No	Comments/Action
Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?			
Do those working on counter fraud activity have a right of direct access to the committee and its chair?			
Does the committee receive and review an annual report on counter fraud activity?			
Does the committee receive and discuss reports arising from quality inspections by NHSCFA?			

NLG(23)064

Name of the Meeting	**Trust Board - Public**
Date of the Meeting	4 April 2023
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Division of Responsibilities Between the Chair and the Chief Executive**
Purpose of the Report and Executive Summary (to include recommendations)	To present the proposed amendments to the Division of Responsibilities between the Chair and the Chief Executive, to the Trust Board: - Section 1 references the NHS England Code of Governance for NHS Provider Trusts and the NHS Oversight Framework. (Previous references were the Foundation Trust Code of Governance and the NHS Single Oversight Framework). - Section 2.1.14 and 2.1.15 are new additions. - Section 2.1.23 includes the requirement for an externally led assessment at least once in every three years. The Trust Board is recommended to approve the amendments to the Division of Responsibilities Between the Chair and the Chief Executive.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Chair and Chief Executive
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

Northern Lincolnshire and Goole NHS Foundation Trust

Chief Executive's Office

DIVISION OF RESPONSIBILITIES BETWEEN THE CHAIR AND THE CHIEF EXECUTIVE

Reference:	DCM121
Version:	1.7
This version issued:	
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	
Approving body:	Trust Board
Date for review:	March, 2026
Owner:	Dr Peter Reading, Chief Executive / Sean Lyons, Trust Chair
Document type:	Miscellaneous
Number of pages:	14 (including front sheet)
Author / Contact:	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.

Contents

1.0 Introduction

1.1 Within the NHS England (NHSE) Code of Governance for NHS Provider Trusts:

1.1.1 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.

1.1.2 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.

1.1.3 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.

1.2 The purpose of this document is to set out the division of responsibilities between the Chair and the Chief Executive. In doing so particular reference has been made to:

- NHS E Code of Governance for NHS Provider Trusts
- Trust Constitution
- NHS Oversight Framework
- NHS Foundation Trust Accounting Officer Memorandum (Monitor) (last updated August 2015 in light of changes to the Risk Assessment Framework to strengthen the requirement to consider value for money)
- The Foundations of Good Governance: A Compendium of Best Practice.

2.0 Responsibilities of the Chair

2.1 The discrete responsibilities of the Chair can be summarised as follows:

2.1.1 Reports to the Board of Directors.

2.1.2 Other than the Chief Executive, no Executive reports to the Chair.

2.1.3 The effective running of the Board of Directors and Council of Governors.

2.1.4 Ensuring that the Board of Directors as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

2.1.5 The guardian of the Board of Directors' decision making processes.

2.1.6 Offering counsel and advice on sensitive or complex issues raised by the Chief Executive or Other Executive or Non-Executive Directors.

2.1.7 General leadership of the Board of Directors and the Council of Governors.

2.1.8 Ensuring that the Board of Directors and Council of Governors work together effectively and enjoy constructive working relationships (including the resolution of any disagreements).

2.1.9 Ensuring that Board of Directors' and Council of Governors' agendas take full account of the important issues facing the Foundation Trust.

2.1.10 Ensuring compliance with the Board of Director's approved procedures.

2.1.11 Arranging informal meetings of the Directors, to ensure that sufficient time and consideration are given to complex, contentious or sensitive issues.

2.1.12 Proposing a schedule of matters reserved to the Board of Directors, Terms of Reference for each Board Committee and other Board Policies and Procedures.

2.1.13 Facilitating the effective contribution of all members of the Board of Directors and the Council of Governors to ensure that constructive relations exist between Executive and Non-Executive members of the Board of Directors, elected and appointed members of the Council of Governors and between the Board of Directors and the Council of Governors.

2.1.14 Ensures that the non-executive directors are able to lead in being accountable to the council of governors for the board of directors.

2.1.15 Leads the council of governors in holding the non-executive directors to account, ensuring the accountability process works effectively.

2.1.16 Chairing, or nominating another independent Non-Executive Director to chair, the Remuneration and Terms of Service Committee, and initiating change and succession planning in the Board and the appointment of effective and suitable members and Chairs of Board Committees.

2.1.17 Contributing to the agreement of the membership of Board Committees and proposing their Chairs.

2.1.18 Taking the lead in providing a properly constructed induction programme for new Non-Executive Directors.

2.1.19 Appraising the performance of Non-Executive Directors, and reporting on the outcome of the appraisal to the Council of Governors as appropriate.

2.1.20 Taking the lead in identifying and seeking to continually update their skills and knowledge, and meet the ongoing development needs both of individual Non-Executive Directors and of the Board of Directors as a whole.

2.1.21 Ensuring periodic meetings take place with Non-Executive Directors in the absence of Executive Directors.

2.1.22 Ensure that members of the Council of Governors have the skills, knowledge and familiarity with the Foundation Trust to fulfil their role.

2.1.23 Ensuring that the performance of the Board of Directors and Council of Governors as a whole, their committees, and individual members of both are periodically assessed. This will include an externally led assessment at least once in every three years.

2.1.24 Promoting the highest standards of integrity, probity and corporate governance throughout the organisation and particularly at Board of Directors level.

2.1.25 Ensuring good information flows from and between the Board of Directors, Committees, Council of Governors, Senior Management and Non-Executive Directors.

3.0 Responsibilities of the Chief Executive

3.1 The discrete responsibilities of the Chief Executive can be summarised as follows:

3.1.1 Reports to the Chair and to the Board of Directors directly.

3.1.2 All members of the management structure report either directly or indirectly, to the Chief Executive.

3.1.3 Executive responsibility for running the Trust's business. **N.B.** The Chief Executive will be responsible for ensuring that in his / her absence, a designated Executive Director will deputise.

3.1.4 Acting as the Accounting Officer for the Trust as set out in the 'NHS Foundation Trust Accounting Officer Memorandum', which is attached at **Appendix A**.

3.1.5 Ensuring that the Trust and its staff meets all relevant statutory requirements and service obligations including as set out in the NHS Provider Licence and making sure that the Trust's governance framework and associated structures and processes are 'fit for purpose'.

3.1.6 In conjunction with the Board of Directors and the Council of Governors, responsible for creating, developing and promoting the Trust's strategy, taking account the needs of key stakeholders and enabled by a robust strategy for delivery of the Trust's overall objectives.

3.1.7 Provision of information and support to the Board of Directors and Council of Governors and ensuring that the decisions of the Board of the Directors and its Committees are implemented.

3.1.8 Providing input to the Board of Directors' agenda from themselves and other members of the Executive Team.

3.1.9 Ensuring the Chair is aware of the important issues facing the Trust and proposing agendas which reflect these.

3.1.10 Ensuring that the Executive Team provides reports to the Board of Directors which contain accurate, timely and clear information.

3.1.11 Ensuring that they and the Executive Team comply with the Board of Directors' approved procedures.

3.1.12 Ensuring that the Chair is alerted to forthcoming complex, contentious or sensitive issues affecting the Trust.

3.1.13 Providing input on appropriate changes to the schedule of matters reserved to the Board of Directors and Committee Terms of Reference.

3.1.14 Supporting the Chair in their tasks of facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive members of the Board of Directors, elected and appointed members of the Council of Governors and between the Board of Directors and the Council of Governors.

3.1.15 Providing information and advice on succession planning, to the Chair, the Remuneration and Terms of Service Committee, and other members of the Board of Directors, particularly in respect of Executive Directors.

3.1.16 If so appointed by the Board of Directors, serving on any committee.

3.1.17 Maintaining and strengthening effective working relationships and communications with stakeholders including staff and patients.

3.1.18 Maximising the potential of the Trust's organisation and people by ensuring an appropriate and effective Trust culture, organisation and leadership, supported by effective strategies and systems to manage and develop the Trust's human and physical resources.

3.1.19 Contributing to induction programmes for new Executive and Non-Executive Directors and ensuring that appropriate management time is made available for the process.

3.1.20 Providing leadership and development of the Executive Directors and other Senior Management reporting to him/her and ensuring that the Trust has the capacity, capability and the effective management systems to deliver on the Trust's objectives.

3.1.21 Ensuring that performance reviews are carried out at least once a year for each of the Executive Directors. Providing input to the wider Board of Directors and Council of Governors evaluation process and to the Remuneration and Terms of Service Committee as appropriate.

3.1.22 Promoting and conducting the affairs of the Trust with the highest standards of integrity, probity and corporate governance. Promote continuing compliance across the organisation.

3.1.23 Maintaining and enhancing the Trust's reputation and profile with stakeholders and with the community which the Trust serves.

3.1.24 Provision for effective information and communication systems.

4.0 Shared Responsibilities of the Chair and Chief Executive

4.1 There are a number of areas where the Chair and the Chief Executive carry a joint or shared responsibility, often because there is inter-dependence between the two roles for a responsibility to be fulfilled. These areas of shared responsibility include:

4.1.1 Leading and demonstrating the necessary behaviours that support the values of the Trust.

4.1.2 Ensuring that the Council of Governors and Board of Directors receive accurate, timely and clear information that is appropriate for their respective duties.

4.1.3 Facilitating and supporting effective joint working between the Board of Directors and Council of Governors.

4.1.4 Ensuring effective communication by the Foundation Trust with patients, members, staff and other stakeholders.

4.1.5 Constructing the agendas for both the Board of Directors and Council of Governors (with the input of others as appropriate).

4.1.6 Handling high profile media coverage, particularly where this could be damaging to the reputation of the Trust.

4.1.7 Ensuring that the Trust has in place a clear schedule of matters reserved for the Board and, for the others, ensuring that a Scheme of Delegation is agreed and in place.

4.1.8 Sharing line management of the Trust Secretary, who has a dual reporting line to the Chair and Chief Executive.

5.0 Action Requested of the Trust Board

The Trust Board is asked to consider the division of responsibilities between the Chair and Chief Executive and, following any amendments as may be required, to approve the revised statement.

6.0 Equality Act (2010)

6.1 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.

6.2 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.

6.3 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.

6.4 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).

6.5 Freedom to Speak Up

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this document, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to the Trust's Freedom to Speak Up Policy for the NHS (DCP126). Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact the Trust's Freedom to Speak Up Guardian in confidence by email to nlg.tr.ftsuguardian@nhs.net. More details about how to raise concerns with the Trust's Freedom to Speak Up Guardian or with one of the Associate Guardians can be found on the Trust's intranet site.

Appendix A

NHS Foundation Trust Accounting Officer Memorandum

IRG 24/15
5 August 2015

NHS Foundation Trust Accounting Officer Memorandum

Introduction

1 The National Health Service Act 2006 (the Act) designates the Chief Executive of an NHS Foundation Trust as the Accounting Officer.

2 The principal purpose of the NHS Foundation Trust is the provision of goods and services for the purposes of the health service in England. The NHS Foundation Trust has a general duty to exercise its functions effectively, efficiently and economically.

3 The Act specifies that the Accounting Officer has the duty to prepare the accounts in accordance with the Act. An Accounting Officer has the personal duty of signing the NHS Foundation Trust's accounts. By virtue of this duty, the Accounting Officer has the further duty of being a witness before the Committee of Public Accounts (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.

4 Associated with these duties are the further responsibilities that are the subject of this memorandum. It is incumbent on the Accounting Officer to combine these duties with their duties to the Board of Directors of the NHS Foundation Trust.

5 It is an important principle that, regardless of the source of the funding, Accounting Officers are responsible to Parliament for the resources under their control.

Responsibilities of Monitor

2 In relation to NHS Foundation Trusts, it is the responsibility of Monitor to be satisfied that the NHS Foundation Trust is compliant with its NHS Provider Licence.

The general responsibilities of an NHS Foundation Trust Accounting Officer

3 The Accounting Officer has responsibility for the overall organisation, management and staffing of the NHS Foundation Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:

- there is a high standard of financial management in the NHS Foundation Trust as a whole;
- the NHS Foundation Trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation;
- financial considerations are fully taken into account in decisions by the NHS Foundation Trust.

The specific responsibilities of an NHS Foundation Trust Accounting Officer

4 The essence of the Accounting Officer's role is a personal responsibility for:

- the propriety and regularity of the public finances for which he or she is answerable;
- the keeping of proper accounts;
- prudent and economical administration in line with the principles set out in *Managing Public Money* available via:www.gov.uk/government/publications/managing-public-money
- the avoidance of waste and extravagance; and
- the efficient and effective use of all the resources in their charge.

5 As Accounting Officer you must:

- personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by Monitor in accordance with the Act;
- comply with the financial requirements of the NHS Provider Licence;
- ensure that proper financial procedures are followed and that accounting records are maintained in a form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS Foundation Trust);
- ensure that the resources for which you are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;
- ensure that assets for which you are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate;
- ensure that any protected property (or interest in) is not disposed of without the consent of Monitor;
- ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Council of Governors or in the actions or advice of the NHS Foundation Trust's staff, including yourself; and
- ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as Accounting Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors.

6 An Accounting Officer should ensure that effective management systems appropriate for the achievement of the NHS foundation trust's objectives, including financial monitoring and control systems, have been put in place. An Accounting Officer should also ensure that managers at all levels:

- have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;
- are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made

available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money; and

- have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

7 Accounting Officers must make sure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the *Public Sector Internal Audit Standards*.

Advice to the Board

8 An Accounting Officer has particular responsibility to see that appropriate advice is tendered to the Board of Directors and the Council of Governors on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. Accounting Officers will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to their own duty as Accounting Officer to justify, to the Public Accounts Committee, transactions for which they are accountable.

9 The Board of Directors and the Council of Governors of an NHS foundation trust should act in accordance with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or the Chairman is contemplating a course of action involving a transaction which you as Accounting Officer consider would infringe these requirements, however, you should set out in writing your objection to the proposal and the reasons for this objection. If the Board of Directors, Council of Governors or Chairman decides to proceed, you should seek a written instruction to take the action in question. You should also inform Monitor of the position, if possible before the decision is taken or in any event before the decision is implemented, so that Monitor, if it considers it appropriate, can intervene in accordance with its responsibilities under the Act. If the outcome is that you are overruled, the instruction must be complied with, but your objection and the instruction itself should be communicated without undue delay to the NHS foundation trust's external auditors and to Monitor. Provided that this procedure has been followed, the PAC can be expected to recognise that the Accounting Officer bears no personal responsibility for the transaction.

10 If a course of action is contemplated which raises an issue not of formal propriety or regularity but relating to your wider responsibilities for economy, efficiency and effectiveness, it is your duty to draw the relevant factors to the attention of the Board of Directors and the Council of Governors and to advise them in whatever way you deem appropriate. If your advice is overruled, and the proposal is one which as Accounting Officer you would not feel able to defend to the PAC as representing value for money, you should seek a written instruction before proceeding. Monitor should be informed of such an

instruction, if possible before the decision is implemented. It will then be for Monitor to consider the matter, and decide whether or not to intervene.

11 If, because of the extreme urgency of the situation, there is no time to submit advice in writing in either of the eventualities referred to in paragraphs 13 and 14 before the decision is taken, you must ensure that, if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards.

Appearance before the Committee of Public Accounts (PAC)

12 The C&AG may, under the National Audit Act 1983, carry out examinations into the economy, efficiency and effectiveness with which the NHS foundation trust has used its resources in discharging its functions. An Accounting Officer may expect to be called upon to appear before the PAC from time to time to give evidence on the reports arising from these examinations or reports following the annual certification audit, and to answer the PAC's questions concerning expenditure and receipts for which he or she is Accounting Officer. An Accounting Officer may be supported by one or two other senior officials who may, if necessary, assist in giving evidence.

13 An Accounting Officer will be expected to furnish the PAC with explanations of any indications of weakness in the matters covered by paragraphs 8 - 15 above, to which their attention has been drawn by the C&AG or about which they may wish to question the Accounting Officer.

14 In practice, an Accounting Officer will normally have delegated authority to others, but cannot on that account disclaim responsibility or dilute his or her accountability. Nor, by convention, does the incumbent Accounting Officer decline to answer questions where the events took place before taking up appointment: the PAC may be expected not to press the incumbent's personal responsibility in such circumstances.

15 The PAC has emphasised the importance it attaches to accuracy of evidence, and the responsibility of witnesses to ensure this, in order to ensure that relevant lines of enquiry may be pursued at its hearings. The Accounting Officer should ensure that he or she is adequately and accurately briefed on matters which are likely to arise at the hearing. The Accounting Officer may, however, ask the PAC for leave to supply information not within his or her immediate knowledge by means of a later note. Should it be discovered subsequently that the evidence provided to the PAC has contained errors; these should be made known to the PAC at the earliest possible moment.

16 In general, the rules and conventions governing appearances of officials before parliamentary committees apply to the PAC, including the general convention that officials do not disclose the advice given to the board. Nevertheless, in a case where the procedure described in paragraph 13 was used concerning a matter of propriety or regularity, the Accounting Officer's advice, and it’s overruling by the board, would be disclosed to the PAC. In a case covered by paragraph 14, where the advice of an Accounting Officer has

been overruled in a matter not of propriety or regularity but of prudent and economical administration, efficiency or effectiveness, the C&AG will have made clear in the report to the PAC that the Accounting Officer was overruled. The Accounting Officer should seek to avoid disclosing the advice given to the board, though subject to their agreement the Accounting Officer should be ready to explain the reasons for their decision.

Absence of an Accounting Officer

17 An Accounting Officer should ensure that he or she is generally available for consultation and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the NHS foundation trust who can act on his or her behalf if required.

18 If it becomes clear to the Board of Directors that an Accounting Officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accounting Officer, usually the Director of Finance, pending the Accounting Officer's return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which he or she cannot be contacted.

19 The PAC may be expected to postpone a hearing if the relevant Accounting Officer is temporarily indisposed. Where the Accounting Officer is unable by reason of incapacity or absence to sign the accounts in time for submission, the NHS foundation trust may submit unsigned copies pending the Accounting Officer's return. If the Accounting Officer is unable to sign the accounts in time for printing, the acting Accounting Officer should sign instead.

Sources

This document is based on the guidance outlined in *Managing Public Money*, published in July 2013 and updated in September 2022 available via: www.gov.uk/government/publications/managing-public-money

NLG(23)065

Name of the Meeting	**Trust Board - Public**	
Date of the Meeting	4 April 2023	
Director Lead	Helen Harris, Director of Corporate Governance	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	**Register of Interests**	
Purpose of the Report and Executive Summary (to include recommendations)	The Trust Board is asked to note the Declaration of Interests for Non-Executive Directors and Executive Directors.	
Background Information and/or Supporting Document(s) (if applicable)	Standards of Business Conduct Policy (DCP120)	
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

SUMMARY OF DECLARATIONS OF INTEREST FOR EXECUTIVE AND NON-EXECUTIVE DECISION MAKING STAFF ONLY										
Forename	**Surname**	**Job Title**	**Division**	**Consultants**	**Pharmacy, Digital Services or Procurement**	**Band 8c or above**	**Register of Interest Annual Cohort**	**Declaration of Interest for Loyalty, Shareholdings & Patents (including nil returns)**	**Secondary / Outside Employment (including nil returns)**	**Gifts, Hospitality & Sponsorship (including nil returns)**
Adrian	Beddow	Associate Director of Communications and Engagement	Chief Executive Office Division	No	No	Yes	Yes	Completed	Completed	Completed
Lee	Bond	Chief Financial Officer	Finance Directorate	No	No	Yes	Yes	Completed	Completed	Completed
Stuart	Hall	Associate Non-Executive Director	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Helen	Harris	Director of Corporate Governance	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Linda	Jackson	Vice Chair	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Jugdeep	Johal	Director of Facilities	Facilities Management	No	No	Yes	Yes	Completed	Completed	Completed
Susan	Liburd	Non Executive Director	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Sean	Lyons	Chair	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Ivan	McConnell	Programme Director - Humber Acute Services	Strategic Development	No	No	Yes	Yes	Completed	Completed	Completed
Shauna	McMahon	Chief Information Officer	Digital Services Management Team	No	Yes	Yes	Yes	Completed	Completed	Completed
Eleanor	Monkhouse	Chief Nurse	Chief Nurses Office	No	No	Yes	Yes	Completed	Completed	Completed
Simon	Nearney	Director of People	People and Organisational Effectiveness	No	No	Yes	Yes	Completed	Completed	Completed
Fiona	Osborne	Non Executive Director	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Simon	Parkes	Non Executive Director & Chair of Audit Risk & Governance	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Gillian	Ponder	Non Executive Director	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Peter	Reading	CEO	Chief Executive Office Division	No	No	Yes	Yes	Completed	Completed	Completed
Shaun	Stacey	Chief Operating Officer	Operations	No	No	Yes	Yes	Completed	Completed	Completed
Kate	Truscott	Associate Non Executive Director	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Katherine	Wood	Chief Medical Officer	Chief Medical Officer	No	No	Yes	Yes	Completed	Completed	Completed

DECLARATIONS OF INTEREST INCLUDING FOR LOYALTY SHAREHOLDINGS AND PATENTS FOR ALL STAFF									
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Comments**	**Consent to publish**
ROI Declaration of Interests	28/12/2022	Lee	Bond	Chief Financial Officer	Trust Board Division	Loyalty Interests	Chief Finance Officer and Deputy Chief Executive at Hull University Teaching Hospital		Yes
ROI Declaration of Interests	28/12/2022	Lee	Bond	Chief Financial Officer	Trust Board Division	Loyalty Interests	Trustee of WISHH Charity		Yes
ROI Declaration of Interests	28/12/2022	Lee	Bond	Chief Financial Officer	Trust Board Division	Loyalty Interests	Vice President, Healthcare Financial Management Association (HFMA)		Yes
ROI Declaration of Interests	23/01/2023	Lee	Bond	Chief Financial Officer	Trust Board Division	Loyalty Interests	Am the CFO at HUTH as well as NLAG		Yes
ROI Declaration of Interests	10/11/2022	Stuart	Hall	Associate Non-Executive Director	Trust Board Division	Other	Vice Chair - Hull University Teaching Hospital	Works as Vice Chair at Hull University Teaching Hospital	Yes
ROI Declaration of Interests	10/11/2022	Stuart	Hall	Associate Non-Executive Director	Trust Board Division	Other	Partner is Lay Member of Yorkshire Clinical Senate	Partner is Lay Member of Yorkshire Clinical Senate	Yes
ROI Declaration of Interests	10/11/2022	Stuart	Hall	Associate Non-Executive Director	Trust Board Division	Other	Member of Advisory Committee on Clinical Excellence Awards	N/A	Yes
ROI Declaration of Interests	01/08/2022	Helen	Harris	Director of Corporate Governance	Trust Board Division	Other	Member of Patient Participation Group, Central Surgery, Barton upon Humber (NLCCG)		Yes
ROI Declaration of Interests	30/11/2022	Linda	Jackson	Chairman	Trust Board Division	Other	Associate Non-Executive Director at HUTH.		Yes
ROI Declaration of Interests	25/10/2022	Linda	Jackson	Vice Chair	Trust Board Division	Other	Sister and sister-in-law work at DPoW in Family Services division.	Sister and sister-in-law work at DPoW in Family Services division.	Yes
ROI Declaration of Interests	06/10/2022	Jugdeep	Johal	Director of Facilities	Facilities Management	Other	Chairman, Asian Sports Foundation		Yes
ROI Declaration of Interests	24/05/2022	Jugdeep	Johal	Director of Facilities	Facilities Management	Other	Charity	Chair of the Asian Sports Foundation a UK registered Charity.	Yes
ROI Declaration of Interests	23/01/2023	Susan	Liburd	Non Executive Director	Trust Board Division	Other	Managing Director and Principal Consultant of Sage Blue	Nil NHS, Health & Social Care or Associated contracts undertaken. Will declare interest prior to and in any meeting at any relevant agenda item and abstain where necessary. Act in accordance with all confidentiality agreements.	Yes

DECLARATIONS OF INTEREST INCLUDING FOR LOYALTY SHAREHOLDINGS AND PATENTS FOR ALL STAFF									
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Comments**	**Consent to publish**
ROI Declaration of Interests	06/03/2023	Sean	Lyons	Chair	Trust Board Division	Other	Chairman of a Further Education College - Vision West Nottinghamshire College	No conflicts with NLAG	Yes
ROI Declaration of Interests	06/03/2023	Sean	Lyons	Chair	Trust Board Division	Other	Daughter is a student nurse at Sheffield Hallam University	Will have attachments to Trusts in South Yorkshire and Bassetlaw	Yes
ROI Declaration of Interests	02/02/2023	Sean	Lyons	Chair	Trust Board Division	Other	Chairman at Hull University Teaching Hospitals Trust	Joint Role between HUTH and NLAG	Yes
ROI Declaration of Interests	02/02/2023	Sean	Lyons	Chair	Trust Board Division	Other	Chairman of Vision West Nottinghamshire College, Derby Road, Mansfield, NG18 5BH	No conflicts with NLAG	Yes
ROI Declaration of Interests	10/10/2022	Shauna	McMahon	Chief Information Officer	IT Operations	Other	On exam writing group adding UK content to the Certified Health CIO credential with 10 NHS CIO's	As a CIO I receive 2-3 requests weekly via LinkedIn to a round table or speak to a consultant about a survey. All have been declined to date. They are unsolicited and I delete them. I am approached regularly by partners/suppliers or NHS agencies to speak at conferences/events. These are development sessions arranged by/for professionals. No remuneration in some cases travel expenses are reimbursed or a meal provided. Alternative DOI will be completed for these.	Yes
ROI Declaration of Interests	11/07/2022	Eleanor	Monkhouse	Chief Nurse	Chief Nurses Office	Other	May have contacts with other consultants in Trust	Husband is Yorkshire & Humber Regional Consultants and Specialist Committee Member. Husband is Consultant Foot & Ankle (Leeds Teaching Hospitals)	Yes
ROI Declaration of Interests	26/01/2023	Simon	Nearney	Director of People	People and Organisational Effectiveness	Other	Family Members working at NLAG	Wife - Health Care Worker Daughter - Health Care Worker - Bank Staff Sister In Law - Patient Experience Officer	Yes
ROI Declaration of Interests	26/01/2023	Simon	Nearney	Director of People	People and Organisational Effectiveness	Other	Director at Cleethorpes Town FC / The Linden Club	There is no conflict of interest with CTFC as the club has no dealings with the NHS	Yes
ROI Declaration of Interests	12/09/2022	Fiona	Osborne	Associate Non Executive Director	Trust Board Division	Loyalty Interests	Parish Councillor: Leverton Parish Council, Lincolnshire		Yes
ROI Declaration of Interests	06/01/2023	Fiona	Osborne	Non Executive Director	Trust Board Division	Other	Trustee - Leverton Poor's Land Charity, Parish Councillor - Leverton Parish Council	My roles with the Parish Council nor the charity that owns and rents farming acreage to those living in Leverton Parish is unlikely to a cause any conflict with my Trust duties. However is being declared for completeness	Yes

DECLARATIONS OF INTEREST INCLUDING FOR LOYALTY SHAREHOLDINGS AND PATENTS FOR ALL STAFF									
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Comments**	**Consent to publish**
ROI Declaration of Interests	23/01/2023	Fiona	Osborne	Non Executive Director	Trust Board Division	Loyalty Interests	Leverton Poor's Land Charity, Leverton Parish Council, Foghorn Consulting Ltd, English Country Life	Trustee - Leverton Poor's Land Charity Parish Councillor - Leverton Parish Council Director - Foghorn Consulting Ltd Partner - English Country Life Partnership NB. None of these organisations overlap with the Trust however are included for completeness.	Yes
ROI Declaration of Interests	12/08/2022	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Shareholdings	Director of Lincoln Science and Innovation Park (Unremunerated).	I understand the Trust is considering the lease of a property on the Lincoln Science Park. I am not involved in negotiations or setting terms and will declare relevant interest if and when it comes to NLaG Board - stepping back from from any discussion or decision on the matter.	Yes
ROI Declaration of Interests	31/01/2023	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Loyalty Interests	Lay Canon and Chair of the Finance Committee	Lincoln Cathedral, Minster Yard, Lincoln, LN2 1PJ	Yes
ROI Declaration of Interests	31/01/2023	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Loyalty Interests	Senior Independent Director of Lincolnshire Housing Partnership	Lincolnshire Housing Partnership, Westgate Park, Charlton Street, Grimsby, DN31 1SQ	Yes
ROI Declaration of Interests	12/08/2022	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Loyalty Interests	Deputy Vice Chancellor and CFO of the University of Lincoln	University of Lincoln, Brayford Pool, Lincoln, LN6 7TS	Yes
ROI Declaration of Interests	03/03/2023	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Shareholdings	Director of Visit Lincoln	Unremunerated.	Yes
ROI Declaration of Interests	11/10/2022	Gillian	Ponder	Non Executive Director	Trust Board Division	Other	Employment	Employed by Openreach Ltd in role responsible for large scale recruitment, supply chain and logistics. In the event of any Board discussions about network service contracts or disputes, I would not take part in the discussions or vote on the issue.	Yes

DECLARATIONS OF INTEREST INCLUDING FOR LOYALTY SHAREHOLDINGS AND PATENTS FOR ALL STAFF									
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Comments**	**Consent to publish**
ROI Declaration of Interests	03/03/2023	Peter	Reading	CEO	Chief Executive Office Division	Other	Spouse of Dr Catherine Reading, Director, Catherine Reading Limited		Yes
ROI Declaration of Interests	03/03/2023	Peter	Reading	CEO	Chief Executive Office Division	Other	Company Secretary of spouse's company, Catherine Reading Limited		Yes
ROI Declaration of Interests	10/02/2023	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Other	Trustee for Children's Links, 1&4 Gymphlex Buildings, Boston Road, Horncastle, LN9 6HU		Yes
ROI Declaration of Interests	10/02/2023	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Other	Interim Chair, Active Lincolnshire, Newland House, The Point, Weaver Road, Lincoln, LN6 3QN		Yes
ROI Declaration of Interests	10/02/2023	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Other	Vice Chairman, West Nottinghamshire College, Derby Road, Mansfield, NG18 5BH		Yes
ROI Declaration of Interests	10/02/2023	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Other	Trustee for Linkage Community Trust, Toynton Hall, Toynton All Saints, Spilsby, LN9 6HU		Yes
ROI Declaration of Interests	05/09/2022	Katherine	Wood	Medical Director	Medical Directors Office	Loyalty Interests	Husband is Trust employee (Theatre Manager, DPoW)		Yes

DECLARATIONS OF INTEREST INCLUDING FOR LOYALTY SHAREHOLDINGS AND PATENTS FOR ALL STAFF - NIL RETURNS						
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Consent to publish**
ROI Nil Return Declaration of Interest	24/10/2022	Adrian	Beddow	Associate Director of Communications and Engagemen	Chief Executive Office Division	Yes
ROI Nil Return Declaration of Interest	11/10/2022	Ivan	McConnell	Programme Director - Humber Acute Services	Strategic Development	Yes
ROI Nil Return Declaration of Interest	05/10/2022	Shaun	Stacey	Chief Operating Officer	Operations	Yes

OUTSIDE/SECONDARY EMPLOYMENT FOR ALL STAFF											
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Organisation Name**	**Declaration Start Date**	**Comments**	**Consent to publish**
ROI Outside/secondary employment	10/11/2022	Stuart	Hall	Associate Non-Executive Director	Trust Board Division	Non-executive roles	Vice Chair	Hull University Teaching Hospital NHS Trust	01/04/2020	N/A	Yes
ROI Outside/secondary employment	18/10/2022	Susan	Liburd	Non Executive Director	Trust Board Division	Directorships	Managing Director and Principal Consultant	Sage Blue, Newark Beacon, Beacon Hill Office Park, Cafferata Way, Newark, NG24 2TN	01/12/2000	Nil NHS, Health & Social Care or Associated contracts undertaken. Will declare interest prior to and in any meeting at any relevant agenda item and abstain where necessary. Act in accordance with all confidentiality agreements.	Yes
ROI Outside/secondary employment	02/02/2023	Sean	Lyons	Chair	Trust Board Division	Non-executive roles	Chair at Hull University Teaching Hospital NHS Trust	Hull University Teaching Hospitals NHS Trust	01/02/2022	Joint role between HUTH & NLAG	Yes
ROI Outside/secondary employment	08/02/2023	Sean	Lyons	Chair	Trust Board Division	Non-executive roles	Chairman	West Nottinghamshire College, Derby Road, Mansfield, NG18 5BH	01/02/2019	None	Yes
ROI Outside/secondary employment	03/03/2023	Sean	Lyons	Chair	Trust Board Division	Non-executive roles	Chairman	Vision West Nottinghamshire College, Derby Road, Mansfield, NG18 5BH	01/02/2022	No conflicts with NLAG role	Yes
ROI Outside/secondary employment	08/11/2022	Fiona	Osborne	Associate Non Executive Director	Trust Board Division	Directorships	Director	Foghorn Consulting Ltd, Hideaway Cottage, Hampton Lane, Old Leake, Boston, PE22 9JS	01/04/2021	N/a	Yes
ROI Outside/secondary employment	08/11/2022	Fiona	Osborne	Associate Non Executive Director	Trust Board Division	Directorships	Partner	English Country Life Partnership, Hideaway Cottage, Hampton Lane, Old Leake, Boston, PE22 9JS	01/04/2021	N/A	Yes
ROI Outside/secondary employment	15/12/2022	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Outside employment	Deputy Vice Chancellor	University of Lincoln, Brayford Pool, Lincoln, LN6 7TS	12/08/2021	Start date predates employment with the NLaG. University of Lincoln students have placements in the Trust hospitals but I am not involved in those arranegements	Yes
ROI Outside/secondary employment	07/11/2022	Gillian	Ponder	Non Executive Director	Trust Board Division	Outside employment	Head of Business Analysis, Planning & Resourcing	Openreach Ltd, 81 Newgate Street, London, EC1A 7AJ	01/04/2021	Flexible working which enables me to undertake NED role. Open Reach actively encourage Senior Managers to be NEDs, JPs, Governors, MIlitary Servists	Yes
ROI Outside/secondary employment	20/12/2022	Peter	Reading	Chief Executive	Chief Executive Office Division	Outside employment	Company Secretary	Catherine Reading Limited, Foxhill Farm, Stocking Lane, East Leake, Loughborough, LE12 5RL	01/01/2003	Unpaid work. Company does not trade with the NHS.	Yes
ROI Outside/secondary employment	06/03/2023	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Non-executive roles	Interim Chair	Active Lincolnshire, Newland House, The Point, Weaver Road, Lincoln, LN6 3QN	01/09/2022	Current Role.	Yes
ROI Outside/secondary employment	06/03/2023	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Non-executive roles	Vice Chairman	Vision West Nottinghamshire College, Derby Road, Mansfield, NG18 5BH	01/09/2022	Current role.	Yes
ROI Outside/secondary employment	06/03/2023	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Non-executive roles	Trustee	Linkage Community Trust, Toynton Hall, Toynton All Saints, Spilsby, LN9 6HU	01/09/2022	Current role.	Yes
ROI Outside/secondary employment	06/03/2023	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Non-executive roles	Trustee	Children's Links, Suite 1&4 Gymphlex Buildings, Boston Road, Horncastle, LN9 6HU	01/09/2022	Current role.	Yes

OUTSIDE/SECONDARY EMPLOYMENT FOR ALL STAFF - NIL RETURNS						
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Consent to publish**
ROI Nil Return Outside Employment	14/07/2022	Adrian	Beddow	Associate Director of Communications and Engagemen	Chief Executive Office Division	Yes
ROI Nil Return Outside Employment	05/12/2022	Lee	Bond	Chief Financial Officer	Trust Board Division	Yes
ROI Nil Return Outside Employment	08/08/2022	Helen	Harris	Director of Corporate Governance	Trust Board Division	Yes
ROI Nil Return Outside Employment	26/07/2022	Linda	Jackson	Vice Chair	Trust Board Division	Yes
ROI Nil Return Outside Employment	14/07/2022	Jugdeep	Johal	Director of Facilities	Facilities Management	Yes
ROI Nil Return Outside Employment	14/07/2022	Ivan	McConnell	Programme Director - Humber Acute Services	Strategic Development	Yes
ROI Nil Return Outside Employment	02/11/2022	Shauna	McMahon	Chief Information Officer	IT Operations	Yes
ROI Nil Return Outside Employment	26/07/2022	Eleanor	Monkhouse	Chief Nurse	Chief Nurses Office	Yes
ROI Nil Return Outside Employment	26/01/2023	Simon	Nearney	Director of People	People and Organisational Effectiveness	Yes
ROI Nil Return Outside Employment	04/05/2022	Shaun	Stacey	Chief Operating Officer	Operations	Yes
ROI Nil Return Outside Employment	18/07/2022	Katherine	Wood	Medical Director	Medical Directors Office	Yes

GIFTS, HOSPITALITY & SPONSORSHIP FOR ALL STAFF											
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Organisation Name**	**Declaration Start Date**	**Consent to publish**	**Value (£)**
ROI Gifts and Hospitality	30/12/2021	Adrian	Beddow	Associate Director of Communications and Engagemen	Chief Executive Office Division	Gift	n/a	Pace Communications	16/12/2021	Yes	<£10
ROI Gifts and Hospitality	14/02/2022	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsored Event	HSJ Awards	Grant Thornton LLP, 5th Floor, 7 Exchange Crescent, Conference Square, Edinburgh, EH3 8AN	01/06/2021	Yes	594
ROI Gifts and Hospitality	17/11/2022	Jugdeep	Johal	Director of Facilities	Facilities Management	Hospitality	university & health care estates & innovation - conference 15/11/2022 - presenting	UHEI	15/11/2022	Yes	n/a
ROI Gifts and Hospitality	30/01/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsorship Agreements - General	Our Stars 2023 Awards	Galiford Try	30/01/2023	No	£5000
ROI Gifts and Hospitality	30/01/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsorship Agreements - General	Our Stars 2023 Awards	Morgan Sindall	30/01/2023	No	£3000
ROI Gifts and Hospitality	30/01/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsorship Agreements - General	Our Stars 2023 Awards	Kier Construction	30/01/2023	No	£2500
ROI Gifts and Hospitality	30/01/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsorship Agreements - General	Our Stars 2023 Awards	Bidvest Noonan	30/01/2023	No	£1500
ROI Gifts and Hospitality	30/01/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsorship Agreements - General	Our Stars 2023 Awards	Elior	30/01/2023	No	£500
ROI Gifts and Hospitality	30/01/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsorship Agreements - General	Our Stars 2023 Awards	Amvale	30/01/2023	No	£500
ROI Gifts and Hospitality	30/01/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsorship Agreements - General	Our Stars 2023 Awards	ACA Architects	30/01/2023	No	£500
ROI Gifts and Hospitality	30/01/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsorship Agreements - General	Our Stars 2023 Awards	Fisher Securty	30/01/2023	No	£1500
ROI Gifts and Hospitality	30/01/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsorship Agreements - General	Our Stars 2023 Awards	North Lindsey College	30/01/2023	No	£500
ROI Gifts and Hospitality	30/01/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsorship Agreements - General	Our Stars 2023 Awards	Capsticks	30/01/2023	No	£500
ROI Gifts and Hospitality	30/01/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsorship Agreements - General	Our Stars 2023 Awards	Lexica	30/01/2023	No	£500

GIFTS, HOSPITALITY & SPONSORSHIP FOR ALL STAFF											
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Organisation Name**	**Declaration Start Date**	**Consent to publish**	**Value (£)**
ROI Gifts and Hospitality	06/03/2023	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsored Event	Our Stars 2023 Awards	Gelder Group	20/02/2023	No	£500
ROI Gifts and Hospitality	31/01/2023	Sean	Lyons	Chair	Trust Board Division	Sponsored Event	Speaking Engagement or Association of British Clinical Diabatologists	Associate of British Clinical Diabatologists, 483 Green Lanes, London, N13 4BS	29/09/2022	Yes	£370.00
ROI Gifts and Hospitality	04/11/2021	Shauna	McMahon	Chief Information Officer	IT Operations	Hospitality	Digital Hospital Panel at Conference. Speaker on digital innovation and after dinner event	Convenzis - Public Sector Educational Events and speaker session presented by Atos	03/11/2021	Yes	30
ROI Gifts and Hospitality	14/10/2022	Shauna	McMahon	Joint Chief Information Officer	IT Operations	Sponsored Event	Presentation on Digital Leadership/ICS Challenges for Digital	HPN Conferences Public Sector	13/10/2022	Yes	£150
ROI Gifts and Hospitality	16/01/2023	Shauna	McMahon	Chief Information Officer	Estates Services	Gift	Christmas Gift	AHCL/Andy Williams	30/12/2022	No	50.00
ROI Gifts and Hospitality	24/05/2022	Peter	Reading	Chief Executive	Chief Executive Office Division	Hospitality	HSJ Provider Summit, 31 March to 1 April 2022	Health Service Journal (HSJ)	14/03/2022	Yes	200-250
ROI Gifts and Hospitality	07/12/2022	Peter	Reading	CEO	Chief Executive Office Division	Hospitality	Attendance at the NHS Providers Annual Conference (15-16 November 2022) and one night accommodation.	Saffron Cordery, Interim CEO, NHS Providers, One Birdcage Walk, London, SW1H 9JJ	10/11/2022	Yes	£584.00

GIFTS, HOSPITALITY & SPONSORSHIP FOR ALL STAFF - NIL RETURNS						
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Consent to publish**
ROI Nil Return Gifts and Hospitality	02/11/2022	Lee	Bond	Chief Financial Officer	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	16/08/2022	Stuart	Hall	Trust Board	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	08/08/2022	Helen	Harris	Director of Corporate	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	26/07/2022	Linda	Jackson	Vice Chair	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	11/10/2022	Jugdeep	Johal	Director of Estates and Facilities	Facilities Management	Yes
ROI Nil Return Gifts and Hospitality	10/11/2022	Susan	Liburd	Non Executive Director	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	08/11/2022	Sean	Lyons	Chair	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	14/07/2022	Ivan	McConnell	Programme Director - Humber Acute Services	Strategic Development	Yes
ROI Nil Return Gifts and Hospitality	26/07/2022	Eleanor	Monkhouse	Chief Nurse	Chief Nurses Office	Yes
ROI Nil Return Gifts and Hospitality	26/01/2023	Simon	Nearney	Director of People	People and Organisational Effectiveness	Yes
ROI Nil Return Gifts and Hospitality	07/11/2022	Fiona	Osborne	Non Executive Director	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	14/12/2022	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	10/11/2022	Gillian	Ponder	Non Executive Director	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	04/05/2022	Shaun	Stacey	Chief Operating Officer	Operations	Yes
ROI Nil Return Gifts and Hospitality	02/11/2022	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	18/07/2022	Katherine	Wood	Medical Director	Medical Directors Office	Yes

NLG(23)066

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	4th April 2023	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance & Performance Minutes, January 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	The Finance and Performance Committee Minutes from the meeting held on Thursday 26th January 2023 and approved at the meeting on Wednesday 22nd February 2023.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Finance & Performance
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: Thursday 26 January 2023, TEAMS

Present:	Gill Ponder	Non Executive Director (Chair)
	Fiona Osborne	Non Executive Director
	Jug Johal	Director of Estates & Facilities
	Shaun Stacey	Chief Operating Officer (COO)
	Brian Shipley	Operational Director of Finance
	Shiv Nand	Governor (rep Ian Reekie)
In Attendance:	Ivan McConnell	Director of Strategic Development (Item 7.1)
	Annabelle Baron-Medlam	Compliance & Assurance (item 6.1)
	Richard Peasgood	Executive Assistant to COO
	Abdi Abolfazl	Deputy Chief COO (Item 8.3)
	Ashy Shanker	Deputy Director of Planning and Performance (Item 8.4)
	Lynn Arefi (Minute Taker)	Executive Assistant

ITEM

1. Apologies

Apologies for absence were received from Dr Peter Reading, Lee Bond and Simon Parkes

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

The minutes of the meeting held on the 21 December 2022 were reviewed and accepted as an accurate record of the meeting.

5. Matters Arising / Action Log

5.1 The action log was reviewed and updated as follows:

Meeting held 19.10.22

7.2/8.1 closed
8.3 closed
8.4 closed
8.6 closed

Meeting held 23.11.22

7.4 Jug Johal advised that the system had been regularly tested over the last 12 months; further to this, plans continued to be reviewed. Shaun Stacey confirmed all standards were met and the Trust test and train in accordance with requirements. It was agreed that Ashley Leggott EPRR lead would provide a report in response to the incident which would be presented at the February Committee – JJ/SS

Meeting held 21.12 22

5.2 closed

8.1 as per 7.4 during 23.11.22 above

9.1 due in February, Trust Board is sighted on the actions that go into Urgent Care service. Shaun Stacey to include Urgent Care Service in the Patient Flow Improvement Group (PFIG) Update.

9.3 Closed first part of 9.3 as Trust do not need to complete the return as the Trust is not in Tier 1 or 2

9.3 carried f/wd bring back to Committee in April.

10.1 closed

5.2 Finance & Performance Committee Workplan

The Committee received and noted the Workplan.

5.3 Terms of Reference

The Committee received and noted the revised Terms of Reference.

5.4 Action Plan

The Committee received and noted the Action Plan. All improvement actions from the 2022 Self-Assessment of Committee Effectiveness had been completed.

9.26am Annabelle Baron-Medlam joined the meeting

6. Presentations for Assurance

6.1 **Care Quality Commission (CQC) Progress Report**

Annabelle Baron-Medlam was welcomed to the meeting and spoke to the circulated CQC Progress Report which was taken as read. Highlighted changes to note in the report since last month were as follows:

- One action was uploaded to the CQC as a position paper: (Surgery Division)
- One action has been uploaded to CQC as an assurance paper: 39CC (Proper and safe use of medicines- Surgery Division)
- Following publication of the new CQC inspection report on 2 December, the initial response was returned to the CQC on 22 December. This contained details around action leads, monitoring committees, expected timescale to completion, how each action would be achieved, sustainability, resources and effect on patients of non-compliance.

Recommendations had been made by the Compliance Team to each division on how to deal with open actions from the 2019 report, alongside those from the 2022 report, with 3 options suggested:

- merge into 1 new action (if remain a concern on the new report)
- keep open (where there is no longer a concern, but ongoing monitoring is appropriate) or
- close (where there was positive evidence in the new report).

This would ensure the overall Trust action plan remained manageable and divisions were able to focus on their priorities without being overwhelmed by volume.

A paper would be presented to Trust Management Board (TMB) in relation to the above recommendations.

Annabelle Baron-Medlam added that these recommendations would feature in next month's CQC progress report with the new amalgamated action plan.

Fiona Osborne asked at what point would the CQC be consulted about actions that have assurance, would this be prior or following the recommendations being presented to TMB. Annabelle Baron-Medlam advised that the CQC had not been consulted yet, there was an engagement meeting with the CQC next week and this could be asked and the feedback from the CQC included within the report to TMB.

Shaun Stacey went on to note that all actions were regularly monitored through the engagement sessions. The Trust had consistently delivered on the actions and demonstrated that the improvement actions had been embedded.

The Committee thanked Annabelle Baron-Medlam for the update.

9.32am Annabelle Baron-Medlam left the meeting.

7. Estates & Facilities (SO 1.4)

7.1 Estates Strategy Update – Capital

Ivan McConnell was welcomed to the meeting and took the opportunity to speak to the circulated Power Point presentation which provided the Committee with an update on the progress of the Strategic Capital Investment that the Trust had had and the challenges faced over the coming five years. The paper outlined the following highlights:

• Trust had invested circa £101m over the past three years in infrastructure
• Trust internally generated circa £13m per annum of capital funding
• The Trust capital investment requirement moving forward was significant:

- 6 Facet survey gap of circa £117m
- An annual total growth rate of 6 Facet gap of approximately 10%
- A priority spend over five years of circa £47m

Even with an investment of £47m over 5 years, there would be a residual Backlog Maintenance and Critical Infrastructure risk of £130m

- The circa £47m had no identified funding source

- The Trust had submitted an Expression of Interest (EOI) for Capital Investment through the New Hospitals Program (NHP) on 9th September 2021

- the outcome of that EOI was yet not known
- Several options had been identified to move forward if we received funding, if we received partial funding or if we did not receive funding

- The Trust needed to evaluate options to move forward whilst awaiting a decision from the NHP as it would take many years to build a new hospital even if funding was approved and the estate must be maintained in the meantime to mitigate the risk to continuity of some services

There were 4 identified options

- Do nothing, which would be high risk
- Develop an Outline Business Case (OBC) for a standalone Scunthorpe General Hospital (SGH) on a new build site – part complete
- Develop a suite of OBCs to allow for a phased demolition and rebuild of SGH based on the existing masterplan
- A combination of options 2 and 3 above

Ivan McConnell went on to highlight to the Committee the Capital Investment Risks which included:

- Infrastructure was failing and the Trust could not wait for approvals from the National Funding schemes
- Internally generated capital was small and did not cover investment requirements
- Major capital investment over the past years had received support due to being in Strategic Objective (SO)F4 and Financial Special Measures (FSM) – once that was removed the Trust's access to funding may be limited
- A risk of a significant number of potential critical infrastructure failures over the coming years with no funding sources identified
- Back Log Maintenance (BLM)/Critical Infrastruture Risk (CIR) was not growing evenly
- BLM/CIR risk at SGH was significant and without short term investment may result in service closures
- Digital infrastructure was failing – there were multiple Integrated Care System (ICS) funded opportunities, but those would take time to implement
- The Trust did not have dedicated resources that had the skills or capacity to deliver across the life cycle of a capital investment

The Committee was asked to note the progress that had been made to date, the current issues and risks and the plans that were being put in place to address these.

Gill Ponder invited Jug Johal to comment. Jug Johal referred to the initial slide of the presentation which formed part of a report presented to the Trust Board in 2015. Today's presentation was to outline the facts and background to what had happened since the initial presentation. Jug Johal went on to add that the Trust would have more "failures" as we moved forward and a steer from the Trust Board was required and approval of the master plans previously presented.

Jug Johal then went on to note the positives over the last 2 years in terms of capital investment where the Trust was now starting to see the benefits of significant improvements across the 3 sites. He referred to the following examples: Goole energy, Emergency Department (ED) Diana, Princess of Wales (DPOW), Oxygen upgrade, DPOW, Fire Alarms, Ward 25. Work continued over 35 live schemes. Jug Johal noted that it would be "a race" to get all these completed by 31 March. The biggest concern was the contingency on the ED/Integrated Acute Assessment Unit (IAAU) scheme. The Capital Investment Board would be managing that, but there may be a need for additional unding.

Gill Ponder thanked Jug Johal and Ivan McConnell for the informative presentation. Gill Ponder then went on to add that the Trust were aware that there was a risk to maintain continuity of service, but there were also parallel activities happening with the ICS, including Place based care, the proposed Group Model andthe Humber Acute Services Review (HASR) and she asked how the Trust investment required would all fit in to the bigger picture; was there a danger of investing in something and then finding that services would be provided elsewhere as part of the wider system strategy. Jug Johal confirmed that was why the Trust Board would need to approve the strategy development and plans to move forward. A strong estates infrastructure solution would be required. It was confirmed that this would be a subject for the Joint Trust Board Development session due to take place in February.

7.2 Assurance Confirmation & Board Highlights

Following discussion, the Committee agreed that the following would be highlighted to the Trust Board:

- Key numbers from the presentation
- Scale of risk

10.10am Abdi Abolfazl joined the meeting – Ivan McConnell left the meeting

8. Review of NLaG Monthly Performance & Activity Delivery Integrated Performance Report (IPR) (SO 1.2 / SO 1.6)

8.1 Unplanned Care

Shaun Stacey took the paper as read and went on to summarise the key headlines:

Overall, ED continued to be challenged with demand versus capacity for admitted patients which created flow problems through the department. The impact of the poor flow continued to show in the ambulance handover reported delays for over 60mins which hit 883 in December, an increase on the November position; and the number of patients waiting over 12 hours for movement into a bed was 960 in December. This was the highest recorded figure for the Trust across the last two years.

The links of our flow pressures to the challenges in our communities and the inability to create capacity to discharge 'well patients' back to their homes or other places in a timely way continued in the month, although in January we should see the Acute Respiratory Illness and Frailty virtual wards go live and an increase in the Out-Patient Antimicrobial Therapy (OPAT) capacity. Some improvements in the 4-hour performance had been seen in January so far compared to the December position.

Shaun Stacey noted that staffing concerns remained, with continued high levels of agency and medical spend to support unfunded beds and also the vacancies across all the clinical areas. That was also a factor in the management of flow with inconsistency in approach and compliance to process.. Actions to address recruitment were being taken but these were slow, but there were strong pipelines. A process was being put in place to try to reduce the reliance upon the highest cost agency spends.

The inability to operate the Urgent Care Service (UCS) 24/7 continued to result in a higher than necessary number of admission requests for frail older people and a poor experience for patients with chronic conditions out of hours. It was also resulting in a spike in poorer performance in December out of hours for ‘minors’ patients with a longer waiting to be seen shown again. The positive position with the UCS was that 99% of patients were seen and discharged within 4hrs between 8am - 8pm.

The inability to operate the Same Day Emergency Centre (SDEC) and its corresponding diagnostics 24/7 also continued to result in a higher than necessary number of admission requests for frail older people and those with long term chronic conditions. SDEC remained a positive solution showing 41.2% of patients streamed to this service were discharged the same day, which was above the national picture of 28%.

Average Length of Stay (ALOS) remained in a good position for both non elective at 3.5 days and elective care at 2.5 days and was helping our ability to maintain flow. 7/14 and 21 day stays remained positive, although there had been an increase recently in the 21+ day position. The challenges around Greater Lincolnshire and the East Riding remained a significant concern. Bed occupancy remained close to 90% and the additional use of 60 unfunded escalation beds continued, which was not easily seen in the current bed report contained within the IPR.
COVID and flu were being well managed with some impact on our services. December saw a spike in flu cases, mainly at the Scunthorpe site, but those seemed to be under control again now with next to no positive flu patients in beds.

The Performance Flow Improvement Group (PFIG) programme continued to support the redesign, implementation and training of actions to mitigate the risks, led by John Awuah and Anne-Marie Hall with all the clinical teams. These changes were not quick, as culture was the challenge but small improvements continued to be shown. In particular the 2 week programme in November had shown specifically medical leadership and culture across our frontline practitioners was a major influence in making flow consistently better.

Fiona Osborne noted that there was a tremendous amount of work outside of the Trust in terms of access and flow and asked if the Trust was now seeing those benefits with PLACE structures in supporting the flow. Shaun Stacey advised that the Trust already had a really strong joint infrastructure which was why we were in the current position. However, there was still a challenge around Greater Lincolnshires services, as the Trust continued to struggle to get patients from Greater Lincolnshire home, but some benefits were beginning to be seen from working with East Riding and Hull. Additional ICS funding until 31 March 2023 had also been provided, to assist home first and the use of the discharge lounge.

8.2 Planned Care

Shaun Stacey provided the Committee with the following written note on planned care:

"The sustained approach to planned care an be seen within the circulated report, although limited assurance s shown again this month specifically around cancer but also the number of 52week wait patients which has risen slightly again. Risk stratification continues to be maintained and used to support patient scheduling.

RTT waiting list size has remained relatively static. DMO1 has seen a decrease in performance this month with the overall waiting list size decreasing slightly. The ability to report in a timely way is still being challenged through workforce and contractor commitments. The number of streams for patients urgent, cancer and routine work are also impacting now tipping over the waiting time rather than demand being met by capacity. Work is being undertaken to review the capacity required/provided to attempt to address this and linked to that is work looking at diagnostics capacity in our community (CDC program) and across the system where speciality diagnostics are required remains linked to the competing challenges around.

Cancer shows the unvalidated position but continues to demonstrate significant poor performance in this area which has been exacerbated by the regular seasonal fluctuation in performance for December. The impact is coming from the delays for oncology and tertiary access to diagnostics and the continued challenge we have around the ability to support access to test within 7 days across all modalities despite the work that has been undertaken in radiology. The challenge is with pathology and the lack of 7 day working alongside the capacity for imagining and report in both areas. This is not new and addressing it is extremely challenged in the wider context of our position.

The access to anaesthetic pre assessment is also impacting but again this is not a new cause; addressing the lack of capacity is proving difficult and through the HIT list we have attempted new approaches which are proving positive in achieving a closer access to this. It was also important to note the continued loss of theatres 7 and 8 and the increase trauma and emergency activity at both sites has reduced the elective theatre capacity once again this month. This would be resolved with the refurbishment of the theatres although that will not be until June 2023 at the earliest."

8.3 Planned Care Improvement Programme

Gill Ponder advised the Committee that she had met with Abdi Abolfazi before the meeting and had raised a number of questions about the papers presented in that section of the agenda, some of which had resulted in amendments to the papers presented to the Committee. As all her questions had been answered during that session, she would have few additional questions to raise.

Abdi Abolfazl took the reports as read and went on to highlight the following key points:

- Cancer – deterioration over Christmas period but latest position was showing improvement

- Magnetic Resonance Imaging (MRI) – major challenge to note was capacity
- Mutual Aid impact on the waiting list and diagnostics

Fiona Osborne referred to the section on Breast Cancer (Pain Clinic) and queried that the table indicated that it was not generating the results that the team were expecting. Abdi Abolfazl indicated that breast was the only tumour site over the festive period that remained green in performance and it remained the only tumour site that had been consistent and added he was very pleased with how it was being managed. It was noted that there had been a reduction in workforce availability which had impacted on performance.

Fiona Osborne added that she found the cancer deep dive report very useful but asked if it was the best way – every tumour site was included and therefore it was a lot to get through in a limited time and suggested that maybe an alternative way of presenting and further in depth discussion should be considered. Shaun Stacey suggested that a meeting was arranged outside of the Committee meeting with Gill Ponder and Fiona Osborne to gain more assurance and to agree a clear direction for the report going forward.

ACTION: Shaun Stacey to meet with Gill Ponder and Fiona Osborne

Shaun Stacey noted that he needed to be clear that theatre utilisation was not where it should be, this was a concern in terms of delivery. The seasonality had had an impact which was noted as far worse than planned for.

Gill Ponder referred to page 18 on the IPR and the increase in patients re-admitted within 30 days and asked if there an underlying reason. Shaun Stacey advised that it was related to the chronicity of illness especially in RSV recovery and non-respiratory virus returns; it was noted it was not indicative of a cause for concern.

Fiona Osborne went on to refer to page 8 and Mutual Aid and asked, given the close working relations the Trust had with Hull University Teaching Hospitals (HUTH), was there anything more that needed to be done regarding mutual aid. Shaun Stacey confirmed that the risk was the waiting list position could potentially deteriorate because of offering Mutual Aid and, whilst the Trust would want to support where it could, there was now a further challenge as any Trust having a 104 week waiter would be put into SOF4 automatically. The Trust had a very high standard of waiting list management and would not want to compromise that position to maintain patient safety, but would continue to offer mutual aid wherever possible.

10.54am Ashy Shanker joined the meeting, Abdi Abolfazl left the meeting

8.4 Planning Guidance, Operational & Business Planning Timetable Progress Update

The paper, which provided an update on the progress of the Annual Business and Operational Planning process for 2023/24 and highlighted the risks that were being managed in the Trust, was taken as read. Ashy Shanker highlighted that business and operational planning was work in progress, with the focus upon in-house processes and a robust challenge process with all divisions. Key issues were theatres, as 3 were out of action due to refurbishment until the end of June. Workforce core capacity also remained a major issue.

A confirm and challenge process was due to take place on 6 February with the Executive Team.

Gill Ponder asked if the plan would be presented to the Finance & Performance Committee prior to it being presented to the Trust Board. Ashy Shanker confirmed that timescales were tight with the 16 February being the deadline for the first draft submission to the Integrated Care System, prior to it going to the regional team; that submission would be brought to the Committee.

Fiona Osborne went on to ask what the biggest challenge was in reducing the gap and getting the plan delivered. Ashy Shanker advised that the biggest challenges were theatres, reduction of follow up activity and, utilising the 25% reduction, discharging patients.

Gill Ponder thanked Ashy Shanker for the update and added that the Committee would like to receive the plan to assure themselves on behalf of the Trust Board on the details.

ACTION: Ashy Shanker Draft Business Plan to be presented to February Finance and iPerformance Committee

8.5 Assurance Confirmation & Board Highlights

It was agreed that the following be included within the highlight report:

- Continued challenge on ambulance handovers
- Deep dive assurance on cancer & diagnostics
- Business Planning timetable progressing as expected
- Theatre Utilisation
- Scale of emergency demand (winter pressures) impact on cost
- Delay in diagnostic timescales adding delays into Cancer pathways

11.05am 5 min break

9. Review of NLaG Monthly Financial Position (SO3.1 / SO3.2b)

9.1 Finance Report Month 9 – Achieving the Humber and North Yorkshire (HNY) System Target

Brian Shipley took the Month 9 Finance report as read noting that the format of the report had been reworked. Brian Shipley went on to highlight the key themes from the paper:

The Trust had a £0.73m surplus in month which was £0.21m better than plan. However, the in-month position was supported through further release of £1.45m of non-recurrent technical reserves. It was noted that the Trust also received £2.055m additional non-recurrent funding to support the residual pay award pressures not covered by the tariff increase, £1.54m released in month. This funding should have improved the Trust's financial position, but it had been required to cover additional cost pressures in month in non-pay across Clinical Supplies, Drugs, Energy and referred Pathology testing. Brian Shipley advised that there may be an issue with Supply Chain as invoices had increased and there had been a number of supplies substitutions for more expensive products. Brian Shipley went on to highlight that there was a significant spend in clinical supplies which reflected the highest spend in any month that year. A deep dive into that would be carried out.

Action: Brian Shipley to advise the Committee on the outcome of the deep dive into the additional spend on Clinical Supplies

The Trust's cash balance as at 31 December 2022 was £31.90m which was an in-month reduction of £4.8m.

Brian Shipley went on to add that the Trust was also behind on its improvement trajectory in month by £0.36m and it still had a £2.49m year-to-date deficit, £3.78m worse than plan. It was noted that the Trust was formally forecasting a balanced financial position, but was highlighting a deficit risk of £8.04m if the run rate witnessed in the last two months of November and December continued. The Trust had non-recurrent flexibility of £5.2m, leaving a potential residual unmitigated deficit of £2.8m. To improve the position, there was a need for the Trust to focus on:

- Reducing its material cost pressures, reliance on premium agency in both Nursing and Medical Staffing, minimising additional escalation beds and ensuring greater control of non pay consumables
- Maximising its planned care activity delivery, with a requirement to return to 2019-20 productivity and activity levels within its core capacity and budget, reducing reliance on Independent Sector (IS) and Waiting List Initiative (WLI) premium costs
- Delivering a challenging stretch Cost Improvement Program (CIP), mitigating risks to delivery and converting non-recurrent savings into recurrent delivery schemes, plus identifying new schemes

Moving on to capital, Brian Shipley noted that the Trust's capital funding for 2022/23 was £44.4m. The Trust had received confirmation of additional funding for Electronic Patient Record (EPR) of £0.58m, diagnostics IREFER pilot, home reporting and imaging sharing £0.72m and Cyber £0.05m. Capital spend to 31 December stood at £19.1m.

Gill Ponder thanked Brian Shipley for the comprehensive summary and went on to refer to the supply chain issue and queried if the activity was not increasing, why was the Trust spending more on medical supplies, particularly as the stock levels on the balance sheet had decreased. Did the Trust keep data on the turnover of stock? Brian Shipley confirmed that the Trust did not have the systems to be able to do that and physical stock counts were done by department with Finance team support. Activity had not gone up in terms of planned care, but skill mix had changed. More due diligence was required with supply chain and Brian Shipley reiterated his concern over the spend and this would be monitored closely over the coming months.

Shaun Stacey went on to add that in support of Brian Shipley's report, the Trust was seeing a clinical change in the way of working i.e. single use items, more expensive items. The teams were looking into that and working with the Finance teams.

Gill Ponder referred to the capital spend and asked how confident the Trust was that it would spend the full capital allocation. Brian Shipley acknowledged there was slippage, but was confident that schemes would be brought forward wherever possible. Jug Johal went on to highlight that the capital programme was "heavy" for quarter 4 and the year-end deadline of receipt of goods wouldl certainly be tight. There should be a real spike in spend within the next couple of months before 31 March.

Fiona Osborne noted that it was encouraging to see the divisional action plans and went on to ask how the deep dives were being addressed. Brian Shipley confirmed that the outcomes were reported through Performance Recovery Improvement Meetings (PRIMS). The Finance Recovery Board had been re-launched that month and this would also add a further element of reporting and oversight.

Fiona Osborne then went on to refer to the divisional CIP and asked why the underlying assumptions for Medicine were so far away from where the current position was. Brian Shipley confirmed that medicine did recruit from a nursing perspective but there had been leavers, recruitment and retention remained a major problem as a significant level of savings predicted were dependent o filling vacancies and using less agency staffing. Gill Ponder acknowledged that the Committee fully understood the recruitment and retention position and the associated risks to the spend, which was why it had recommended a Board discussion on that topic at the last meeting.

9.2 Recovery Support Programme – Letter for Information

It was noted that a letter had not been received by the Trust to be presented to the Committee, but discussions were taking place around the exit of the Recovery Support Programme with an outcome expected in April.

9.3 Business Case Assurance – Establishment of a Shared Procurement Collaborative

It was noted that this paper had been removed from the agenda. Fiona Osborne observed that from the Business Case assurance point of view, the Shared Procurement Collaborative report that was due to be presented was covered within the Terms of Reference of the Committee, so she felt that the Committee should have received that report..

9.4 Assurance Confirmation & Highlights to the Trust Board

The Committee agreed they were assured on actions being taken, but were concerned about the risk to achieving the end of year plan. The following would be highlighted to the Trust Board:

- Month and Year to date position
- Stock and non-pay issues
- Capital spend and the actions being taken to maximise the available funding
- Planned activity affected by the increased demand for unplanned care
- Concerns for the future, due to the balanced position that year being achieved through the release of reserves which would not be available after the end of March.

10 Finance & Performance Committee Governance Documents

10.1 SO 3 – 3.1 BAF Review - The Committee carried out a deep dive into that risk, but were assured that the controls, gaps and mitigations were accurately reflected in the current risk score. As a result, there were no further questions raised.

11 Items for Information

11.1 Performance Letters to Divisions – PRIMS

Received and noted by the Committee.

12 Any Other Urgent Business

None raised.

12.1 **Matters to Highlight to other Trust Board Assurance Committees**

None identified.

13 Matters for Escalation to the Trust Board

Items for escalation to the Trust Board were discussed at the end of each section of the agenda and are listed in the minutes above.

13.1 Review of Meeting

The Committee agreed that it had been a very valuable meeting but noted that attendance was low. The quality of the reports was improving and informed a good debate.

14 DATE & TIME OF NEXT MEETING:

WEDNESDAY 22 February 2023 1.30pm TEAMS

Meeting Attendance 2023/24

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Gill Ponder	√											
Fiona Osborne	√											
Lee Bond	√											
Jug Johal	√											
Shaun Stacey	√											
Ian Reekie	x											
Richard Peasgood	√											
Simon Parkes	x											
Brian Shipley	√											
Annabelle Baron	√											
Abdi Abolfazl	√											
Ashy Shankar	x											
Shiv Nand	√											
Dr Peter Reading	x											

NLG(23)067

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	4 April 2023	
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 3 November 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Health Tree Foundation Trustees' Committee held on 3 November 2022 and approved at its meeting on 9 March 2023.	
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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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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MINUTES

MEETING: Northern Lincolnshire & Goole NHS Foundation Trust
Health Tree Foundation Trustees' Committee

Date: **3 November 2022 – Via Teams Meeting**

Present:	Neil Gammon	Independent Chair of HTF Trustees
	Gill Ponder	Non-Executive Director
	Susan Liburd	Non-Executive Director
	Peter Reading	Chief Executive
	Melanie Sharp	Deputy Chief Nurse
	Paul Marchant	Chief Financial Accountant
	Clare Woodard	Head of Smile Health
	Lucy Skipworth	HTF Charity Manager
In attendance:	Simon Leonard	Communications Assistant
	Lauren Short	Finance Admin (For the Minutes)
	Sarah Fox	Consultant Radiographer Practitioner
	David McDermott	Head of Nuclear Medicine

Item 1 11/22 **Apologies for Absence**

Apologies for absence were received from: Lee Bond, Kate Wood, Ellie Monkhouse and Christine Brereton

Item 2 11/22 **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 11/22 **Minutes of Meeting held on 8 September 2022**

Gill Ponder highlighted a minor amendment of item 6.2, dealing with the HTF Risk Register, whereby the agreement for the agenda item was to be brought to every committee meeting as a standard agenda item.

Subject to the minor amendment stated above, the minutes from the meeting held on 8 September 2022 were approved.

Item 4 11/22 **Matters Arising**

All matters arising were covered within the action log.

Neil Gammon took the opportunity to introduce our new Trustee, Non-Executive Director, Susan Liburd, to the committee meeting where introductions took place.

Item 5 11/22 **Review of Action Log**

The action log was updated accordingly.

Item 6 11/22 **Items for Discussion / Approval**

6.1 Wish Ref 168/22 - £30,000 (inc VAT) Pink Rose Suite
X2 Tomosynthesis Biopsy Software License and x4 SecurView Tomosynthesis Option License
Presenter: Sarah Fox

6.2 Wish Ref 307/22 - £9,000 (inc VAT) Pink Rose Suite
Additional License for Affirm Breast Biopsy system
Presenter: Sarah Fox

6.3 Wish Ref 308/22 - £21,600 (inc VAT) Pink Rose Suite
X2 Hologic 2D Software Option for the two new Mammography Machines
Presenter: Sarah Fox

Sarah Fox joined the meeting at 13:10

Neil Gammon asked for the members of the committee to introduce themselves and for Sarah Fox to inform trustees why this wish had been submitted and the benefit it would bring to patients, visitors and/staff.

Sarah Fox explained that this request was to fund software for equipment the Trust has on order for the current financial year.

These software licenses enable specialised images to be produced which would allow the Breast Unit to view breast tissue, layer by layer with those layers being a few millimetres thick. It can detect even the smallest of cancers which would reduce the need for patients to be sent through to Theatre. Avoiding patients having to go to Theatre and undergo a surgical biopsy would decrease stress levels, avoiding scarring, the risk of infection, hospital stays and reduce the recovery time for the patient.

This software would help the Trust diagnose cancers at the earliest opportunity which would have huge benefits as it has been proven that when a cancer is diagnosed early there is a better life expectancy for the patient.

The Hologic software would reduce radiation exposure for the patient due to the reduced time in which a scan is undertaken. Due to the reduced scanning time, the patient would feel more comfortable, reduce the risk of the patient moving which would provide more accurate data and avoid having to re-scan. Having this equipment and software in both breast unit rooms would help with capacity and better patient management.

Melanie Sharp thanked Sarah for a well-articulated presentation and asked why these licenses were not bought along with the equipment.

Sarah explained that the original request submitted for the replacement equipment was to have this software included, however this was denied as it was above and beyond what the Trust is expected to fund due to the software licenses being non-mandatory.

Gill Ponder queried whether the procurement team had examined the contract with regards to updating the software on the current machines as the upgrades should be ours by right when the equipment was purchased. After discussions took place it was identified that all the necessary upgrades had already taken place but that the equipment was too old to undergo further upgrades.

Neil Gammon queried whether the licenses would be for life and this was confirmed.

Questions were posed around the need to train staff on this new software. Sarah Fox confirmed no extra funding would be requested as the training would be provided by the supplier once the software licenses are purchased.

Peter Reading praised Sarah for a good presentation and supported all three wishes.

Neil Gammon thanked Sarah for attending and confirmed that the Health Tree Foundation will inform her of the outcome of these wishes.

Sarah Fox left the meeting at 13:42

Gill Ponder understood the enhanced benefit this would have for patients and the Trust, however, was not quite sure why the original request for the equipment with the software included was denied by the Trust.

Peter Reading spoke honestly about how the Trust is unfortunately in financial special measures with a very restricted budget, therefore must prioritise the mandatory element of requests and not the enhanced packages.

Melanie Sharp agreed and added that the equipment group are only allocated a limited budget and this request would have taken up a large amount of the FY 22/23 budget.

Susan Liburd agreed to support these wishes due to it being a one-off purchase for the lifetime of the equipment which will be of huge benefit to the patient and the Trust.

There was a unanimous vote to approve the three wishes to be funded via the Pink Rose fund which had been mentioned in the past as being a very well-established fund.

Neil Gammon asked Lucy Skipworth to advise Sarah Fox of the Trustees' decision.

Action: Lucy Skipworth

David McDermott joined the meeting at 13:55

6.4 Wish Ref 289/22 - £31,200 (inc VAT) Nuclear Medicine Technegas Generator Lung Ventilation – DPOW
Presenter: David McDermott

David McDermott ran through the key points of his wish and provided justification for the patient benefit.

The existing machine is 20 years old and is becoming increasingly unreliable with a 'best efforts' style of support contract due to its age. If this piece of equipment was not purchased, around 50-60 patients annually could be falsely diagnosed, undiagnosed or need to travel to another hospital site. Due to Coivd-19 the Trust will likely see an increase in these numbers due to respiratory issues and breathing difficulties and therefore these patients will require this type of lung scan. Being able to diagnose lung problems is life changing for patients and staff are already trained to use this machine therefore, would mitigate the need to fund any further training.

Neil Gammon opened for questions.

Susan Liburd asked what the estimated lifespan was for the requested equipment and whether on-going maintenance costs had been factored into the request. It was confirmed the supplier guarantees a 10-year lifespan, however the current machine the Trust is using is now coming up to its 18th year. Regarding the maintenance, the current contract is through the Trust's Medical Engineering team which will continue if a new machine is to be purchased.

Neil Gammon questioned whether a request for replacing this piece of equipment had been to the Equipment Group. David was unsure but added that this was more complex as it had not ever featured on the asset register until the past 5 years due to historically inheriting the machine, not purchasing it.

Working with HUTH had been explored as an option, however they use the Smart Vent which is not the preferred option. There would be a benefit for HUTH if our Trust was to purchase this equipment as there would then be two different systems to scan the lungs which would better diagnose patients.

Paul Marchant confirmed there are enough funds to split the cost between the Covid-19 fund and the Amethyst fund if this wish were to be approved.

From the quote received in January 2022, the lead-time of the machine would be 12 weeks from receipt of order.

Neil Gammon commented that this is not a clear-cut scenario, therefore thanked David for attending and confirmed that Lucy Skipworth from the Health Tree Foundation would feedback the outcome of the final decision to approve or decline the wish.

David McDermott left the meeting at 14:10

Trustees reflected on the request and acknowledged the need for this type of machine due to the added pressure of Covid-19, however if it were to be purchased via the charitable funds, it needed to feature on the divisions asset register and be replaced via the Trust's rolling equipment programme in future.

Neil Gammon and Peter Reading were in favour of approving the wish but Gill Ponder expressed how she was more on the fence with this request due to it being a piece of replacement equipment within an existing service, rather than being over and above. Susan Liburd agreed that there was a need for the equipment, however there is an equipment replacement fund where it has not featured and wondered whether this is an 'over and above' request or whether this type of equipment is standard for the Trust to provide.

Melanie Sharp was in support of the wish but understood the conflicting issues with regards to how it should be funded. With the equipment replacement funds being very limited there is a worry for would happen to our patients if we were not to support.

After discussions took place, it was agreed for Lucy Skipworth to determine the equipment group's decision and feed back on whether this machine can be funded through the equipment replacement budget. If the funds are not available for this then the HTF would be happy to fund this wish.

Action: Lucy Skipworth

Post Meeting Note: Lucy Skipworth attended the Equipment Group. This machine did not meet the requirement set by the division to make their top three priorities, and therefore will not be funded in this year's allocation.

Item 7 11/22 **Updates from Health Tree Foundation**

7.1 HTF Manager Update Report

Clare Woodard raised how HTF could potentially improve rest areas, staff rooms, and break out rooms for staff and informed trustees of a meeting which had taken place with Peter Reading to discuss this matter. Peter Reading confirmed he has raised this due to it being brought to his attention via a number of different channels including, the staff survey and Ask Peter. Moreover, Peter Reading noted that the matter was raised by a national meeting of Trust Chief Executives, where it was clearly accepted that favourable staff rest facilities enhance retention and feelings of staff wellbeing at work. It was suggested that a carefully planned, rolling programme be created to improve these areas. This would boost staff morale and positively impact patient care.

Melanie Sharp added that the staff areas within the new A&E have phenomenally improved staff morale and was in support of this project.

Discussions took place regarding staff fundraising for their own areas to have some extra luxury benefits; however, it was made clear that the communications around this needed to be sensitive. Peter Reading was not in favour of advertising this as it could have a reverse effect on morale.

Gill Ponder expressed the need for external communications to be managed carefully as there would be a potential for external stakeholder not seeing the benefit this would have to patients.

All trustees were in favour of a rolling improvement programme for staff areas and therefore, Clare Woodard took an action to work with the team to ensure a wish is submitted.

Action: Clare Woodard

Neil Gammon noted that expectations needed to be managed with a clear plan and timeline.

Gill Ponder suggested that each room could be entered into a draw which could be drawn out at each team briefing event. Peter Reading was pleased with this suggestion and confirmed that a walk around would be necessary determine the potential scope of the scheme.

Clare Woodard shared a donor story with trustees for a potentional donation of £10k for community services. Gill Ponder reminded trustees that the community teams sometimes feeling left out at times and was pleased to receive this donation.

The KPIs had been updated and RAG ratings had been compiled which would give a good measure and something tangible to work against.

The HTF newsletter has been finalised and will be circulated through the usual route.

7.2 Risk Register

Clare Woodard had completed an action from the previous meeting by aligning the HTF risk register with the Trust risk register template. This will be a working document going forward.

The HTF have a standing relationship with the League of Friends, however recently a couple of the trustees have become unwell and unable to undertake their usual duties. The HTF continues to work with them and provide as much support as possible.

Item 8 11/22 Sparkle Programme

8.1 Sparkle Update

The report was taken as read with items slowly being ticked off the list, noting a few delays due to estates work.

Item 9 11/22 **Finance Update**

9.1 Finance Report – September 2022

Paul Marchant presented the Finance report and highlighted the key points, including;

- Income for the 6 months to September 2022 is £506k which includes £233k of NHSCT grant income. This is not in the plan but has now been included in the full year forecast. When NHSCT grant income is excluded, income is £273k, which is £223k less than budget.

- Expenditure for the 6 months to September 2022 is £587k, which includes £233k of NHSCT, grant payments. When these are excluded, expenditure is £354k, which is £230k less than budget.

- Equipment purchased in the 6 months to September includes Feature Ceiling for DPOW A&E £29k, ChargeBox for DPOW A&E £8k, MotoMed Exerciser £8k and ECG & trolley £8k.
- The CCLA investment fund was revalued on 30th September resulting in a loss for the quarter of £6k, making a total loss of the year of £127k. Investments will be revalued again at 31st December 2022.

Following a discussion on the income short fall it was agreed that Clare Woodard and Paul Marchant present a revised fund-raising plan at the next meeting.

Action: Clare Woodard & Paul Marchant

9.2 CCLA Investment Update

Trustees noted the written investment update provided by Heather Lamont from CCLA. The target benchmark for total returns is CPI + 5% which is 15.06% for the year to September 2022. The actual return was negative 4.14%. The report noted that equity markets have been struggling since the start of 2022 and the outbreak of war in Ukraine has compounded market worries.

It was agreed to ask Heather Lamont to attend the next meeting to give a further update.

Action: Paul Marchant

9.3 Draft Annual Report & Accounts 2021/22

Paul Marchant presented the draft 2021/22 Annual Report & Accounts explaining that these were still subject to final audit review which is expected by the end of the month. He commented that the income figure is to be adjusted down by £15k, reflecting a donation from the SGH League of Friends (LoF) which is still outstanding & due to illness cannot be confirmed by the SGH LoF.

Trustees noted the Annual Report & Accounts & agreed that once approved by the auditors, the Chair & Chief Executive would sign the accounts and they would be noted at the next Trust Board.

Item 10 11/22 **Any Other Business**

None.

Item 11 11/22 **Matters for Escalation to the Trust Board**

It was agreed that Neil Gammon would highlight the following to the Trust Board:

- Team changes to HTF
- Approval of the 3 wishes for the Pink Rose Suite
- Rest Rooms / Staff Room improvements – Rolling Programme
- Turbulent financial markets have contributed to a loss in value of HTF investments.

Action: Neil Gammon

Item 12 11/22 **Date and Time of the next meeting:**

Thursday 12 January 2023
13:00 – 15:30
Via MS Teams

Attendance Record:

Name	Jan 2022	March 2022	May 2022	July 2022	Sept 2022	Nov 2022
Neil Gammon	Cancelled	✓	✓	✓	✓	✓
Peter Reading		✓	✓	✓	✓	✓
Terry Moran						
Linda Jackson						
Gill Ponder		✓	✓	✓	✓	✓
Mike Proctor		✓	Apols	Apols	Apols	
Maneesh Singh		✓	✓	✓		
Lee Bond		✓	✓	✓	Apols	Apols
Jug Johal		Apols	-	✓	✓	✓
Kate Wood		✓	✓	Apols	✓	Apols
Ellie Monkhouse		✓	Apols (Rep)	Apols	Apols (Rep)	Apols (Rep)
Christine Brereton		-	✓	-	-	-
Paul Marchant		✓	✓	✓	✓	✓
Andy Barber		-	-	-	-	-
Victoria Winterton		Apols	✓	✓	-	
Clare Woodard		✓	✓	✓	✓	✓
Adrian Beddow		-	-	-	-	-
Ian Reekie (Governor)						
Tony Burndred		✓	-	-	-	-
Susan Liburd						✓
Total		**10**	**10**	**9**	**7**	**7**

NLG(23)068

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	4 April 2023	
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 – January and 1 March 2023	
Purpose of the Report and Executive Summary (to include recommendations)	The paper includes the minutes of the Quality and Safety Committee (QSC) meetings for January and 1 March 2023.	
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
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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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NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 24 January 2023 from 1.30pm to 4pm
Via MS Teams

Present:

Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Kate Truscott	Non-Executive Director

In attendance:

Dr Kate Wood	Chief Medical Officer
Ellie Monkhouse	Chief Nurse
Jenny Hinchliffe	Deputy Chief Nurse
Dr Peter Reading	Chief Executive
Richard Dickinson	Associate Director of Quality Governance
Jennifer Granger	Interim Associate Director of Quality Governance
Ashy Shanker	Deputy Chief Operating Officer
Kay Fillingham (item 007/23)	Lead Mental Health Professional
Mr Kishore Sasapu (item 011/23)	Deputy Chief Medical Officer
Mr Joseph Muang (item 009/23)	Clinical Lead for ENT (Trustwide)
Kirsty Harris (item 009/23)	Assistant General Manager, Surgery & Critical Care
Mr Ramana Kallam (item 010/23)	Clinical Lead for Endoscopy (Trustwide)
Sarah-Jayne Thompson (item 010/23)	Assistant General Manager, Surgery & Critical Care
Miss Preeti Gandhi (item 012/23)	Associate Medical Director, Women & Children's
Debbie Bray (item 013/23)	Associate Chief Nurse, Family Services
Jane Warner (item 014/23)	Associate Chief Nurse, Midwifery, Gynae & Breast Services
Elaine Graham (item 015 /23)	Pathology Site Manager, DPoW
Diana Barnes	Governor (Observer)
Laura Coo	PA to the Chief Medical Officer **(minute taker)**

001/23 Welcome and Apologies for Absence

Apologies for absence were received from: Sue Liburd, *Shaun Stacey, Jan Haxby, Mick Chomyn, Ian Reekie*

002/22 Opening remarks

Fiona Osborne welcomed members to the meeting and advised that as was the usual process now there was limited time at the meeting so Fiona asked for a two minute introduction of the papers emphasising any key points before moving on to questions.

003/23 Declaration of Interests

There were no declarations of interest related to any agenda item.

004/23 To Approve the Minutes of the Previous Meeting held on 20 December 2022

The minutes were accepted as an accurate reflection of the previous meeting.

005/23 Matters Arising

Fiona Osborne advised that the quality and Safety Committee Workplan had been revised and uploaded to the hub page earlier today. There were some minor things outstanding but overall, there was now a good baseline.

006/23 Review of action log

258/22 Risk Stratification – This paper was being presented today by Kishore Sasapu therefore this action could be closed.

259/22 CNST update (training, numbers of attendance and when training was taking place) – Sue Liburd had followed up with Preeti but had not received a response yet.

262/22 Nursing Assurance report and Pressure Ulcer Deep Dive – this had been added to the workplan. As the focus was on the community element Ellie Monkhouse suggested for Donna Smith to provide the update. Action closed.

263/22 Annual SI report, reporting in Ulysses - Discussions were ongoing but the action needed to remain open until reporting was confirmed as available.

290/22 End of Life (EoL) – A date was being arranged so hopefully this action could be closed next month

294/22 Newborn Audiology Issue – it was agreed this action could be closed as it was included in the SI update and would be discussed at the Private QSC meeting

321/22 Walk through the SI Process for NEDS – Action closed

328/22 Referral to the Workforce Team about recruiting times/waits (highlighted through the Nursing Assurance Report) – this had been referred to the Workforce Committee so should be able to close after their next meeting.

Regular Reports

007/23 Suicide Annual Report

Kay Fillingham referred to the report distributed which was taken as read and highlighted the key points.

Kay was confident the work the team did across the region had a strong foundation however Humber Coast and Vale were losing their Coordinator in July and whilst they were nervous as they were the glue that held things together the team were hopeful relationships would be maintained.

It was sometimes difficult to get the figures on suicide rate i.e. for local people who died out of the area and the length of time before a Coroner formally declares a death as a suicide.

This paper would also be taken to OMG and TMB

Fiona Osborne invited any questions for Kay.

Whilst Fiona thought the report was very informative, however she did not understand from the report how it changed the behaviour in the Trust for those patients who were suspected of being at risk of suicide.

Kay explained that if somebody presented as an in-patient or community and they had suicidal thoughts they would get referred, but that was different from suicide intent, part of their assessment would be looking into the understanding of that.

For NLaG and people ending their lives in this region one of the main reasons was chronic pain so they had started some work about how acute pain was measured which was challenging but hopefully that gave an idea of how some of the actions fed into that work.

Fiona requested for the next annual update to include an anonymised case study from within the Trust..

Kate Truscott asked if there was an increased number of patients coming in through A&E because of the pandemic and wondered how much support the multi-disciplinary team was given in A&E.

In response Kay agreed there was an expectation there would be more of an increase due to the pandemic but there was now a cost of living crisis and noting that NLaG covered some of the regions most deprived areas they were cautious that they had not seen such an increase.

From a service point of view and people presenting to A&E, patients would be seen by the Mental Health Professions but there were challenges within that with resources being tight so they had tried to focus on keeping people safe whilst waiting for the referral. They were looking into having ‘Mind workers’ within A&E to be able to support patients waiting for and during their assessment. Navigo at Grimsby worked slightly different but overall, it was extremely challenging although Kay felt they worked very well together.

Capacity management of risk and guiders of that risk had been looked at which was difficult if there were a lot of challenges going on in the area which was also linked to missing and absconding policy. There were some IT digital issues with the Mind workers, the sharing agreement was something completely different, the issues were if we employed Mind workers in our A&E department they would be using independent systems and it was about getting that privacy right.

Fiona thanked Kay for the update.

Kay Fillingham left the meeting at 1.50pm

008/23 IPR

Kate Wood & Ellie Monkhouse referred to the paper distributed which was taken as read.

Kate highlighted the Structured Judgement Reviews (SJR's) and the backlog in Medicine. This was linked to operational pressures and the change to electronic SJRs. Training was taking place but they are well cited on it and a plan was in place. Kate pointed out that SJRS were about thematic collation and not about checking peoples work.

Patient Safety Alerts for Insulin pumps – Kate would not sign them off unless they were not robust enough and we did not have the evidence to support sign off however that had now been gathered and would go through QGG but it was important for us to demonstrate robust compliance within the organisation before we declared compliance outside the Organisation.

Fiona Osborne commented on the excellent SHMI score it was the best result in a long time as well as the improvement in weight recording in IAAU.

Ellie highlighted *C.Diff* the Trust was perilously close to the target but were still on track and was worth noting that NLaG were one of the best performers on *C.Diff* in the country.

Complaints was an unseen consequence of the operational pressures however there had been an improvement and was now up to 74% which meant the team were maintaining progress but were not back to where they were previously yet. Complaints continued to be discussed at PRIMS too.

Fiona asked if it would be suitable to highlight *C.Diff* to the Trust Board, Ellie agreed it would be.

009/23 Head & Neck Cancer

Mr Joseph Maung referred to the document distributed which was taken as read Kirsty Harris had put the paper together and Joseph passed on his thanks to Kirsty who was also in attendance.

The conversion rate for the Head and Neck service for 2022 was 4% of suspected referrals translated into a confirmed cancer, which was slightly less than the national average of 5%

All the 31 patients were on time for the 62 patients there were delays in Histology which was not a new thing.

Joseph invited any comments or questions.

Ashy Shanker commented about the growth assumptions for ENT and wanted to ensure it was incorporated in the capacity and demand. Kirsty was working through

their business plan and operational planning process and was already looking at what could be managed in house.

Kate Wood reminded everybody that Pathlinks was NLaG not a third party provider, if there were issues around capacity this was for the operational teams to be working from Pathlinks across Ships to work together, through the paper Joseph and Kirsty had rightly brought to our attention the risks that come with it but Pathology is us.

In terms of the planning round they would consider the increases and Ashy knew that Mick Chomyn in Pathology had put some business cases forward for funding so that had been considered for capacity.

Fiona Osborne noted there was reference to the Service Level Agreement (SLA) with HUTH and asked what would happen if HUTH were not meeting their obligations. Ashy advised they had some recharging arrangements but in terms of contractual arrangements a lot of it was due to vacancies. They were looking to provide additional doctors where they could through locums etc, it still was not what it should be but the doctors were not there.

Fiona noted there were a number of areas of concern highlighted MRI, CT and PET scans and asked if there were any mitigations in place. In response Ashy explained that there was a diagnostic plan with a set reduction of 5% in terms of performance by 2025, had submitted a trajectory which met that and there was a performance plan in place. MRI was the biggest problem as they had a back log to go through so there were some variables that were not totally within our control, in the operating plan as well the faster diagnostics the target was to reach 75% so hopefully that would be delivered. Overall, the biggest risk was workforce.

In summary all the risks and concerns in the paper were already being considered through the risk and planning process.

Joseph referred to the chart on last page of the report which showed the increase in the number of referrals each year. The team continued to do everything possible to meet the targets but were at the very early stages with the Cancer Head and Neck Networks.

Fiona thought the paper was informative and helped the Committee to understand what challenges the service faced.

Kirsty had submitted an outline business case for some ultrasound machines for the clinicians to be able to carry those out themselves to give patients a quicker diagnosis so was trying to speed up the diagnostic process. Ashy confirmed that would be considered along with all the other priorities within the Trust.

Kishore Sasapu added for awareness for everyone as we talk about group structures with NLaG and HUTH, ENT was one of the examples of how it should be working, appointments were being combined and worked very well and Kishore thought a lot of specialties had a lot to learn from how ENT worked despite the capacity problems they worked together really well and were fully engaged with the transformation programme.

Kate Wood suggested that if they did not get the funding through the business planning for the ultrasound machines then they could put a bid in through the Health Tree Foundation as it would absolutely benefit the patients and would be making the pathway better.

Fiona thanked Joseph Maung and Kirsty Harris for attending to give their update.

010/23 Colorectal Cancer

Ramana Kallam & Sarah-Jayne Thompson referred to the document distributed which was taken as read and highlighted the key points.

Ramana advised that there were a few changes since the last update. Previously we were not in line with the national cancer strategy straight to test service so the team had realigned themselves. The simple journey of a patient is they are referred as a 2 week wait referral and the service aims to see the patient for their first appointment within 72 hours of referral. The delays in the pathway are mainly patient factors which accounted for approx.15- 20%. Once the patient has their first appointment with the CNS they are referred for a diagnostic test. This would be carried out by a consultant grade clinician who would identify any cancer or not. If there was no cancer detected the patient would get reassurance and be removed from tracking on a cancer pathway. Colorectal were at the top for diagnostics and it was only where there was a real risk of cancer that the samples would be sent usually within 7 days so once a cancer was diagnosed Colorectal was the only specialty that did this.

Overall, the service had consistently achieved the faster diagnosis, however, it was not without difficulties, the main difficulty was the number of referrals and out of 100 referrals two cancers are detected which is below national cancer conversion rates. They are trying to improve that by redirecting the referrals appropriately.

Fit tests, uptake for national bowel screening was very poor in this catchment population. Our percentage of cancers was going down and if the screening programmes worked they were not seeing the affect as they were seeing more and more advanced cancers.

Kate Truscott found the paper very informative and easy to read and congratulated everybody on achieving everything that had happened so far.

Preeti Gandhi joined the meeting at 2.20pm

Kate Truscott asked about the rapid diagnostic pathway not being used by GPs properly and wondered why there was a reluctance. Ramana could not say for sure the reality was that when the pathways were agreed it was in full engagement with Primary care although there was initially some resistance but funds had been used to streamline the pathways. Kate went on to ask if there was more testing needed in Primary Care, were there the resources to do it and what was being done to help the patients with the psychological effects of being given bad results. With such a low percentage of positive results, Ramana thought the psychological effects were minimal but they were keen to improve services. The only missing piece to the puzzle was robotic surgery which was their wish to deliver Colorectal surgery. That had been included in the business planning process for consideration.

Fiona thanked Ramana Kallam & Sarah-Jayne Thompson for attending to give their update.

011/23 Risk Stratification

Kishore Sasapu referred to the document distributed which was taken as read and highlighted the key points.

Kishore thanked Fiona Osborne for her help with the paper to ensure this Committee received the information it wanted.

Kishore explained that risks exist because of various reasons; the provision of care, lack of resource, capacity etc. this was specifically to understand the risk within our patch, what was happening with the patients, how we used the capacity that we had in the right way and in the long term managing the risks as best we can. The risk strategy was put together at the beginning of the Pandemic as it became more magnified but we needed to optimise our risks to use our resources. There were now thoroughly embedded systems and the numbers were quite stable. The numbers were regularly discussed through OMG and PRIMs. Kishore had tried to include examples within the paper of where quality improvements continued to happen and where they had made a difference.

There was quite a lot of focus on the patient follow ups as ordinarily patients would have been seen face to face. There were multiple changes that had been brought in for follow ups but despite all that the capacity was not there Quite a lot of those patients should be cared for in the community and this was the journey they had to make. Kishore thought there could be a more hybrid solution.

In his time as Divisional Medical Director in Surgery and Critical Care Glaucoma was the area where they did not manage to achieve as much as they wanted to, the patient did not require a consultant to see them, they required a pathway. There had been quite a lot of changes within the pathways but the size of the PTL was so huge that whatever changes were made it would not change it.

Fiona Osborne thought the paper was great in demonstrating how risk stratification has moved to a business as usual process from a risk stratification initiative. Fiona knew it was not without its challenges but was an excellent process structure but asked if there were any areas where they had not managed to make the progress they wanted to.

Kishore advised when it came to In-patients for example or somebody waiting for a procedure they were very well managed in categories one and two and when it came to categories three and four it was a very arbitrary line between the categories and was where the lack of capacity was very stark. This was where the improvements to capacity needed to kick in to improve the productivity.

Kishore explained the ratings within the report. Reds tended to be for out-patients, greens probably did not need to be seen in Secondary care, maybe hybrid Secondary care or discharged to Primary care but not all of them. The amber ones were not time critical but could become time critical i.e. glaucoma patients could

come to harm and the only way to decrease that risk was to decrease the size of the green PTL.

Kate Truscott thanked Kishore for the paper it was helpful and Kate thought the approach was positive in actively targeting their resources. The paper provided Kate with a great deal of assurance and enabled her to understand the approach.

Fiona thanked Kishore Sasapu for the update.

Kishore Sasapu left the meeting at 2.43pm

012/23 Family Services update

Preeti Gandhi referred to the document distributed which was taken as read.

Fiona Osborne asked if the Committee could have a Family Services Deep Dive next time that included all of Family Services with a focussed deep dive paper on Facing the Future as per the Workplan, rather than a Children's and Young Persons Paper which separated out paediatrics from Family Services.

Preeti explained that the paper included Gynae and Breast as this was an area of focus and was a very comprehensive paper. The paper talked about the challenges they were facing, the overall patient experience and the Governance aspect.

The main issues were around capacity and demand, capacity was a big issue when talking about the elective recovery and cancer waits. They had been left with an imbalance from a demand perspective, and Preeti knew there was a big piece of work ongoing and the baseline internally at the end of this month would be meeting with the Clinical Leads to get more intelligence into the data so they could align the capacity and demand better.

Outpatient follow ups – they were conscious this would not be achieved in some areas i.e. Paediatric Diabetes. They were also looking at an increase in delivery of cancer diagnosis but wanted to focus on the capacity work they had started, in an ideal world this work would be implemented from 1st April to align the services and would involve the holistic work in terms of job plans as well. A lot of work was happening in collaboration with GIRFT and length of stay and that had moved on well.

Breast service was doing well and were slowly increasing the pathway in Gynae. Had done well in Family Services with advice and guidance so they could realign the capacity to area of need.

Fiona invited any comments or questions for Preeti.

Kate Wood thanked Preeti for the update but thought it was important for the Committee to be aware that there was going to an external review of the Gynae and Oncology MDT.

Fiona referred to the Patient Safety section of the report and thought from an assurance point of view rather than having a list of statistics, it would be more

helpful to have more context and detail in the next update. Preeti agreed to look at this.

Fiona was interested in the ICB and the significantly longer waits for access to gynaecological care across the providers with a resulting need to rebalance demand across the region through mutual aid. Preeti advised they were in the early stages of talks with HUTH however it was important to consider the holistic care of the patient.

Ashy Shaker agreed there needed to be a clear indication of the risks when going into this with HUTH. They were having conversations looking at how and where we can support mutual aid but they needed to be clear in terms of what the impact from Surgery, Diagnostic and after care would be before entering into a contract.

013/23 Children & Young Person update

Debbie Bray referred to the document distributed which was taken as read there was nothing that Debbie needed to highlight from the paper so was happy to take any questions.

Kate Truscott was interested in Debbie's take on the compliance for sepsis for young people. Debbie explained there was not any quantative or qualitative evidence but knew their audits were not robust enough, sepsis screening tools needed to be embedded into practice. Their audits found there were some robust processes in place but Debbie was working with colleagues in audit and the division for a wider robust sepsis management plan. That would come to light in future reports.

Kate Truscott asked about the recruitment of registered sick children's nurses, although Kate knew it was a challenge. Debbie though it was only in the last 18 months that NLaG had really started to feel that national picture. They were trying to keep our students and were also doing some work with the Chief Nurse Directorate to pursue international nurse recruitment.

Kate Truscott asked about conversion courses and if there was any mileage to that. Those opportunities had gone but Debbie informed there were some developments within the universities who were looking to make changes to try to develop something.

Kate Wood reaffirmed what Debbie had said about what was audited was relevant. Relevant data needed to be collated, that was what the QI workshop was about, pulling all the right people together to make sure we were looking at the right things, what we were going to do and how we were going to do it.

Fiona Osborne referred to the Facing the future table, second bullet point about quoracy of meetings and general attendance being a challenge and asked if Facing the Future was seen by members as a priority. Debbie agreed it had led to an inability to progress actions so they had tried a different approach this year but currently it remained the same. The was not just about ability to attend meetings; it was often linked to capacity issues but was a challenge and Debbie was open to suggestions of how to improve that.

There was a vast amount of work to be done around the Surgery and Critical Care suite of standards, two sets for Surgery, a Paediatric and Emergency Care. The real focus this year needed to be on evidence collation and sign off. Another key thing was to accept that some of the standards were not achievable given our remit but would make sure robust mitigation was in place for reassurance.

Fiona thanked Debbie Bray and Preeti Gandhi for their updates.

014/23 Maternity Safety Oversight update (including Ockendon & Metrics)

Jane Warner gave a verbal update referring to key points already mentioned in the updates from Preeti Gandhi and Debbie Bray.

There had now been two Ockenden reports followed by an Easy Kent report. It was a very involved and lengthy action plan for the original report, and there were only four outstanding actions from the first report all around audits and one SOP. Jane aimed for it to be fully ratified by the end of February.

With respect to the second Ockenden report and East Kent the wish for compliance should come to us by the end of March. It was expected that would be more difficult and Jane did not believe there would be any additional monies coming our way.

The QI work was moving forward, had the Maternity triage running, which they had been desperate for at both sites. This was being rolled out on a staged approach started with a telephone triage on 31st October. Since then until yesterday they had received 2373 calls which was tremendous but prior to that all those calls would have been going through to the delivery suite and maternity wards. The times of the service had been extended until 1am. The final stage was to have a triage area by the end of February. They were also about to start an Antenatal Clinic and everybody was very keen to explore different ways to run that service

Vacancy rate was 25wte for Midwives which was an improvement from 40. They were waiting for eight Midwives from overseas and had the pastoral support from NHSE/I so far they had not seen any attrition

Continuity of carer continued with two teams and they were managing, they had been doing this for over three years now and although they wanted to expand it, they could not at present as they did not have the midwives.

CNST – had demonstrated full compliance for all 10 quality safety actions.

From the first Ockenden report there were no immediate actions other than those relating to documentation and audit.

Fiona thanked Jane Warner for the update.

Jane Warner left the meeting at 3.19pm

015/23 Pathlinks update

Elaine Graham referred to the report distributed which was taken as read and noted that things had not changed much since the last report was submitted.

Elaine highlighted the poor response rate for friends and family test, there was a bit of a gap with ULHT and NLaG and they were unsure why but they had some ideas about where to re-site boxes

There was a new concern with regards to Cellular Pathology struggling to meet the obligations, they were monitored through the KPIs and the OMG meetings but it did remain a risk that we would not get to where we wanted to be.

PDL1 – It was found that it was potentially giving false negative results and they were now retesting 97 patients.

Wax shortage – the back log associated with the wax shortage was minimal now, and Elaine hoped to be able to potentially remove that risk shortly. Whilst there was the shortage they were only able to test the suspected cancers not routine ones

DART – this was the replacement project for WebV version 3 that had been delayed and suspended but were looking to restart that roll out which would mean the DART contract could be ended March.

Mortuary – plans were in place and refurbishment works would be undertaken

There was a risk to their accreditation with regards to the 7 day cancer target, had not been able to demonstrate that improvement, but were unable to get funding for 7 day services.

ULHT SLAs – Estates and Facilities were slightly behind schedule but the SLA was virtually complete and the plan was to extend the current SLA by one year

Kate Wood referred to the reagent testing and the 96 patients and asked if there was a timescale for that to be completed.

Action: Elaine Graham to find out that date and feedback to his Committee

Kate Wood referred to the table on page nine and noted there was a difference in the turnaround times for NLaG and ULHT for the cancer pathways and asked why there was a clear postcode differential.

Action: Elaine Graham to find out and feedback to his Committee

Fiona referred to the Cancer pathways in general, Elaine had clearly mentioned the 7 day services business case being turned down in the previous year. Elaine drew the members attention to the 2ww performance, Pathology was working on a 5 day service but if the Pathology team were able to work in a 7 day service for the samples it would move things forwards quicker.

Fiona stated this Committee had highlighted their support for 7 day working to the Board and asked for it to be given specific attention. Fiona Osborne asked if it this needed to be reiterated to Board although this Committee can only recommend, not agree.

Ashy Shanker informed that this was scored the highest but unfortunately there were other competing things that were considered priority. It had also been taken

through the Yorkshire and Humber ICB, who may fund it for two years and then the Trust would have to look at funding it.

Action: Fiona Osborne to add this to the Highlight report to Trust Board

Kate Truscott asked about the impact of the changes for the Cellular Pathology and UKAS accreditation. Elaine explained this would be in terms of our service users, reputation etc. and we would be given time to work through those improvements but Cellular Pathology did seem to be the biggest challenge. They were doing what they could to maintain that as they were accredited entire body. The inspection would be in March 2023 and the knew it would be a new team this time which meant it could be more challenging.

Fiona asked about the PDL test issues and if that meant there could be psychological harm to patients. Elaine clarified that was basically a tumour test and had been added to the risk register, all those so far had been confirmed negative but this was a national service affecting a few regional sites.

Fiona mentioned that the last update was when we had extreme temperatures so assumed that no longer applied but asked if the mitigations put in place were suitable should we be in the same position again. Elaine stated that the issues with Cellular Pathology remained where the air conditioning would be inadequate if the temperatures were to get that high again and would need to put mitigation in place i.e. portable air conditioning.

016/23 Nursing Assurance Report

Ellie Monkhouse referred to the report distributed which was taken as read and highlighted the key points.

Ellie referred to page 12 of the report, following reflection at the last QSC they started to attempt to demonstrate the acuity across the organisation. Had the very high level results from the safer nursing level tool and would extract the data that needed to be included.

Still had several escalation beds open but they were not captured anywhere on our data systems

QI hub had some good data around projects that were going on and the Divisions they were happening in but Ellie found it was a good visual of what was going on in terms of QI.

Kate Truscott referred to page 31 of the report where it mentioned there were no issues in lapses of care yet a child had a fractured skull and a bleed on the brain. Ellie informed that full Nursing huddles were held and incidents were logged through another system called ICB where it was delogged as there were no lapses of care but Ellie thought we needed to accept that people do fall but agreed the language used was not at all helpful.

Fiona Osborne referred to the HCA vacancy rates, back in September there was a big recruitment event which seemed to be quite successful, but Fiona could see the vacancy rate had fallen by 17 at the end of November and wondered why that was.

Ellie thought it was a mixture of reasons for example there were some delays to onboarding, losing people to other job opportunities not necessarily in the same industry and felt there needed to be more focus on our non-qualified workforce.

Jenny Hinchliffe agreed it was a range of factors, retention just because there were so many opportunities out there. Recruitment was currently ongoing but we do lose some people.

For a Nursing Report Deep Dive for a future QSC Fiona suggested looking at the supportive care posts. Fiona would want the challenges in the acuity increased and the substantive support roles. There was a float tool, but Ellie would have to think about this subject. Fiona's suggestion was about the red flag process and understanding the balance to having an open culture and the getting to a stage to understand where the red flags were. Ellie thought it was much more complex than that and Fiona needed to understand the depths of the nursing panels. Ellie suggested for Fiona to sit on one of the panels. Fiona suggested that the intended nursing assurance report focus may not work in practical terms. Fiona and Ellie agreed to talk outside of the meeting.

Action: Fiona Osborne and Ellie Monkhouse to have a conversation about the Nursing Assurance Report Deep Dive outside of this meeting.

017/23 BAF

Kate Wood & Ellie Monkhouse referred to the paper distributed which was taken as read and invited any comments or questions.

Fiona Osborne commented that she had not seen cancer pathways in the action plans and asked if that was something worth thinking about. Ellie and Kate had already requested that Shaun Stacey or somebody from the Ops team should be included in this.

Action: Fiona Osborne to highlight to Board in the BAF recommendations section of the Highlight report.

018/23 Key SI update including Maternity

Richard referred to the report distributed which was taken as read and invited any comments or questions. None were received.

019/23 CQC Framework

Jennifer Granger referred to the paper distributed which was taken as read and gave a brief overview of the changes since the previous report.

The actions from the previous report were going to TMB on 6th February which would detail what was happening with those actions that remained open. It would feature on the next month's report as they would be amalgamated. Terminology would change from RAG ratings would be full assurance, moderate assurance etc

In the background they were doing a costing exercise for any of those actions that had a financial aspect. 87 new actions, 150 actions all together

020/23 Potential Deviations from National Documentation

Jennifer Granger advised there were not any updates to discuss.

021/23 PSIRF update

Richard referred to the report distributed which was taken as read summarised the key points.

The paper was at a point in time. A meeting was held the day before where there was some discussion around the implementation plan and it was agreed to have a slightly different approach. There were some things there needed to be a lot more engagement with and some correlation and appropriate themes to take things forward. i.e. thematic review of falls and falls huddles. They were looking to increase some of the simpler investigations and draw things from that. There was more training and education needed for some of the investigative work. Richard hoped this would be implemented in Autumn time.

Highlight reports

022/23 Quality Governance Group (QGG)

The highlight report was distributed and taken as read.

023/23 Mortality Improvement Group (MIG)

The highlight report was distributed and taken as read.

024/23 Patient Safety Champions group (PSG)

The highlight report was distributed and taken as read.

Items for information

025/23 Quality Governance Group (QGG) minutes

Distributed for information.

026/23 Mortality Improvement Group (MIG) minutes

Distributed for information.

027/23 Patient Safety Champions group (PSG) minutes

Distributed for information.

028/23 Any Other Business

None raised.

029/23 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 .

- Pathlinks seven day service
- *C.Diff* rates
- BAF recommendation for Ops involvement

030/23 Meeting review

Fiona Osborne was happy that the Quality of papers had improved and thanked everybody for talking to their teams.

031/23 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 1st March 2023
Time: 9am – 11.30am
Venue: Via MS Teams

The meeting closed at 4.02pm

Annual Attendance Details:

Name	Dec 2021	Jan 2022	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
Michael Proctor	✓	✓	x	✓	✓	✓	✓	✓	✓					
Michael Whitworth														
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maneesh Singh	✓	✓	✓	✓	✓	✓	✓	✓	x	✓				
Dr Kate Wood	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
Ellie Monkhouse	x	✓	✓	✓	✓	✓	✓	x	✓	x	✓	x	✓	✓
Dr Peter Reading	✓	✓	✓	✓	x	✓	✓	✓	x	x	x	x	✓	✓
Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
Jennifer Granger										✓	✓	✓	✓	✓
Richard Dickinson														✓
Helen Harris	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Jan Haxby	x	x	✓	✓	✓	✓	x	x	✓	x	x	x	✓	x
Shaun Stacey	✓	x	x	x	✓	x	x	x	x	✓	✓	x	x	x
Susan Liburd											✓	✓	✓	x
Kate Truscott											✓	✓	✓	✓

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Wednesday 1 March 2023 from 9am to 11.30am
Via MS Teams

Present:	
Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Kate Truscott	Non-Executive Director
In attendance:	
Dr Kate Wood	Chief Medical Officer
Ellie Monkhouse	Chief Nurse
Shaun Stacey	Chief Operating Officer
Richard Dickinson	Associate Director of Quality Governance
Jan Haxby	Director of Quality and Nursing, North East Lincolnshire Health and Care
Jenn Orton (item 041/23)	Associate Chief Operating Officer
Nicky Foster (item 042/23)	Deputy Head of Midwifery
Donna Smith (item 043-44/23)	Associate Chief Nurse, Community & Therapies
Simon Buckley (item 045/23)	Associate Chief Nurse, Medicine
Anabelle Baron-Medlam (item 051/23)	Interim Inspection Compliance & Assurance Manager
Ian Reekie	Lead Governor
Rachel Wright	PA to the Chief Nurse **(minute taker)**

035/23 Welcome and Apologies for Absence

Apologies for absence were received from: *Susan Liburd, Simon Thackray, Fiona Moore, Jane Warner, Mathew Thomas, Dr Peter Reading*

036/22 Opening remarks

Fiona Osborne welcomed members to the meeting and advised that as was the usual process now there was limited time at the meeting so Fiona asked for a two minute introduction of the papers emphasising any key points before moving on to questions.

037/23 Declaration of Interests

There were no declarations of interest related to any agenda item.

038/23 To Approve the Minutes of the Previous Meeting held on 24 January 2023

The minutes were accepted as an accurate reflection of the previous meeting.

039/23 Matters Arising

A committee effectiveness review will be undertaken shortly and members will receive a questionnaire. The terms of reference will also be reviewed. The results will be shared at the April meeting and an action plan agreed.

040/23 Review of action log

197/22 Pharmacy & 202/22 Age profile – Fiona reported that she had attended the Workforce Committee and both aspects of concern to the Committee were discussed in detail. The Workforce Committee are tracking age profile and have put mitigations in place including return to work and engaging with staff due to retire. The team are also aware of Pharmacists shortages and are working on a plan with Divisional staff to attract Pharmacists in a nationwide shortage.

259/22 CNST update – Preeti had been in touch with Sue Liburd. There is now a task and finish group being led by Preeti and Jane Warner, with the support from radiology dept. Sonographers from both DPOW & SGH are now being trained to do it. She feels there has been significant progress since the enquiry was first made. This action can now be closed.

262/22 – Nursing Assurance Report – Donna Smith presenting the pressure ulcer deep dive (item 7.5) at today's meeting. NEDs are also meeting on 02/03/23 to discuss the pressure ulcer process. This action can be closed.

263/22 Annual SI Report, reporting in Ulysses – the risk team continue to work with the digital team. Shaun Stacey asked that digital issues were raised with the CIO to ensure focus is maintained. Shaun, Kate and Ellie will also raise at Exec team. The action should remain open.

290/22 End of Life – a meeting is being co-ordinated. Kate Wood is delivering a COG briefing on EOL and suggested Kate Truscott and Sue Liburd attended.

328/22 Referral to the Workforce Team about recruiting times/waits – an extensive discussion took place at the Workforce committee and identified a bottle neck in occupational health. Simon Nearney is undertaking a full review of the recruitment process. QSC will review the time to recruit again in May noting any improvements and refer to the Workforce committee if required. The action would remain open until a review in the May meeting.

Regular Reports

041/23 Surgery Update

Jenn referred to the report distributed which was taken as read and highlighted the key points. In terms of the ophthalmology backlog, the un-booked position was 3100. There are no 78 week patients and minimal 52+ week patients waiting for surgery. Twenty six patients are at the 40 – 51 week position. The position is supported by the external providers doing weekend work which has incurred significant costs but there here is now a significant process in place for red high risk

patients. There is a decreasing number of overdue follow ups. A paper has been submitted through the business planning process to bridge the gap with capacity and demand to fill with substantive posts which should support the service longer term.

End of Life equipment is being reviewed on a monthly basis. Alternative routes are being sourced where items can't be renewed via capital funding. A significant amount of money has been spent in S&CC during the last year on anaesthetic machines. Both CS and S&CC are continually reviewing and prioritising equipment requirements working closely with medical engineering colleagues.

Targets for cancer and front door performance are achieved. Reports are completed within the 24 – 48 period as per the national standard. DMO1 capacity is mapped due to a lack of capacity in CT and MRI. A paper is being developed around bringing a van on site to increase capacity. An issue with reporting has been addressed and numbers have come down from 6000 – 3000 approx. The DMO1 performance is in a good position over all modalities and is reviewed on a weekly basis and the team ensure the right capacity is in the right place so that patients are not disadvantaged. Mitigations include St Hugh's providing a further 2 days at SGH and ICB will be providing a van from March.

A number of duty of candours were outstanding and have now been resolved. The never event is going to plan and is progressing.

Kate Truscott asked what the time frame was for double running with written prescriptions. Jenn explained there were a minimal number which should be resolved with next 4 – 8 weeks and a plan is in place.

Kate Truscott asked for an update on sepsis screening. Jenn explained the QI team were working with Debbie Bagley and meetings were taking place with Divisions with good engagement to maximise completion of the sepsis screening tools. The deteriorating patient lead role has been extended to September. The critical care outreach business case is a priority this year.

Kate Truscott asked whether there was a problem for medical staff accessing mandatory training. Jenn confirmed mandatory training was now included in job plans; mandatory training was delivered to approx. 150 staff at the S&CC Quality and Safety session on 22 February and time is also included within rotas.

Fiona Osborne referred to the good achievements highlighted in the report in terms of ophthalmology and complaints. Fiona commented that to support the team manage pressures the QGG report could be submitted to the Committee going forward but requested that it is refreshed before submission to highlight areas of assurance. She asked that future reports highlight patient safety and psychological harm to patients.

Fiona asked whether any additional mitigations had been put in place to manage the risk of harm in relation to DMO1. Jenn explained nothing was in place regarding psychological delays for patients. Patients are triaged which highlights how soon they need to be seen. Targets are predominantly being met for the less than 6 weeks. Jenn will go back to radiology leads to see whether any additional measures can be put in place and will work with Mat Thomas to engage with the

clinical body on a solution. Shaun Stacey added DMO1 was a statistical measurement and not a good indication of harm. DMO1 performance is monitored by the finance and performance committee the main indicator being capacity. The caravan supplied by the Cancer Alliance to provide additional capacity is allocated to Trusts based on the number of access waits.

Fiona Osborne asked whether the duty of candour issue related to the never event. Jenn confirmed the issue related to outstanding pressure ulcers and was now resolved. The never event is on trajectory and there are no concerns.

Jenn Orton left the meeting at 9.33am

042/23 Maternity Safety Oversight Update (including Ockendon & metrics)

Ellie Monkhouse explained the maternity team were having discussions around exiting the Maternity Improvement Programme and are using the NHSE/I maternity self- assessment tool. The self-assessment tool was being shared at TMB on 6 March and will form part of the update to QSC in March and Trust Board on 4 April for organisational oversight. Ellie has linked in with executive colleagues around the organisational response element. Simon Nearney will be joining the Maternity Transformation and Improvement Board to support OD and cultural work. Significant progress has been made with QI programmes particularly triage and work continues around induction of labour.

CNST was submitted with no feedback received to date. Other reports are expected following Ockenden and East Kent and a national maternity improvement is being developed. Another set of assurance visits by the LMNS and regional team are also expected. The timeframe for receiving the CNST outcome has not be confirmed.

Nicky Foster added that the triage project was going well and the 2nd phase was due to commence within the next 2 weeks. The first Ockenden action plan has been completed and the team are now working to complete the 2nd action plan.

Fiona explained the verbal updates on maternity were extremely useful and asked the committee whether these should continue. The Committee agreed to continue. Ellie explained the maternity board report template was being restructured and will include a dashboard highlighting national indicators. A draft will be shared at the next Maternity and Transformation Board. The main focus currently is to exit from the Maternity Improvement Programme with wide support needed from the executive team.

Nicky Foster left the meeting at 10.44am

043/23 End of Life Update (Community & In-patient)

Donna Smith referred to the document distributed which was taken as read and highlighted the key points. There have been significant improvements in compliance with syringe driver training. Clinical teams have been targeting individuals and groups of staff which has had a positive impact on compliance. The palliative medicine consultant is attending divisional meetings to raise awareness of Respect training.

An ‘Always QI event’ for End of Life is being held on 9 March with approximately 60 medical and nursing colleagues attending. In addition to patient stories and staff feedback, the event will discuss the barriers and enablers to inform the Trust wide QI project which will ultimately support the Trust quality priority for end of life to enable people to have good personalised care and a good death in all services. Donna added the Trust has a lower than national average number of patients coded as receiving palliative care and further work is needed to understand the issues around coding.

Kate Truscott highlighted that the report stated staff were not aware of the EPAC (Electronic Palliative Care Co-ordination System). Donna explained EPAC was a single co-ordinated approach system and records were created in primary/community care for people entering the last year of life. The record has been available via WebV for some time. Comms to raise awareness of EPAC will be included as part of the QI event on 9 March. The EDs use a different clinical system (Symphony) and WebV cannot be viewed so the team are exploring alternative ways to access it.

Kate Truscott referred to appointment of the specialist nurses and asked what the likelihood was of attracting a palliative care consultant. Kate Wood explained other options were being looked at in North East Lincolnshire. Donna added the consultant post would be readvertised at an appropriate time as neighbouring Trusts are also seeking similar appointments. Jan Haxby added the post had been advertised twice with no applicants. The post will be readvertised at an appropriate time. Alternative options including recruitment from Kerala are being explored.

Fiona Osborne said she welcomed the reset to the End of Life plan and requested that future updates referenced commitments to action in this report, whether these were delivered or not and what was planned for the next period.

Fiona Osborne referred to the note the anecdotal evidence found that advanced care conversations with patients were improving and asked if there was a way of empirically measuring this for assurance. Donna Smith advised that measures were being developed.

Fiona Osborne asked whether the importance of faith had been included in the End-of-Life plan. Donna explained there had been good engagement from the chaplaincy team in the End-of-Life group.

Fiona Osborne asked what evidence there was that advanced care plan conversations are improving the process for documenting Respect forms. Donna confirmed the chair of the Quality Governance Committee felt the Respect was being discussed more and the number of complaints and incidents have reduced although it was important to see the data to support this. Donna added the coding issue needs to be included in any triangulation.

It was agreed that the ‘Always QI event’ would be highlighted to the Board by the Committee.

044/23 Pressure Ulcers Deep Dive

Donna Smith referred to the document distributed which was taken as read and highlighted the key points. Donna explained the team were working on implementing the standardised risk assessment tool (Braden). The time taken on investigations has been reduced and external assurance is provided by the ICB quality team allowing time to focus on lapses in care and learning. Donna referred to the patients who live in their own homes and choose whether they follow guidance and advice and still develop pressure damage. The purpose of introducing the risk assessment tool is to reduce the number of patients developing pressure damage.

Fiona Osborne asked given there was an excellent framework in place why there was an increase in the number of pressure ulcers. Donna explained the acute and community teams will undertake a deep dive to understand the reasons in more detail.

Fiona Osborne asked whether the PUFFIN process ran in parallel with the SI process. Donna explained when pressure damage is identified it is recorded on Ulysses and incidents are reviewed by the harm group to identify any lapses in care; where lapses in care are identified the SI process is commenced. Duty of candours are also completed in timescale as part of the initial review. Donna felt the introduction of the tool would reduce pressure ulcer prevalence and didn't expect to see a spike in pressure ulcer numbers.

Fiona asked whether PSIRF requirements were still being assessed and reviewed. Richard Dickinson explained the model mirrored that used for most other incidents and the development of a work programme to take forward quality improvements would make significant differences. There will no longer be SI reporting and somethings will require detailed investigation with others needing a simpler methodology i.e., after action review. Ellie Monkhouse added the new methodology relating to incidents was around learning and it was important to understand the reasons pressure ulcers are acquired rather than focussing on numbers.

Fiona asked if we would expect to see a spike in pressure ulcer cases recorded as we moved to the Braden Scale. Donna advised that she did not expect this to happen but that they would be mindful in monitoring numbers.

Donna Smith left the meeting at 9.54am

045/23 Diabetes Management

Simon Buckley referred to the document distributed which was taken as read and highlighted the key points. Simon explained that compliance had increased across the sites since the last presentation and the paper provided more detailed information on non-compliant cases. The audit period had coincided with a significant increase of paediatric attendances to ED linked to the Strep A scare and resource at senior medical level was put in promptly and is reflected in the clinical information. There were some missed opportunities in processes regarding clinical decision making for the PEN team in terms of not completing a BM but not documenting their reasons and the team were addressing this. Approximately half of the cases were seen by the PEN team but did not have the reasons for not completing document. More than half of the cases were seen by the PEN or

paediatric team; the rest were seen by a senior registrar or consultant prior to discharge. All of the cases were seen by suitably qualified clinicians and clinical judgement would have been used.

Kate Wood felt the report showed a clear rationale for why the BMs weren't taken and the next step of the audit should be staff adding the rationale in.

Fiona Osborne felt the report didn't give assurance. Simon explained the audit wasn't extended to review the paediatrics notes as patients referred to the paediatric team would be seen and reviewed by paediatric experts. WebV records were reviewed and BMs that were not recorded were included in the audit. Simon added there was clear clinical decision making and diagnosis which meant BM didn't need to be completed however there were missed opportunities in not recording the reason for not completing.

Fiona asked for clarity on the following statement: - *'6 were seen by the PEN Team (all at DPoWH). It was agreed the PEN Team would use clinical judgement to identify if BM required or not, however in all cases there was no documentation to identify that BM had been considered but not clinically indicated' and asked* whether there was insufficient documentation or BM wasn't clinically indicated. Simon explained the PEN team had been given the ability to use clinical judgement but had not documented the reasons why BM wasn't required. Ellie Monkhouse felt the 'ask' may need to be restructured as the PEN team are not managed by Simon. Fiona asked whether the committee felt assured that monitoring could move from quarterly to 6 monthly/annual review of process. Kate Wood suggested information was shared via the Medicine highlight report at QGG; the Committee supported this approach.

Simon Buckley left the meeting at 10.34am

046/23 Nursing Assurance Report

Ellie Monkhouse referred to the document distributed which was taken as read and highlighted the key points. Escalation areas remained open during December with day surgery beds converted into inpatient beds and use of the discharge lounge. PALS numbers are at the lowest level for some time. Going forward the funding for the additional roles which has had a significant impact in PALS will cease at the end of March which is a potential risk.

Ellie explained the fill rates (page 6) showed the overall Trust position and does not reflect the difficulties in maintaining shift fill rates through the escalation beds. The 'over fill' rate areas have continuous escalation beds or have converted from a medical to surgical i.e., ward 5 being funded for 12 beds but has had 22 beds open for the last 2 years.

Fiona Osborne asked what the mitigation was around mixed sex breaches or whether there were restrictions were due to the estate. Ellie explained the estate was not an issue and that mixed sex breaches were caused when patients who are deemed medically fit to leave the critical care setting and cannot be repatriated to Wards due to operational pressures. Shaun Stacey added mixed sex breaches were flagged at every ops meeting and are a priority for site managers.

Fiona Osborne referred to the annual establishment review and asked if the full complement of nursing staff were in place would the Trust be in a position to have the right skill sets and numbers to cope with higher dependency. Ellie explained the staffing model created some flexibility to manage patients needing more cognitive input and the number of patients with multiple conditions was also increasing. Ellie added that managing unplanned care was extremely complex and the purpose of improving establishments was to allow flexibility and reduce the need for bank and agency use. Work is also ongoing to review bed provision and a further staffing review will be undertaken. Fiona felt it was important the committee monitored the staffing position going forward. Ellie felt the changes in nursing practices and standards were due to wards being staffed appropriately.

Ellie shared concern that clinical teams are increasingly being expected to do non-clinical tasks which was raised as a theme in the establishment reviews and clinical hours are being taken away due to staff completing other tasks. Fiona shared Ellie's concern and felt this should be raised at Board level via the highlight report and to request an assessment and review of non-clinical tasks. The Committee Ellie added that data was available to support this and will be included in the establishment review report. Shaun Stacey added admin staff i.e. ward clerks were removed during the admin review in 2014. Discharge is carried out by junior doctors and takes approx. 2 hours to discharge a patient. A physician assistant role that would support with these tasks has been considered but not developed further. Shaun added there were pressures in both medicine and nursing and a £750k investment was needed in the physician assistant/ward clerks' roles which would need to be available 24 hours a day, 7 days a week. Another issue is that some digital systems are not linked creating additional administrative workload. Kate Truscott supported Ellie and Shaun's comments and felt supporting clinical teams would be a sound investment.

Fiona Osborne asked Ellie if data quality was an issue in terms of the Nursing Assurance Report and whether a different timeframe was possible i.e. one month behind. Ellie added significant progress had been made to maintain the level of data presented in the report and there were challenges in obtaining some of the data.

Action: Fiona and Kate Truscott will raise data collection with the NEDs in particular the Nursing Assurance Report, IPR, End of Life and sepsis.

047/23 IPR

Kate Wood & Ellie Monkhouse referred to the paper distributed which was taken as read. Kate Wood explained the SHMI continued to be the as expected range. VTE assessment targets continue to be met; Kate added the sustainability of the changes that have been should be recognised. In relation to issues around MPSA alerts (insulin leakage) Kate did not feel assured the evidence was in place and therefore the alert wasn't signed off. Changes in processes have now been put in place in Divisions. Kate added the out of hospital SHMI referred to patients dying within 30 days of discharge from hospital i.e., those having end of life provided in an alternative place. Fiona Osborne asked if patients supported to die at home would impact the out of hospital SHMI. Kate explained work was underway to ensure the correct pathways were in place to prevent end of life patients coming into the hospital and earlier recognition of patients was also needed.

Ian Reekie asked whether the ambulance service had access to the EPAC system. Kate Wood was unable to provide this information but will seek a response.

Post Meeting Note

Following Ian Reekie's query Kate Wood checked and the ambulance crews can access EPACs but only by specifically asking the control room to gain access – so not a straightforward means of viewing it. However, the Respect form is held by the individual patient within their own home, and so is an excellent means of communication between health care providers.

Ellie Monkhouse added the Trust remained at 19 *C.Diff* cases against a trajectory of 21. Kate Truscott highlighted the work of the IPC team had done towards achieving the target especially during the challenging winter months. The Committee agreed to highlight to the Board the potential that the C. Diff target would be missed.

048/23 Quality Priorities & Quality Account

Richard Dickinson referred to the report distributed which was taken as read. Richard acknowledged the work Ryan Sutton and Fiona Moore to pull together the new report. The quality improvement workshop was well attended with good engagement. Fiona Moore has had a number of meetings since the QI event to finalise the outputs. The team are reviewing QI methodology and are being supported by the QI team to collate the information. Richard's team are now identifying ways to collect data to provide the outcome measures and enable automated/electronic process measures to reduce the burden on manual data collection. Richard added the paper summarised the progress to date.

Kate Wood acknowledged the stakeholder engagement but added the data that is collect needed to be meaningful and deliver the required change. Kate felt the communication with patients quality priority could be moved to next year and use the year to agree how this can be measured differently. Discharge and flow priorities are also monitored elsewhere (i.e., Finance and Performance Committee) and having a quality priority will not deliver any additional benefits to the Trust.

Kate Truscott asked which stakeholders attended the QI workshop. Richard confirmed there had been engagement from the End of Life team (Donna Smith, Dr Yousef), Deteriorating Patients & Sepsis group, Information Team, Medicine Safety team and Jo Loughborough. Kate Wood confirmed that the Governors and patient forms/reps have also been involved previously. Ellie Monkhouse added that FFT (Friends & Family Test) was not a good measure of how the Trust communicated with patients and the communication quality priority wasn't clear and needed further defining. Ellie explained there were complexities of using FFT as a benchmarking tool as it provided feedback rather than communication. There are ongoing procurement issues relating to FFT which may also impact on achieving this priority. Another issue is resource as there is no capacity available to manage FFT. Ellie felt this priority should be considered for 2024. Fiona Osborne asked Richard Dickinson to progress Ellie's suggestions as actions.

Ian Reekie asked where the quality priorities were signed off and felt communication should remain on the list and featured in most patient concerns. Ian asked for consideration to be given for potential measures to be put in place. Ellie

Monkhouse added communication was a priority but the concern was around how it was measured; there would also need to be a way of measuring improved communication. It was agreed to keep communication as a quality priority noting that measurement is not clearly defined.

Action: Richard Dickinson to progress suggestions around improved communication measurement

Fiona Osborne highlighted that recommendations from the QI workshop focussed on data improvements/digital strategy developments and asked how this work would be progressed as the digital strategy plan currently takes up majority of digital resource in the organisation. Kate Wood explained the Information Team were part of the discussions and integral to the process and further discussions would be needed with digital colleagues.

049/23 Key SI update including Maternity

Richard Dickinson referred to the report distributed which was taken as read and highlighted the key points. There were 6 SI's in maternity services and no further change from the previous reporting period. Further SI's in the report included the never event, paediatric medication error and audiology case work. There was nothing further to highlight.

050/23 CLIP Report

Richard Dickinson referred to the report distributed which was taken as read and highlighted the key points. Page 3 of the report showed a clear summary of the themes. Going forward Richard will be exploring alternative ways to provide meaningful information i.e. some themes can be one off event where themes usually occur more regularly. Fiona Osborne added the previous report listed items of limited assurance and asked Richard to include progress on these items for the next meeting's report. Richard gave the following updates

- TPN – 3 audits completed during 2015/16, 2018/19 & 2020/21 with moderate levels of assurance. The model used illustrates the systems and processes in place. During 2018/19 a nutritional support team was developed led by Martin Gough and Melanie Sharp. Focussed case review are now in place rather than specified audits. There are no ongoing concerns.
- GI bleed/Blatchford score – the score has now been included on the Symphony system and will be audited in due course. Work around fluid balance and weight management is ongoing. The results from the recent fluid balance are being collated.

051/23 CQC Framework

Belle Baron-Medlam referred to the paper distributed which was taken as read and gave a brief overview of the changes since the previous report. There had been good engagement from Divisions during a review of the 2019 & 2022 of actions. Referring to the CQC actions progress report, Belle explained there were approx. 116 actions with some actions needing splitting down further. Assurance papers will be circulated to the Executive Team for sign off in March.

Anabelle Baron-Medlam left the meeting at 11.11am

052/23 Potential Deviations from National Documentation

Richard Dickinson advised there were not any deviations to discuss

053/23 PSIRF update

Richard Dickinson referred to the report distributed which was taken as read and summarised the key points. The terms of reference were approved at QGG and the first meeting of the implementation group was held on 27 February. The group were briefed about the plan and were asked for reflections and taking the plan forward. Most of the elements in phase one should be reached before the next meeting.

Fiona Osborne added HSIB training was proposed for investigative training with a budget of £9k although HSIB is free. Richard confirmed HSIB was the preferred option and the issues were around access and capacity to do the training. Those needing investigator training will require more focus and time. Fiona asked if there were concerns getting the right people to attend the meetings – Richard confirmed attendance was good and was hopeful it would continue. Richard accepted there were resource challenges but it was important to ensure the system works going forward and will learn from other organisations. Divisions will need to ensure time is made available to spend on training and it is anticipated investigations will be less time consuming. Shaun Stacey added that Divisions need to release people to undertake the training. In addition, there will need to be mutual support for staff once training has been completed.

Highlight reports

054/23 Quality Governance Group (QGG)

The highlight report was distributed and taken as read.

055/23 Mortality Improvement Group (MIG)

The highlight report was distributed and taken as read.

056/23 Patient Safety Champions Group (PSC)

The highlight report was distributed and taken as read.

Items for information

057/23 Quality Governance Group (QGG) minutes

Distributed for information.

058/23 Mortality Improvement Group (MIG) minutes

Distributed for information.

059/23 Patient Safety Champions group (PSC) minutes

Distributed for information.

060/23 Any Other Business

None raised.

061/23 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.

- QI event for End of Life
- Non-clinical tasks being completed by clinical staff and appropriateness
- Sustainability of changes for SHMI
- *C.Diff*

062/23 Meeting review

N/A

063/23 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 28th March 2023
Time: 1.30pm – 4pm
Venue: Virtual via MS Teams

The meeting closed at 11.27am

Annual Attendance Details:

Name	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023
Michael Proctor	x	✓	✓	✓	✓	✓	✓							
Michael Whitworth														
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Maneesh Singh	✓	✓	✓	✓	✓	✓	x	✓						
Dr Kate Wood	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	
Ellie Monkhouse	✓	✓	✓	✓	✓	x	✓	x	✓	x	✓	✓	✓	
Dr Peter Reading	✓	✓	x	✓	✓	✓	x	x	x	x	✓	✓	x	
Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓						
Jennifer Granger								✓	✓	✓	✓	✓		
Richard Dickinson												✓	✓	
Helen Harris	x	x	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	✓	
Susan Liburd									✓	✓	✓	x	x	
Kate Truscott									✓	✓	✓	✓	✓	

NLG(23)069

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 4 April 2023
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jenny Hinchliffe, Deputy Chief Nurse Melanie Sharp, Deputy Chief Nurse
Title of the Report	**Nursing & Midwifery 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 8.6 in January. The latest model hospital data indicates a provider value of 7.8 (quartile 2 mid-low 25%) against a peer median of 8.2 and provider median of 8.0. There is the continued clinical requirement to open escalation beds, including the use of the day surgery wards during January. The midwife to birth ratio was 25.4 at DPoW and 21.6 at SGH 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. There is a total of 202.72 WTE (10.87%) registered and 106.77WTE (11.02%) unregistered nursing vacancies across the Trust. 170.4WTE of these are on inpatient wards. Recruitment and retention work remain a priority. The total number of falls reported in January 2023 has decreased for the third consecutive month. The number of pressure ulcer incidents reported in January 2023 has increased and the same increase has been seen in January for the last three years suggesting a seasonal variation. New formal complaint numbers rose in January to 29 with a 24% increase in open complaints. The reduction in complaints over 60 working days continues. Trust wide the number of new PALs concerns received increased to 165. Open PALS still maintained a positive low position of 46. 161 PALs concerns were closed in January. January saw the seasonal reduction in patient feedback and a slight reduction in the overall organisational FFT response rate, 89% of those respondents rated they would recommend the Trust. In January the Trust had 9 mix sex breaches which involved 2 patients. Five 15 Steps Challenge visits and one mock assurance visit were completed during January 2023. Some visits were paused in January due to increased pressures to enable all staff to support clinically.

	The Trust has reported 20 C.difficile onset cases since 1st April with a trajectory of 21. The Trust is performing very well compared to peer trusts. We have exceeded the number for Pseudomonas aeruginosa with a total of 12 cases with the threshold being 7. Winter has proven 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. There are various QI projects in progress across the Trust. In focus this month are Improving Pain assessment and reassessment, Reducing Thermoregulation of new-born babies and improving how we care for patients in their End of Life.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	✓ Divisional SMT ✓ Other: QSC
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

Northern Lincolnshire and Goole NHS Foundation Trust

Nursing & Midwifery Assurance Report March 2023

(January 2023 data)

Contents

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 sign-off by the Chief Nurse prior to additional wards being opened.

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.

Overall Fill Rate by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jan 2023	DPoW	100.2%	10.6%	89.6%	
Jan 2023	GDH	94.9%	8.7%	86.3%	
Jan 2023	SGH	99.5%	6.7%	92.8%	

Overall Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jan 2023	Medicine	101.4%	8.8%	92.6%	
Jan 2023	Surgery & Critical Care	99.6%	8.6%	91.0%	
Jan 2023	Women & Children's	94.9%	9.4%	85.5%	

Actual 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 9am.

The Chief Nurse inpatient establishment review has been undertaken for 2022 and the report is being completed. The Safer Nursing Care Tool (SNCT) data was collected during May/June 2022 following the increase in establishments and collected again 20 days during October/ November to account for seasonal variation. Meetings have been held with ward and department managers to review the SNCT data and nurse sensitive indicators.

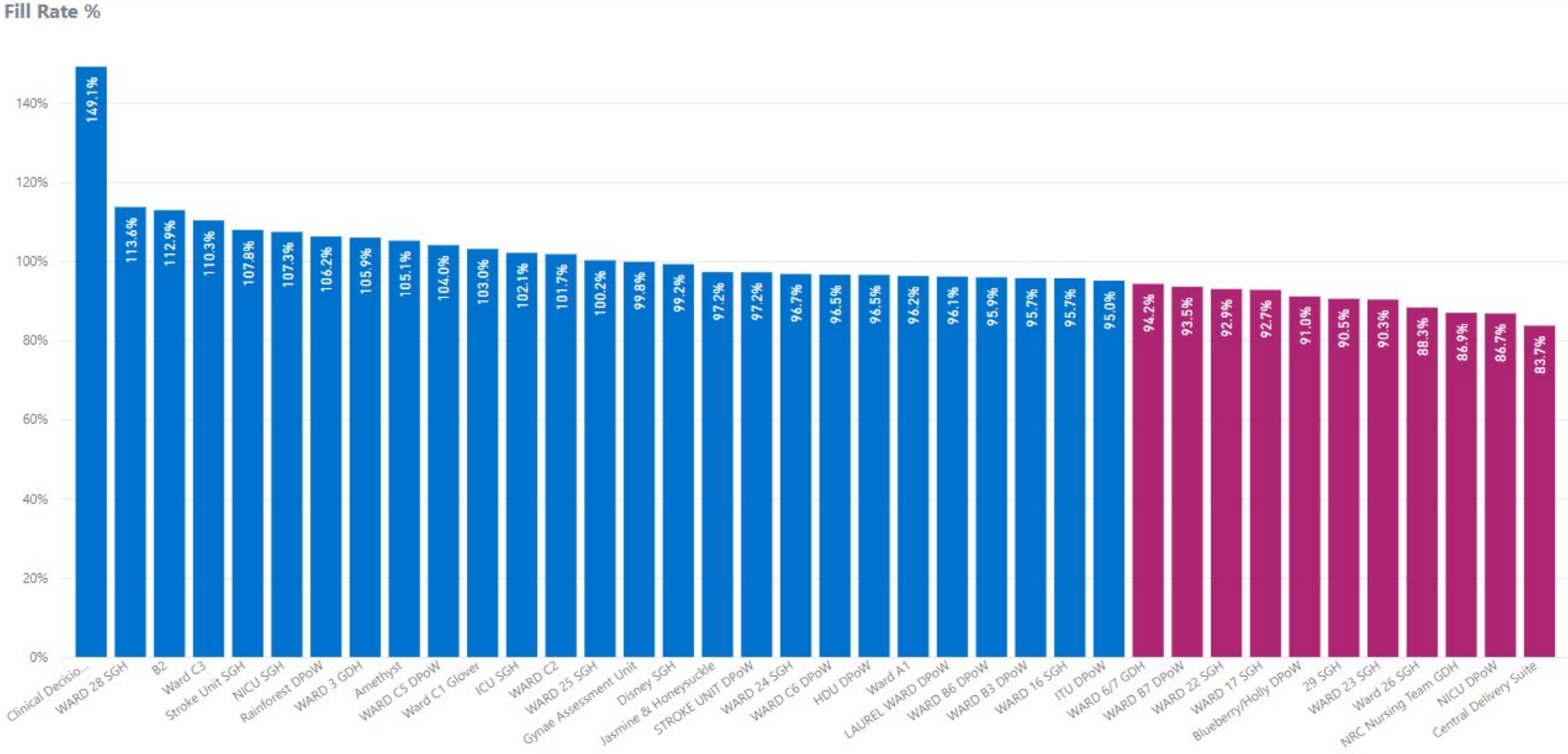
The graphs above show the fill rate trends from the Nursing Assurance Dashboard for inpatient wards. The combined fill rate shows some variance from month to month, in January being 99.6%.

The overall fill rate for each ward varies from 83.7% to 149.1% (see chart below). Some of this high fill rate can be attributed to those wards that have unestablished escalation beds, in particular the Clinical Decision Unit (ward 5) which is funded for 12 beds but has had 22 beds open for the last 2 years. Additional shifts are created to staff escalation beds which are filled by temporary staff. This impacts on the overall fill rates and does not provide a true picture. Additional shifts created for 1:1 supportive care requirement will also be contributing to the care staff fill rate. Work is underway with informatics to ensure planned hours and therefore fill rate are reported accurately.

Fill Rate Wards Chart Jan 2023

Site: All | Division: All

Northern Lincolnshire and Goole NHS Foundation Trust

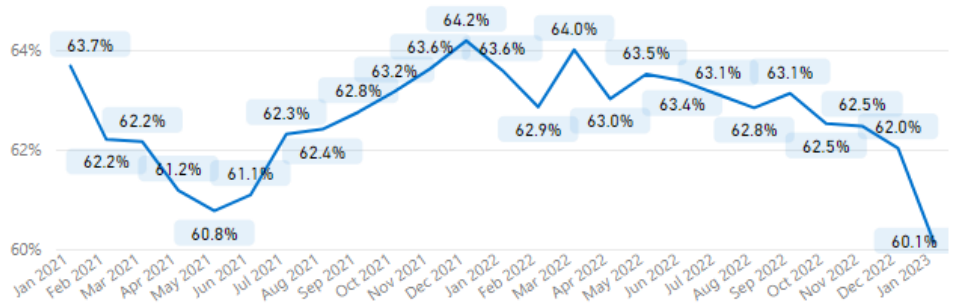


RNMW Ratio Summary Jan 2023

RNMW Ratio

60.1% ▼ -1.9%

RNMW Ratio



RNMW Ratio by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jan 2023	DPoW	58.4%	-1.5%	59.9%	
Jan 2023	GDH	54.6%	-1.6%	56.2%	
Jan 2023	SGH	62.9%	-2.4%	65.4%	

RNMW Ratio by Division

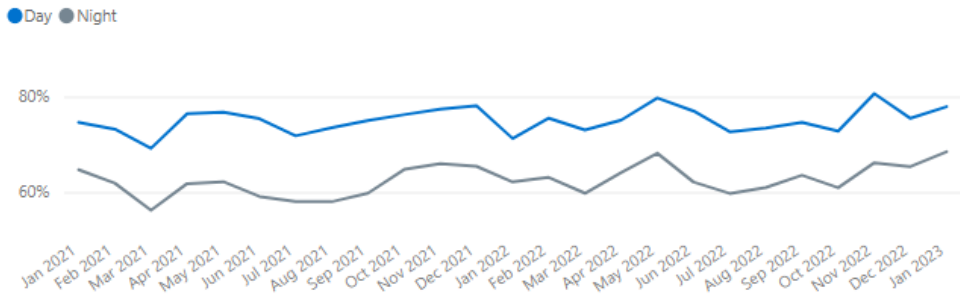
Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jan 2023	Medicine	53.7%	-2.3%	56.0%	
Jan 2023	Surgery & Critical Care	68.9%	-2.2%	71.0%	
Jan 2023	Women & Children's	67.3%	-0.5%	67.8%	

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 January at 53.7%. Surgery & Critical Care has the highest RN ratio and is reflective of the number of level 2 and 3 beds within the division.

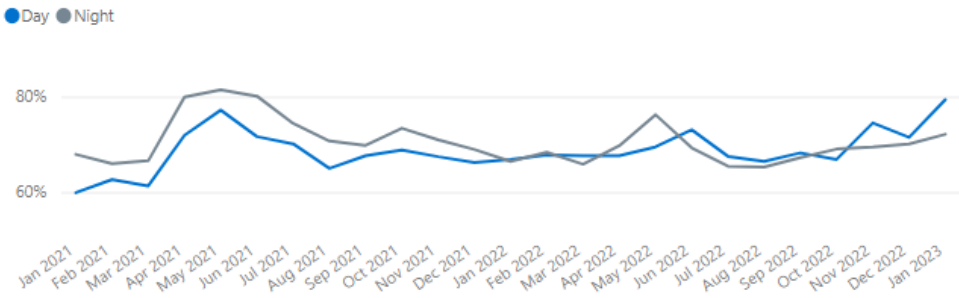
Substantive Fill Rates Summary Jan 2023

RNMW - Day	RNMW - Night	Care Staff - Day	Care Staff - Night
77.9% ▲ 2.4%	68.5% ▲ 3.1%	79.4% ▲ 7.9%	72.1% ▲ 2.0%

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
Jan 2023	DPoW	79.0%	3.0%	76.0%	
Jan 2023	GDH	76.0%	15.4%	60.6%	
Jan 2023	SGH	76.8%	0.2%	76.6%	

RNMW - Day Substantive Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jan 2023	Medicine	77.7%	2.4%	75.2%	
Jan 2023	Surgery & Critical Care	79.8%	-2.3%	82.1%	
Jan 2023	Women & Children's	75.9%	8.3%	67.6%	

Wards with Substantive Fill Rate Below 50% **Jan 2023**

Staff	Registered Nurses and Midwives	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
Central Delivery Suite	32.8%	▼ -42.3%

Staff	Registered Nurses and Midwives	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD C5 DPoW	41.9%	▼ -2.2%
Ward A1	40.3%	▼ -31.2%
Central Delivery Suite	40.1%	▼ -32.4%
WARD 17 SGH	34.8%	▼ -0.7%
LAUREL WARD DPoW	32.5%	▼ -35.4%

Staff
Day or Night
Ward name

Staff	Care Staff	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD 25 SGH	46.8%	▲ 3.2%
NRC Nursing Team GDH	37.4%	▼ -28.7%
ITU DPoW	29.0%	▼ -3.2%
WARD 23 SGH	17.2%	▼ -35.5%

Substantive versus temporary staff fill rate is monitored and an increase in substantive staff fill rate is seen for days and nights in January for all staff. This is because of the active recruitment that has taken place for both registered nurses and healthcare support workers.

Central Delivery Suite had a substantive fill rate less than 50% on days.

On night shifts there were 5 wards with a fill rate less than 50% for RNs which is a decrease from the10 wards in December 2022.

Of the 5 wards that had RN substantive fill rate less 50%, only 2 of these feature in last month's report and are contained in the table below to triangulate with sickness and vacancy. None are raising concerns when triangulated with quality and safety data, however ward 17 is being monitored due to high sickness absence and poor skill mix. A new Ward Manager has recently commenced in post.

The information below demonstrates the level of sickness and vacancy in the areas with the lowest substantive fill rate.

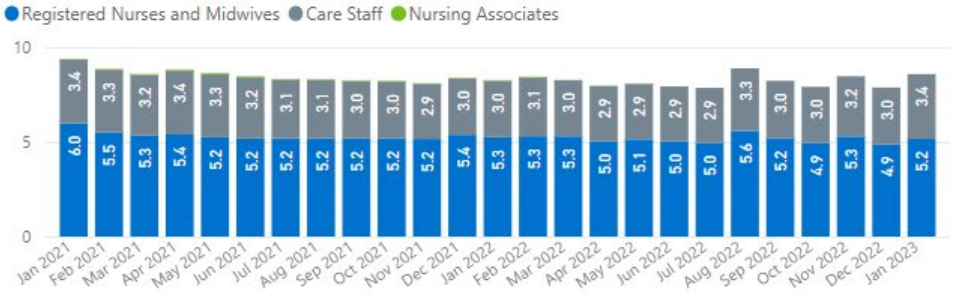
Ward	Sickness	RN vacancy wte	HCA vacancy wte
Ward C5	7.45%	1.08	1.66
Ward 17 SGH	12.61%	7.97	1.09

CHPPD Summary Jan 2023

Overall	Registered Nurse...	Care Staff
8.6 ▲ 0.71	5.2 ▲ 0.28	3.4 ▲ 0.43

Overall CHPPD

CHPPD by Staff Group



CHPPD by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jan 2023	DPoW	9.0	1.1	7.9	
Jan 2023	GDH	7.2	0.7	6.5	
Jan 2023	SGH	8.3	0.3	8.0	

CHPPD by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jan 2023	Medicine	7.5	0.7	6.8	
Jan 2023	Surgery & Critical Care	9.5	0.6	8.9	
Jan 2023	Women & Children's	12.3	0.9	11.5	

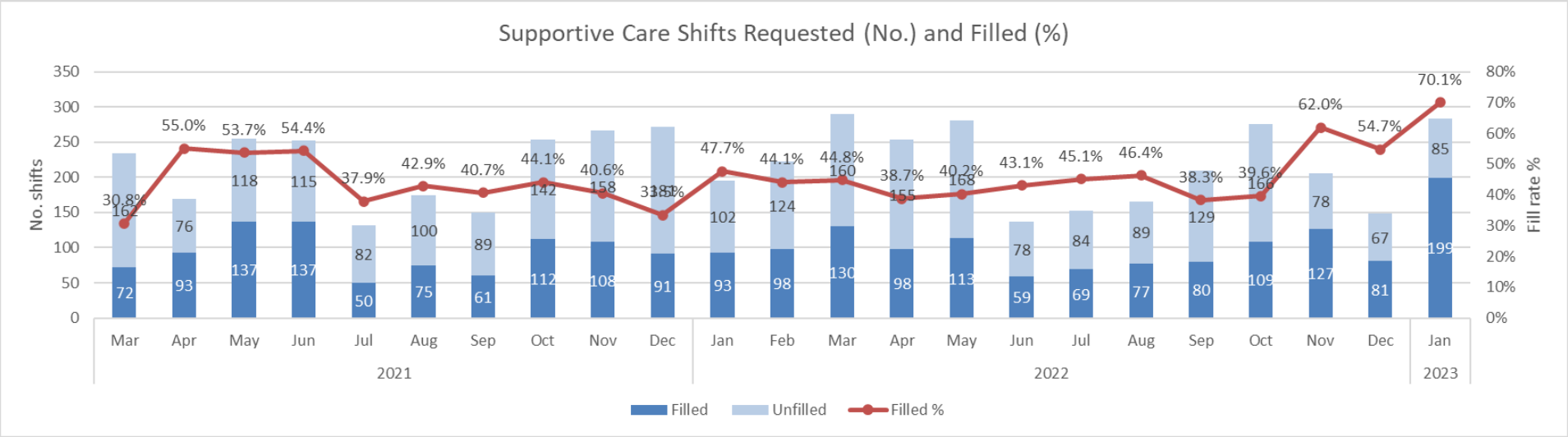
Wards with CHPPD Below 6.0 **Jan 2023**

Staff	Registered Nurses and Midwives		Care Staff		Nursing Associates		**Total**	
Ward name	CHPPD	Change	CHPPD	Change	CHPPD	Change	**CHPPD**	**Change**
WARD 3 GDH	3.4	▲ 0.04	2.6	▲ 0.09	0.0		**5.9**	**▲ 0.12**
WARD 22 SGH	3.1	▼ -0.09	2.7	▲ 0.31	0.0		**5.8**	**▲ 0.22**
WARD B4 DPoW	1.9	▲ 1.95	1.2	▲ 1.23	0.0		**3.2**	**▲ 3.18**
Ward 19	0.0		0.0		0.0		**0.0**	

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 overall CHPPD was 8.6 in January.The latest model hospital data for December 2022 indicates a provider value of 7.8 (quartile 2 mid-low 25%) against a peer median of 8.2 and provider median of 8.0.

2.2 Supportive Care



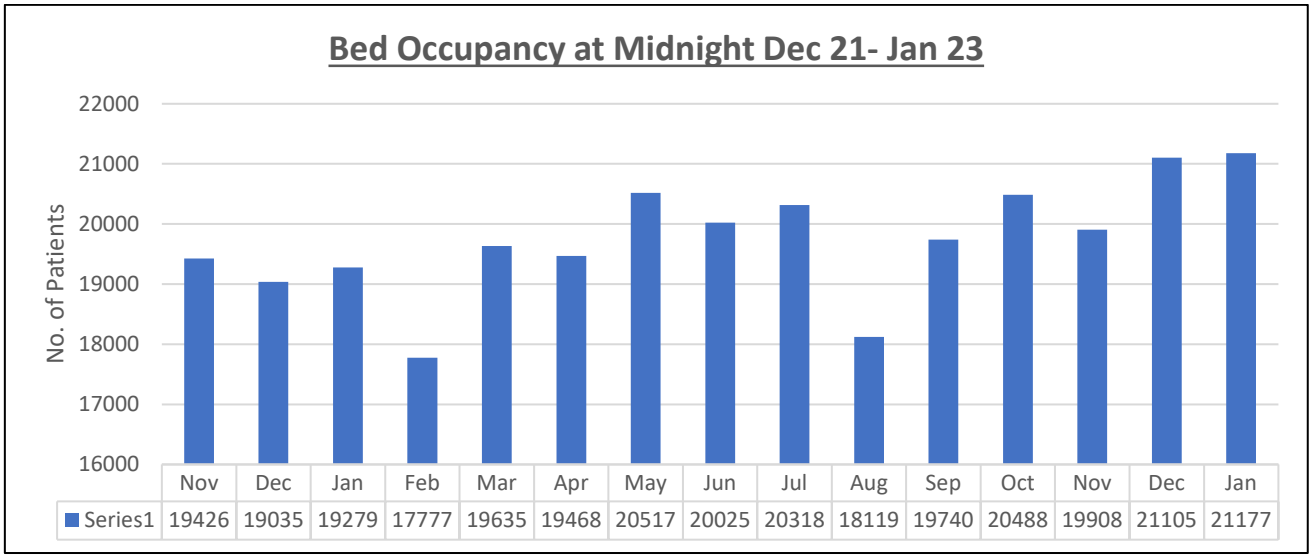
The wards are seeing an increase in number dependent patients, several which require 1:1 supportive care. These shifts are not part of the ward establishment. Shifts are sent to the temporary staffing team to source unregistered cover via the Bank. Additional processes have been put in place for risk 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 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 shows a substantial increase in the percentage of filled shifts for the last 3 months This is the highest fill rate in the last 18 months and is thought to reflect the active recruitment to substantive and bank healthcare assistants. Recruitment onto the Bank continues, and it is hoped that improvements can be sustained.

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. In addition, Ward B4 and Ward 19, which are both day case surgery wards, have opened escalation beds periodically over December and January.

The graph below shows the monthly bed occupancy at midnight (NB Series 1 = total number of patients occupying a bed at midnight) which was the highest it has been in January since November 2021 and is reflective of the increased use of escalation beds.



2.4 Staffing Indicators

2.4.1 Vacancies

The information presented below shows data on **inpatient wards** only.

Vacancies Summary Jan 2023

Vacancies - Total

170.4 ▼ -1.0

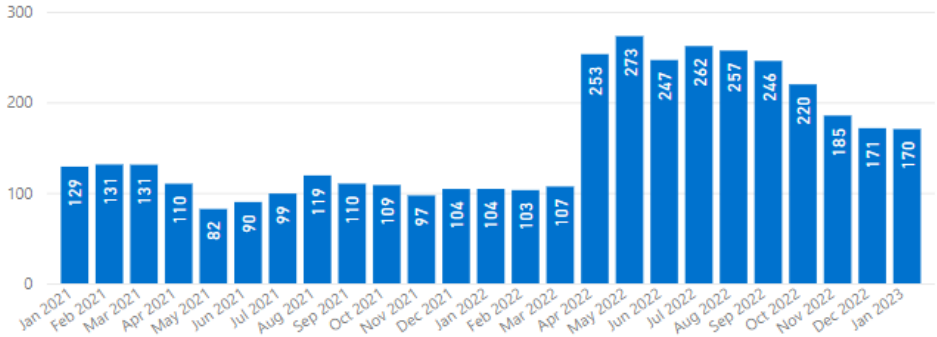
Vacancies - Qualified

107.6 ▼ -4.2

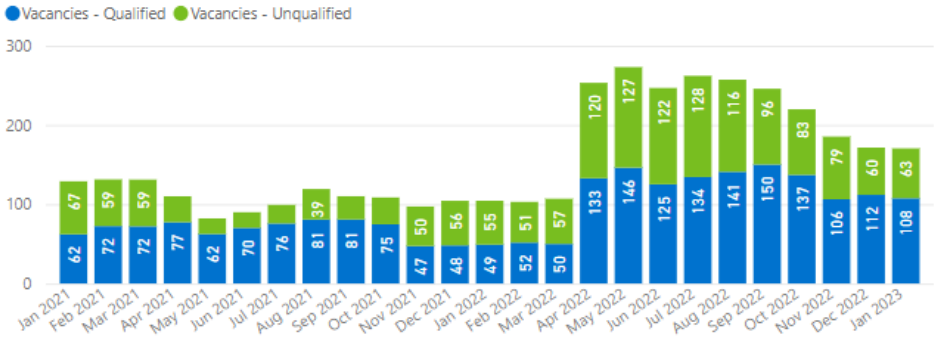
Vacancies - Unqualified

62.9 ▲ 3.2

Vacancies



Vacancies by Staff Group



Vacancies - Qualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jan 2023	DPOW	59.0	-7.1	66.1	
Jan 2023	GDH	10.5	-2.2	12.7	
Jan 2023	SGH	38.1	5.1	33.0	

Vacancies - Qualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jan 2023	Community & Therapies	10.5	-2.2	12.7	
Jan 2023	Family Services	33.1	3.6	29.5	
Jan 2023	Medicine	39.3	0.2	39.1	
Jan 2023	Surgery	24.7	-5.8	30.5	

Vacancies - Unqualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jan 2023	DPOW	27.7	-1.3	29.0	
Jan 2023	GDH	3.6	0.0	3.6	
Jan 2023	SGH	31.5	4.5	27.0	

Vacancies - Unqualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jan 2023	Community & Therapies	3.6	0.0	3.6	
Jan 2023	Family Services	9.8	3.2	6.6	
Jan 2023	Medicine	39.1	3.7	35.3	
Jan 2023	Surgery	10.3	-3.7	14.1	

Vacancies on the inpatient wards in January for Registered Nurses shows a slight decrease and Healthcare Assistants show a slight increase.

There is a total of 202.72 WTE (10.87%) Registered and 106.77WTE (11.02%) Unregistered vacancies across the Trust. A total of 87 newly qualified nurses and midwives commenced in post over the autumn/winter, with a further 20 commencing in January and February. 44 international nurses (INs) have commenced in post over Q3/4.

The overseas Pre-registration nurses who have joined the Trust continue to progress through their OSCE preparation and induction programme with a 100% OSCE pass rate. Funding has been awarded from NHSE to support recruitment of an additional 90 INs between April and November 2023.

A risk associated with the ability to continue to support international nurse recruitment includes Practice Development team capacity to support OSCE prep and induction. Additional risks are accommodation availability and the availability of training rooms for OSCE prep which is resulting in additional costs associated with transporting IENs across sites.

Recruitment continues for the nursing apprenticeship programmes which have proved to be popular:

- Five started on the RNA – RN Top-up programme at the University of Hull in January 2023
- Nine started on the TNA programme at the University of Lincoln in January 2023
- RNDA programme to commence September at the University of Hull

A workforce plan and RN forecast has been developed with finance and workforce colleagues to support recruitment initiatives going forward.

Recruitment work includes:

- Targeted recruitment campaigns with workforce colleagues – community nursing, ED
- Working with workforce colleagues to diversify the IEN pipeline and ensure adequate support for ambitions
- International Midwife recruitment
- Increased engagement with HEIs and introduction of newly qualified nurse rotational posts from Sept 2023 – NQN Open Days and interviews have commenced
- Widening Access Project (NHSE funding for 12 months) – nurse appointed, and work has commenced

Retention work includes:

- Ongoing delivery of career clinics, continued development of the nursing career framework and nursing apprenticeships
- Flexible working team rostering pilot with the Resource Centre team (PIU and Stroke Unit DPoW)
- Legacy mentor project (NHSEI funding) 2023/24 – Legacy Mentor post advertised
- Delivery of the Professional Nurse Advocate programme
- International recruitment stay and thrive work
    - Development of a Stay & Thrive Task & Finish Group with IEN membership
    - Development of Team Channel for IENs
    - Buddy system
    - Updated Ward Manager and Staff Guide
    - Preceptorship Workbook pilot
    - IEN experience survey live
    - Welcome/celebration events
    - Preparation of application for NHS Pastoral Care Quality Award
- Training & development

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
SGH - ICU	0	0	8	▲ 5
DPOW - C2	2	▲ 1	4	▼ -4
DPOW - Maternity	3	▼ -2	1	▼ -1
SGH - Disney	3	0	1	0
SGH - Stroke SGH	3	▲ 3	1	0
SGH - Ward 5	2		2	
DPOW - C3 Short Stay	0	0	3	▲ 2
SGH - Ward 27	0	0	3	▼ -5
DPOW - B3	1	▲ 1	1	0
DPOW - C5	1	▲ 1	1	0
DPOW - NICU DPW	1	0	1	▲ 1
DPOW - Stroke DPW	0	0	2	▼ -7
SGH - NICU SGH	2	▼ -1	0	▼ -2
SGH - Ward 25	0	0	2	▲ 1
SGH - Ward 28	1	▼ -1	1	▼ -7
DPOW - C1 Glover	0	0	1	▲ 1
DPOW - ITU	1	0	0	▼ -1
GDH - GNRC	0	▼ -1	1	▲ 1

20 nurse staffing incidents were reported in January 2023 on the Ulysses system compared to 33 in December 2022.

2.4.3 Red Flags

A total of 33 staffing red flags were reported in January; 24 reported on Safecare Live and 9 on Ulysses. This was a decrease compared to 74 in December. Some fluctuation is seen month by month. This decrease triangulates with the increased fill rate which was seen in January.

Red Flags on SafeCare Live

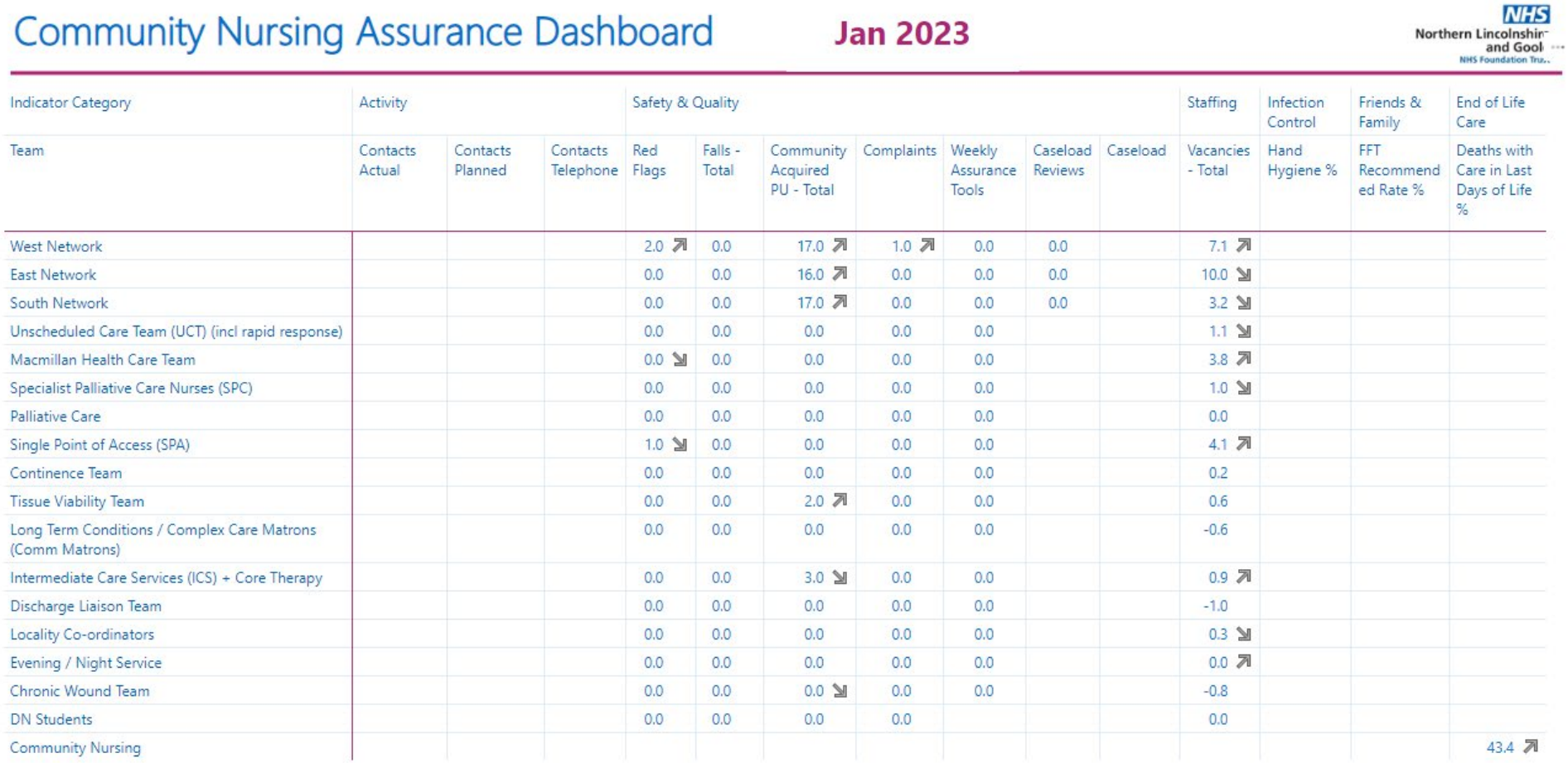
Red Flag type, Ward	No.
Below Safe Staffing Levels	12
Ward 27	3
Stroke DPW	2
C3 Short Stay	2
Ward 25	1
C2	1
NICU DPW	1
C1 Glover	1
GNRC	1
Area outside of normal Footprint	8
ICU	8
Less than 50% substantive staff on shift	4
C2	3
C3 Short Stay	1
Trained Nurse less than 12mths qual left in Charge	1
Ward 25	1

Red Flags on Ulysses

Red Flag type, Ward	No.
Trained nurse less than 12 months qualified, or still i	3
Ward 5	2
B3	1
More than 50% of staff under 12 months qualified	1
C5	1
Below safe staffing levels following escalation	1
Maternity	1
Delay in administration of IV medications by 1 hour t	1
Ward 28	1
Not Completed	1
SDEC DPW	1
Less than 2 trained nurses on a clinical area	1
Stroke SGH	1
Less than 50% substantive staff on a shift	1
Disney	1

3.0 Community Nursing

Activity data not currently available.



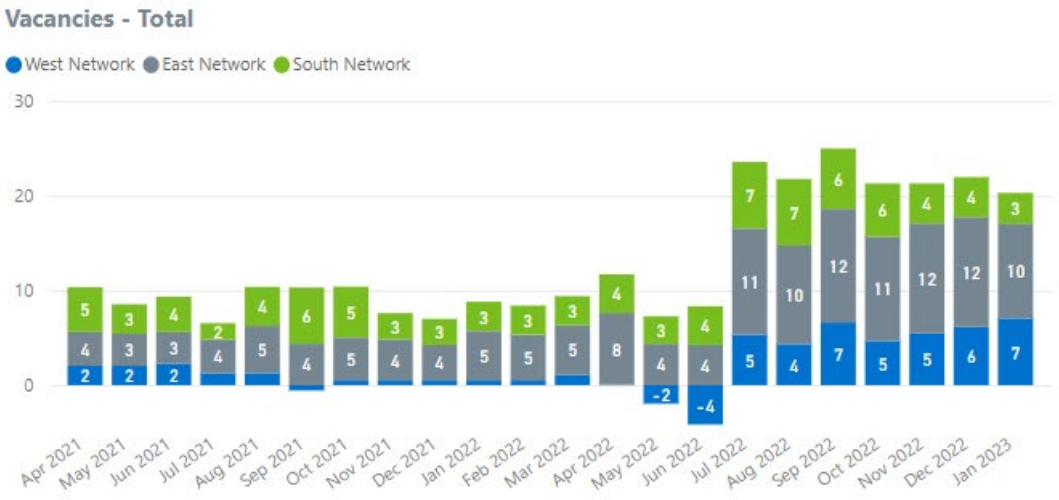
Community Nursing Assurance Dashboard **Jan 2023**

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	17.0 ↗	1.0 ↗	0.0	0.0		7.1 ↗			
East Network				0.0	0.0	16.0 ↗	0.0	0.0	0.0		10.0 ↘			
South Network				0.0	0.0	17.0 ↗	0.0	0.0	0.0		3.2 ↘			
Unscheduled Care Team (UCT) (incl rapid response)				0.0	0.0	0.0	0.0	0.0			1.1 ↘			
Macmillan Health Care Team				0.0 ↘	0.0	0.0	0.0	0.0			3.8 ↗			
Specialist Palliative Care Nurses (SPC)				0.0	0.0	0.0	0.0	0.0			1.0 ↘			
Palliative Care				0.0	0.0	0.0	0.0	0.0			0.0			
Single Point of Access (SPA)				1.0 ↘	0.0	0.0	0.0	0.0			4.1 ↗			
Continence Team				0.0	0.0	0.0	0.0	0.0			0.2			
Tissue Viability Team				0.0	0.0	2.0 ↗	0.0	0.0			0.6			
Long Term Conditions / Complex Care Matrons (Comm Matrons)				0.0	0.0	0.0	0.0	0.0			-0.6			
Intermediate Care Services (ICS) + Core Therapy				0.0	0.0	3.0 ↘	0.0	0.0			0.9 ↗			
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			0.3 ↘			
Evening / Night Service				0.0	0.0	0.0	0.0	0.0			0.0 ↗			
Chronic Wound Team				0.0	0.0	0.0 ↘	0.0	0.0			-0.8			
DN Students				0.0	0.0	0.0	0.0				0.0			
Community Nursing														43.4 ↗

3.1 Community Nursing Workforce

3.1.1 Safe Staffing



3.2 Vacancies

Staffing capacity is an ongoing issue with work being undertaken to recruit to vacancies and retain existing staff and new starters, particularly in community nursing where the largest number of unfilled posts remain. The vacancy position within the community networks links to risk 2921 on the risk register. A slight decrease overall in our vacancies for January 2023 has been seen.

In the community nursing networks the vacancies are split as below. There have been some changes due to realignment of caseloads. Ongoing recruitment continues for band 5 nurses along with discussions with staff about career progression.

Vacancy and pipeline

Team	Update and actions	Current position
EAST	Recruited to Band 5 0.8 wte. Experienced community nurse already held discussions re progression pathway to DN. Band 7 vacancy to be filled by Sept 23.	
SOUTH	Daily staffing position for capacity and demand has been met on occasion, positive way forward.	
WEST	Recruited to 1 wte Band 5 experienced community nurse, again good discussion re development pathway to DN. Recruited to bank Band 3 for training re upcoming vacancy option.	

EAST

	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	21.71	13.53	8.18	38%	0.8	1	8.38	39%
B4	6.78	6.8	-0.02	0%	0	0	-0.02	0%
B3	2.73	3	-0.27	-10%	0	0	0	0%

SOUTH

	Est WTE	In post	Shortfall	Vacancy %	Due In	Leavers	Forecast	Vacancy %
B7	2	2	0	0%	0	0	0	0%
B6	6.6	3.8	2.8	42%	0	0	2.8	42%
B5	23.71	22.13	6	25%	0	0	0	0%
B4	6.78	6.6	0.18	3%	0	0	0	0%
B3	2.73	2.73	0	0%	0	0	0	0%

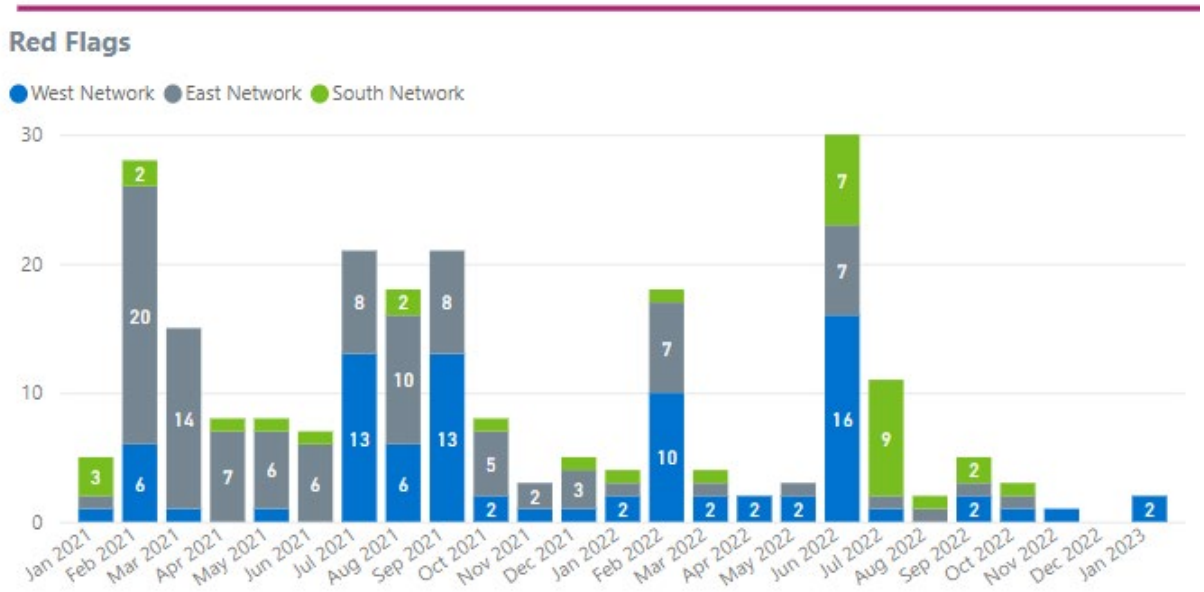
WEST

	Est WTE	In post	Shortfall	Vacancy %	Due In	Leavers	Forecast	Vacancy %
B7	1	1	0	0%	0	0	0	0%
B6	3.8	3.6	0.2	5%	0	0	0.2	5%
B5	22.75	18.8	3.95	17%	0	0	3.95	17%
B4	6.78	5	1.78	26%	0	0	0	0%
B3	2.73	2.73	0	0%	0	0	0	0%

The vacancies in Single Point of Access 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 all been recruited to with 2wte commenced in post and 1wte to commence in April 2023.

3.3 Community Nursing Red Flag incidents



The total nursing red flag incidents for January 2023 is two, both reported by West Network. One of these relate to a shortfall in nurse staffing, although this is not reflective of the more frequent workforce challenges in Community Nursing.

3.4 Activity

There is limited activity information for January 2023 due to the BlueFish reporting contract ending.

3.4.1 Activity not delivered - Community Nursing Networks

Information from the electronic allocation tool shows a slight improvement in the position of visits deferred from planned date in January 2023. It is also important to note the significant increase in the visits allocated in January 2203 and the number of visits completed in comparison to December 2022.

Visits Allocated Dec 22	Visits Completed Dec 22	Visits Deferred Dec 22
12414	11188	1226
	90.13%	9.87%

Visits Allocated Jan 23	Visits Completed Jan 23	Visits Deferred Jan 23
13868	12621	1227
	91.0%	8.99%

3.5 Community Nursing Capacity

What have we done?

- Efficient allocation now achieved with improved data quality
- Minimum rostered and actual staffing levels being monitored weekly with monthly ACN oversight
- Demand being proactively managed within limits of daily capacity to proactively reprioritise visits over 7 days
- Safe staffing SoP in place and being managed through weekly and monthly meetings
- Demand being proactively managed to within limits of capacity
- Sickness has impacted on OPEL 3 escalations and unallocated visits
- CNSST training underway ahead of consensus week to take place in the next 2 months which will underpin next establishment reviews

So what?

- Red flags remain static
- Staff feel that workload is being more appropriately allocated
- Reduction in PALs & complaints associated with missed visits and communication since October 2022
- Good patient feedback through 15 steps and leadership engagement

What next?

- Roster approval processes / confirm and challenge to be held monthly to ensure appropriate action is taken to mitigate risk in the event of unsafe staffing levels
- 75% of staff have completed CNSST training ahead of consensus week to take place in March 2023 which will underpin next establishment reviews
- QI project to combine DN Hub & SPA into a True SPA with dedicated resource underway which will enable District Nurses to focus on oversight and review of their caseloads
- QI project to improve referral in process
- Divisional Community Nursing priorities reflective of National Community Nursing Plan

4.0 Maternity Dashboard and Red Flag Incidents

4.1 Maternity Staffing

The Chief Nurse undertook a desktop review with ward managers at the end of May 2022 and an establishment review using the Birthrate Plus workforce planning tool has been undertaken and the final report presented to TMB in November. The Trust is compliant with Birthrate Plus calculations with a positive variance of 2.55wte.

4.2 Maternity Fill Rates and CHPPD

Maternity Wards Fill Rates and CHPPD Jan 2023

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**91.0%**	**▼ -1.1%**	**77.6%**	**▼ -5.8%**	**12.2**	**▼ -2.10**
Registered Nurses and Midwives	90.6%	▼ -1.5%	76.1%	▼ -9.3%	7.7	▼ -1.37
Care Staff	91.8%	▼ -0.4%	80.3%	▲ 0.4%	4.5	▼ -0.73
Central Delivery Suite	**83.7%**	**▲ 5.8%**	**46.0%**	**▼ -26.6%**	**33.5**	**▲ 3.63**
Registered Nurses and Midwives	81.0%	▲ 3.0%	36.4%	▼ -37.4%	26.1	▲ 2.03
Care Staff	94.8%	▲ 17.2%	85.4%	▲ 17.7%	7.4	▲ 1.60
Jasmine & Honeysuckle	**97.2%**	**▲ 10.6%**	**79.3%**	**▲ 9.2%**	**13.0**	**▲ 3.42**
Registered Nurses and Midwives	95.5%	▲ 9.8%	79.2%	▲ 10.5%	8.6	▲ 2.21
Care Staff	100.6%	▲ 12.3%	79.6%	▲ 6.6%	4.4	▲ 1.20
Ward 26 SGH	**88.3%**	**▲ 7.6%**	**66.1%**	**▲ 13.4%**	**7.0**	**▼ -0.19**
Registered Nurses and Midwives	86.6%	▲ 7.0%	62.1%	▲ 9.3%	5.0	▼ -0.16
Care Staff	92.7%	▲ 9.1%	76.8%	▲ 24.4%	2.0	▼ -0.03
Total	**90.4%**	**▲ 5.5%**	**68.4%**	**▼ -2.3%**	**12.1**	**▲ 0.51**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	63.4%	▼ -0.3%
Central Delivery Suite	77.9%	▼ -2.7%
Jasmine & Honeysuckle	66.2%	▼ -0.5%
Ward 26 SGH	71.7%	▼ -0.4%
Total	**69.0%**	**▼ -0.7%**

The fill rate in maternity remains <95% except on Jasmine & Honeysuckle ward. Staffing shortfalls have been experienced across both sites and in the community due to sickness absence 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 09.00hour 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. The first four international midwives will join the Trust in March 2023.

4.3 Midwife: Birth ratio

Assurance that safety was maintained within the maternity units is supported by the Midwife to Birth ratio data. In January 2023 the data for both units is DPOW 25.4 and SGH 21.6 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 January 2023. 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	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
Midwife to Birth Ratio	24.9 ↗	24.0 ↘	23.9 ↘	24.9 ↗	24.8 ↘	26.5 ↗	26.5	25.6 ↘	25.5 ↘	23.3 ↘	24.8 ↗	
Red Flags	12.0 ↗	6.0 ↘	11.0 ↗	2.0 ↘	2.0	7.0 ↗	9.0 ↗	5.0 ↘	3.0 ↘	3.0	3.0	2.0 ↘
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	3.0 ↗	2.0 ↘	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0	0.0	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)	0.0	1.0 ↗	0.0 ↘	0.0	1.0 ↗	2.0 ↗	0.0 ↘	1.0 ↗	1.0	0.0 ↘	0.0	0.0
(c) Missed medication during an admission to hospital	0.0	0.0	0.0	0.0	0.0	1.0 ↗	0.0 ↘	0.0	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	0.0	0.0	2.0 ↗	2.0	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	1.0 ↗	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 ↗	2.0 ↘	2.0	0.0 ↘	1.0 ↗	2.0 ↗	4.0 ↗	2.0 ↘	0.0 ↘	1.0 ↗	0.0 ↘	1.0 ↗
(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.	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	5.0 ↗	1.0 ↘	9.0 ↗	1.0 ↘	0.0 ↘	0.0	2.0 ↗	2.0	2.0	1.0 ↘	2.0 ↗	1.0 ↘
Continuity of Carer %	24.0 ↗	19.0 ↘	20.0 ↗	21.0 ↗	21.0	23.0 ↗	24.0 ↗	24.0	25.0 ↗			
In Receipt of %	23.0 ↗	9.0 ↘	14.0 ↗	10.0 ↘	15.0 ↗	13.0 ↘	14.0 ↗	15.0 ↗	15.0			
CoC In Receipt of %	83.0 ↗	56.0 ↘	82.0 ↗	79.0 ↘	72.0 ↘	89.0 ↗	72.0 ↘	68.0 ↘	66.0 ↘			
Continuity Team Caseload	334.0 ↘	319.0 ↘	347.0 ↗	314.0 ↘	314.0	305.0 ↘	305.0	295.0 ↘	311.0 ↗			
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	
Actual v Planned Staffing %	91.5 ↘	95.1 ↗	94.0 ↘	91.5 ↘	92.2 ↗	86.0 ↘	86.0	89.0 ↗	89.5 ↗	97.9 ↗	90.1 ↘	
Labour Co-ordinator Supernumerary Status %	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	11.8 ↘	11.2 ↘	19.3 ↗	19.4 ↗	19.1 ↘	20.2 ↗	20.3 ↗	26.3 ↗	20.7 ↘	20.5 ↘	20.1 ↘	22.4 ↗
Vacancies - Registered	10.9 ↗	10.2 ↘	16.4 ↗	17.4 ↗	17.5 ↗	17.7 ↗	17.8 ↗	19.5 ↗	19.1 ↘	16.1 ↘	16.2 ↗	17.9 ↗
Vacancies - Unregistered	0.9 ↘	0.9	2.9 ↗	2.1 ↘	1.5 ↘	2.5 ↗	2.5	6.8 ↗	1.5 ↘	4.4 ↗	3.9 ↘	4.5 ↗
Serious Incidents	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0	0.0	1.0 ↗	1.0	0.0 ↘	0.0	0.0	0.0
Complaints	0.0	1.0 ↗	2.0 ↗	1.0 ↘	1.0	2.0 ↗	1.0 ↘	0.0 ↘	0.0	1.0 ↗	0.0 ↘	0.0
PALS	1.0 ↘	2.0 ↗	3.0 ↗	4.0 ↗	3.0 ↘	1.0 ↘	5.0 ↗	2.0 ↘	2.0	3.0 ↗	2.0 ↘	2.0

SGH Maternity Dashboard

Indicator	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
Midwife to Birth Ratio	23.9	23.9	26.4	25.3	25.5	25.8	25.8	26.0	23.8	22.4	24.9	
Red Flags	24.0	17.0	19.0	22.0	15.0	27.0	6.0	4.0	14.0	6.0	14.0	
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	3.0	0.0	2.0	0.0	1.0	5.0	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)	2.0	0.0	1.0	2.0	2.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
(c) Missed medication during an admission to hospital	1.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	2.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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	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	2.0	3.0	1.0	11.0	5.0	11.0	1.0	2.0	5.0	2.0	9.0	0.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	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	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	16.0	13.0	15.0	9.0	7.0	10.0	4.0	1.0	9.0	2.0	4.0	0.0
Continuity of Carer %	16.0	21.0	18.0	20.0	13.0							
In Receipt of %	7.0	5.0	6.0	6.0	5.0	3.0						
CoC In Receipt of %	38.0	47.0	44.0	50.0	30.0	33.0						
Continuity Team Caseload	151.0	171.0	177.0	174.0	174.0	0.0	0.0	0.0	0.0			
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	
Actual v Planned Staffing %	88.8	88.1	80.2	83.3	82.7	81.4	81.4	80.9	88.3	94.0	85.1	
Labour Co-ordinator Supernumerary Status %	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	18.3	20.5	27.9	28.5	25.1	24.9	25.5	26.1	21.5	21.2	21.0	20.6
Vacancies - Registered	15.7	17.3	22.3	23.5	21.9	22.7	23.4	23.2	21.3	18.9	19.0	19.0
Vacancies - Unregistered	2.6	3.2	5.6	5.0	3.2	2.2	2.0	2.8	0.3	2.3	2.1	1.6
Serious Incidents	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	0.0
Complaints	0.0	1.0	0.0	0.0	2.0	0.0	2.0	1.0	3.0	1.0	0.0	1.0
PALS	3.0	2.0	2.0	2.0	1.0	0.0	1.0	3.0	3.0	1.0	1.0	1.0

Trustwide Maternity Dashboard

Indicator	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
Midwife to Birth Ratio	24.5	24.0	24.9	25.1	25.0	26.2	26.2	25.8	24.8	22.9	24.8	
Red Flags	37.0	23.0	30.0	24.0	18.0	34.0	16.0	9.0	17.0	9.0	20.0	3.0
(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)	6.0	2.0	2.0	1.0	1.0	5.0	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)	2.0	1.0	1.0	2.0	3.0	2.0	2.0	1.0	1.0	0.0	3.0	1.0
(c) Missed medication during an admission to hospital	1.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	3.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	0.0	0.0	2.0	2.0	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	1.0	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	6.0	5.0	3.0	11.0	6.0	13.0	5.0	4.0	5.0	3.0	9.0	1.0
(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	1.0	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	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	22.0	14.0	24.0	10.0	8.0	10.0	6.0	3.0	11.0	3.0	6.0	1.0
Continuity of Carer %	20.0	20.0	19.0	20.0	18.0	12.0	12.0	12.0	14.0			
In Receipt of %	16.0	7.0	11.0	8.0	11.0	9.0	8.0	9.0	8.0			
CoC In Receipt of %	67.0	49.0	69.0	68.0	58.0	70.0	72.0	68.0	66.0			
Continuity Team Caseload	485.0	490.0	524.0	488.0	488.0	305.0	305.0	295.0	311.0			
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	
Actual v Planned Staffing %	90.3	92.1	88.1	88.0	88.1	84.1	84.1	85.5	89.0	96.2	88.0	
Labour Co-ordinator Supernumerary Status %	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	30.7	32.2	46.6	47.3	43.5	44.5	45.2	51.7	41.6	41.1	40.4	42.2
Vacancies - Registered	27.2	28.2	38.1	40.3	38.8	39.8	40.6	42.2	39.8	34.4	34.4	36.0
Vacancies - Unregistered	3.5	4.1	8.5	7.0	4.7	4.7	4.6	9.6	1.8	6.7	6.0	6.1
Serious Incidents	0.0	1.0	0.0	0.0	0.0	0.0	2.0	1.0	0.0	0.0	1.0	0.0
Complaints	0.0	2.0	2.0	1.0	3.0	2.0	3.0	1.0	3.0	2.0	0.0	1.0
PALS	4.0	4.0	5.0	6.0	5.0	1.0	6.0	5.0	6.0	4.0	3.0	3.0
Sickness Absence (Division) %	7.2	8.0	8.8	5.9	5.8	6.8	6.4	6.0				

5.0 Quality (Falls)

5.1 Reported Falls Incidents

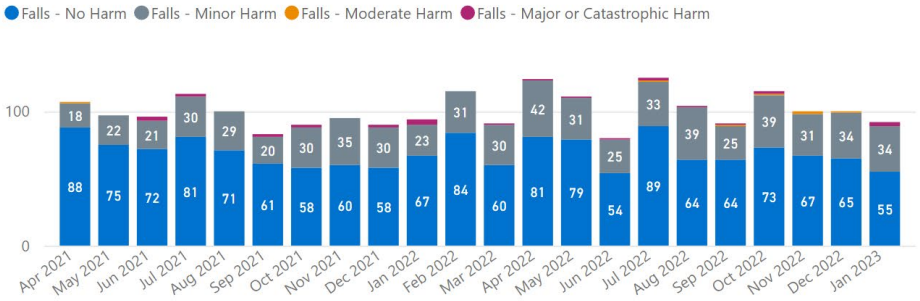
The information presented shows data for inpatient wards only and is the standard throughout the report.

Falls Incidents Summary Jan 2023

Falls - Total	No Harm	Minor Harm	Moderate Harm	Major or Catestrophic
92 ▼ -8	55 ▼ -10	34	0 ▼ -1	3 ▲ 3

Falls - Total

Falls by Category



Falls - Total by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jan 2023	DPOW	50	! 2	48	
Jan 2023	GDH	5	✓ -7	12	
Jan 2023	SGH	37	✓ -3	40	

Falls - Total by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jan 2023	Community & Therapies	5	✓ -7	12	
Jan 2023	Family Services	2	! 2		
Jan 2023	Medicine	75	! 1	74	
Jan 2023	Surgery	10	✓ -4	14	

The total number of falls reported in January 2023 has decreased for the third consecutive month.

There were three falls reported with major harm in January 2023 in in-patient areas. All falls were reported at the Grimsby site and resulted in the patients sustaining fractured neck of femurs. No lapses in care were identified in the huddles for the incidents which occurred on Ward A1 and C1 Glover, and the ICB agreed to de-log both incidents. Both huddles were completed within one working day of the incident.

The incident which occurred on Ward C2 is being fully investigated as a serious incident due to lapses in care. The huddle for this incident took place eight working days after the fall. This was due to a delay in identifying the fracture which is being investigated as part of the serious incident investigation.

A further four falls with harm were reported in January 2023 which are not included within the data. These falls were all reported within the Emergency Care Centers (ECC). These incidents are not included within the in-patient data used within this report.

One fall with major harm was reported in ECC at the Scunthorpe site. The patient sustained a fractured neck of femur following the fall. The huddle was held two working days after the fall. No lapses in care were identified and the ICB agreed to de-log the incident.

Two falls with major harm were reported by ECC at the Grimsby site. Both patients sustained catastrophic head injuries as a result if the falls and sadly died. One of the incidents is being fully investigated as a serious incident as lapses in care were identified at the huddle. No lapses in care were identified in the second incident and the ICB agreed to a de-log. The huddles were completed within two working days of the falls.

One fall with moderate harm was reported by ECC at the Grimsby site. The patient sustained a head injury following the fall. The huddle identified areas of learning which will be investigated as a concise investigation. The huddle was completed within 7 days of the incident. There was a delay whilst the level of harm was confirmed.

A thematic review of the ECC falls was completed with the only consistent theme noted is that all the patients who fell were awaiting admission. Following the rise in incidents within the ECCs, the Lead Nurse Patient Safety has met with the Clinical Educators to support them to deliver focused training within the departments and additional equipment has been purchased to support safe falls care for patient who are waiting for extended periods for admission.

5.2 Falls per 1,000 Bed Days

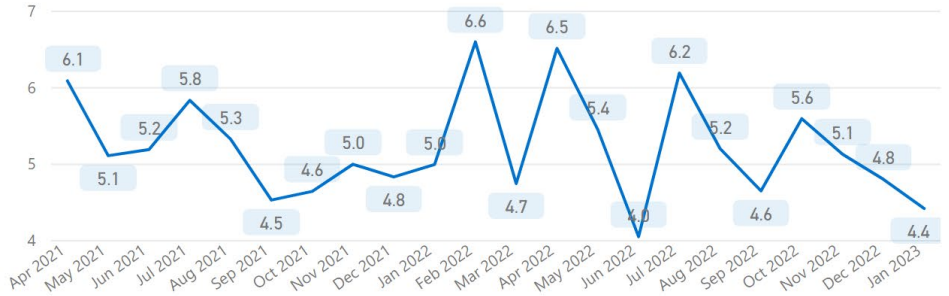
The falls per 1000 bed days across the Trust has decreased in January 2023. Caution should be used when interpreting the data as not all escalation beds are captured within the occupied bed days.

Falls per 1,000 Bed Days Summary Jan 2023

Falls per 1,000 bed days

4.4 ▼ -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
Jan 2023	DPOW	4.9	0.3	4.6	
Jan 2023	GDH	4.4	-5.5	9.9	
Jan 2023	SGH	3.9	-0.4	4.4	

Falls per 1,000 Bed Days by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Jan 2023	Community & Therapies	4.4	-5.5	9.9	
Jan 2023	Family Services	0.8	0.8		
Jan 2023	Medicine	6.2	0.2	6.0	
Jan 2023	Surgery	2.0	-0.9	2.9	

5.3 Wards with Highest Incidence of Falls

Highest Reporting Wards with Falls Incidents Jan 2023

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
DPOW - C2	6	▲ 5	6	▲ 3	0	0	1	▲ 1	13	▲ 9
DPOW - B2 Assessment Unit	4	▲ 3	4	▲ 3	0	0	0	0	8	▲ 6
SGH - Stroke SGH	4	▲ 2	4	▲ 1	0	0	0	0	8	▲ 3
DPOW - C1 Glover	2	▲ 2	3	▲ 2	0	0	1	▲ 1	6	▲ 5
SGH - Ward 5	4		2		0		0		6	

Highest Reporting Wards - Falls per 1,000 Bed Days

Site - Ward	Falls per 1000 Bed Days	Change
DPOW - C2	15.8	▲ 10.8
SGH - Stroke SGH	12.3	▲ 4.6
SGH - Gynae Assessment	11.6	▲ 11.6
DPOW - B2 Assessment Unit	10.1	▲ 7.7
SGH - Ward 5	8.9	

Ward C3 (Short Stay) Grimsby not has triggered as a higher reporting ward for the first time in six months. The Ward Sister previously identified a theme of missed reassessments on transfer to the ward. Local actions have been taken to ensure reassessments are completed.

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.

6.0 Quality - Pressure Ulcers

6.1 Hospital Acquired Pressure Ulcer Incidents

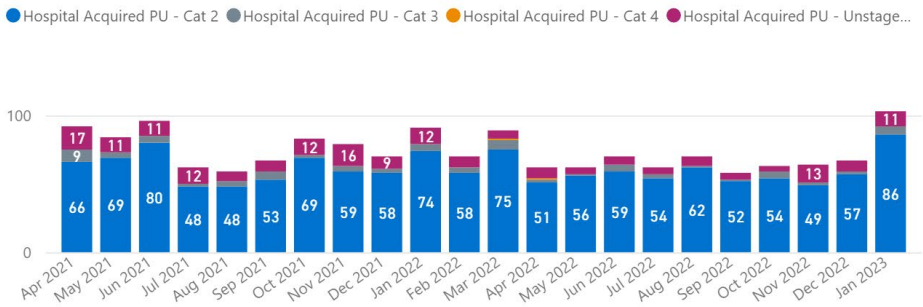
The data includes hospital acquired category 2,3,4 and unstageable pressure ulcers and is the standard throughout the report. Data changes from month to month due to ongoing validation and these figures may contain un-validated pressure ulcers.

Hospital Acquired PU Incidents Summary Jan 2023

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
103 ▲ 36	86 ▲ 29	6 ▲ 4	0	11 ▲ 3

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
Jan 2023	DPOW	63	▲ 28	35	
Jan 2023	GDH	1	▼ -4	5	
Jan 2023	SGH	39	▲ 12	27	

Hospital Acquired PU - Total by Division

Latest Month	Divison	Result	Variance to Previous	Previous Month	Trend
Jan 2023	Community & Therapies	1	▼ -4	5	
Jan 2023	Family Services	1	◆ 0	1	
Jan 2023	Medicine	73	▲ 32	41	
Jan 2023	Surgery	28	▲ 8	20	

The number of pressure ulcer incidents reported in January 2023 has increased significantly. The largest increase has been in category 2 pressure ulcers. The number of reported pressure ulcers has increased in January for the last three years suggesting a seasonal variation.

A thematic review of incidents reported in January 2023 is currently being completed to establish if there are any new, or emerging, themes.

Both the Grimsby site (DPOW) and the Medicine division continue to report higher numbers of pressure ulcers.

6.2 Hospital Acquired Pressure Ulcers per 1,000 Bed Days

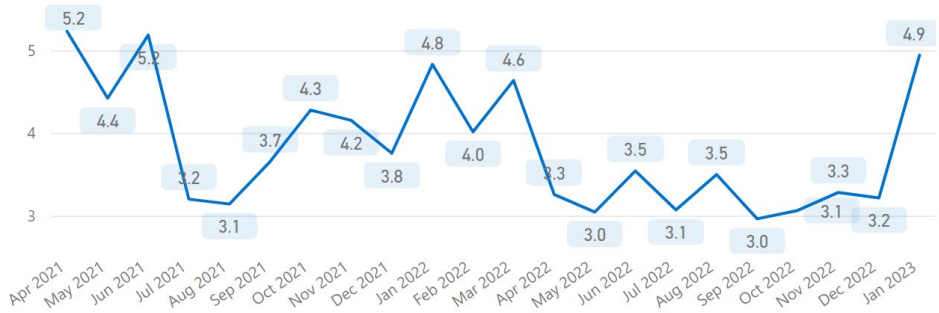
The incidence of reported pressure ulcers per 1000 occupied bed days has increased in January 2023 and remains higher at the Grimsby site.

Hospital Acquired PU per 1,000 Bed Days Summary — Jan 2023

PU per 1,000 bed days

4.9 ▲ 1.7

PU per 1,000 Bed Days



PU per 1,000 Bed Days by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Jan 2023	DPOW	6.1	▲ 2.8	3.3	
Jan 2023	GDH	0.9	▼ -3.2	4.1	
Jan 2023	SGH	4.1	▲ 1.2	2.9	

PU per 1,000 Bed Days by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Jan 2023	Community & Therapies	0.9	▼ -3.2	4.1	
Jan 2023	Family Services	0.4	▼ 0.0	0.4	
Jan 2023	Medicine	6.0	▲ 2.7	3.3	
Jan 2023	Surgery	5.6	▲ 1.4	4.2	

6.3 Wards with the Highest Incidence

Highest Reporting Wards with PU Incidents **Jan 2023**

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 - B3	11	▲ 5	0	0	0	0	0	0	11	▲ 5
DPOW - A1	7	▲ 4	1	▲ 1	0	0	2	▲ 1	10	▲ 6
DPOW - C1 Glover	8	▲ 7	0	▼ -2	0	0	0	0	8	▲ 5
SGH - Ward 22	8	▲ 3	0	0	0	0	0	0	8	▲ 3
DPOW - C2	4	▲ 2	0	0	0	0	2	▲ 1	6	▲ 3
DPOW - C3 Short Stay	5	▲ 4	0	0	0	0	1	▲ 1	6	▲ 5

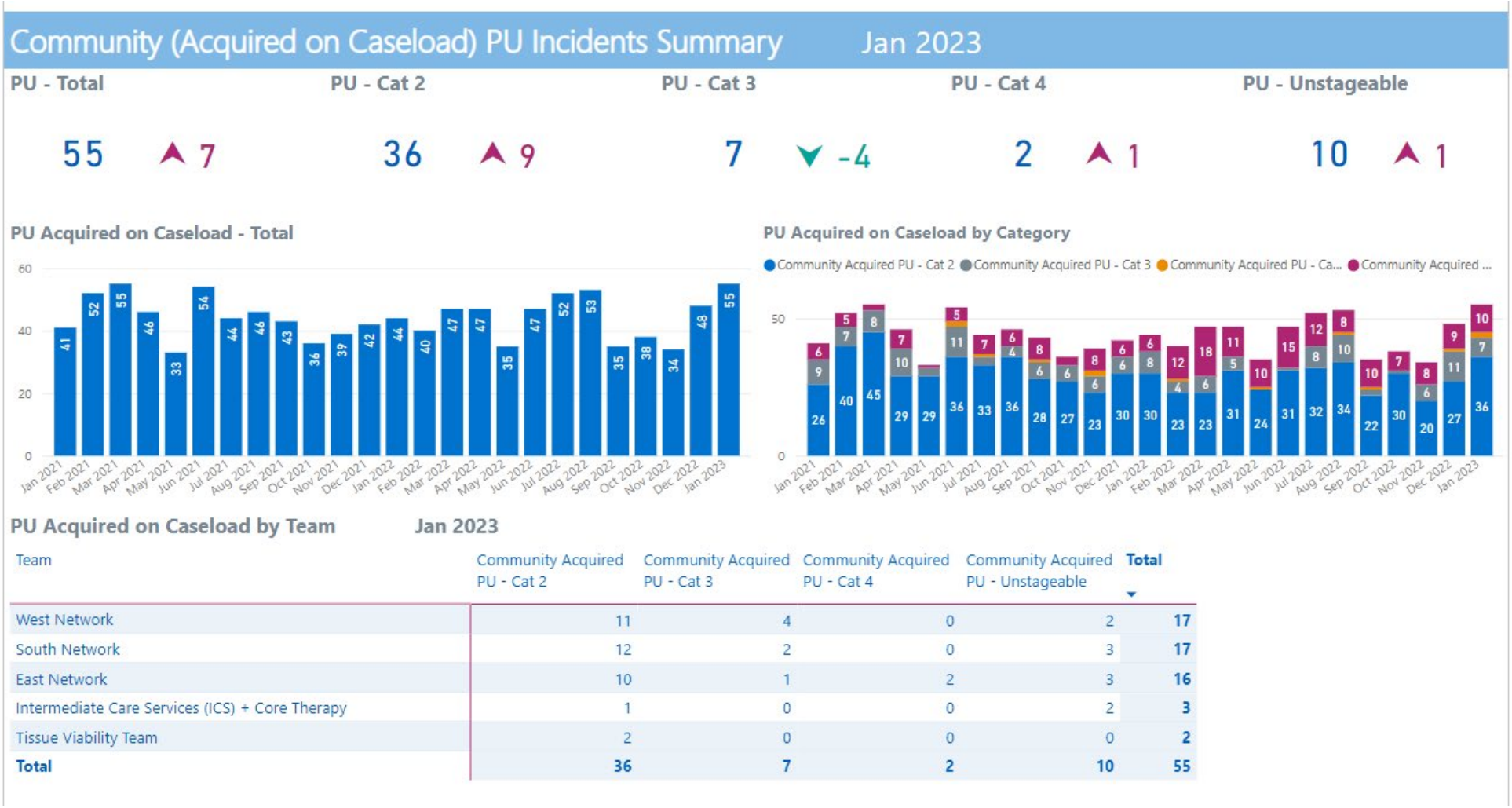
Highest Reporting Wards - PU per 1,000 Bed Days

Site - Ward	Hospital Acquired PU per 1000 Bed Days	Change
DPOW - A1	18.5	▲ 11.2
DPOW - ITU	18.4	▼ -0.6
SGH - ICU	17.1	▲ 8.7
DPOW - B3	14.5	▲ 6.7
DPOW - HDU	11.4	▼ -4.8

Wards B3 and A1 at Grimsby and Ward 22 at Scunthorpe have reported higher numbers of pressure ulcers for the second consecutive month. None of the other higher reporting wards are currently demonstrating any concerning trends. The areas identified above will be discussed in more detail at the Nursing Metrics Panel alongside other indicators.

6.4 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.



Team	Community Acquired PU - Cat 2	Community Acquired PU - Cat 3	Community Acquired PU - Cat 4	Community Acquired PU - Unstageable	Total
West Network	11	4	0	2	17
South Network	12	2	0	3	17
East Network	10	1	2	3	16
Intermediate Care Services (ICS) + Core Therapy	1	0	0	2	3
Tissue Viability Team	2	0	0	0	2
Total	**36**	**7**	**2**	**10**	**55**

The incidence of pressure ulcers acquired on caseload has seen an increase in January 2023 from 49 to 55. This increase may be reflective of the increase in visits allocated in January 2023 which has risen from 12,414 in December 2022 to 13,818 in January 2023.

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. However, we have seen an increase in our 'moderate harm' incidents.

All moderate harm pressure ulcers for January 2023 have been reviewed at the Community and Therapy weekly Pressure Ulcer Meeting with no lapses in care identified in any of the cases.

All 3 of the networks have reported equal numbers of pressure ulcers with less moderate pressure ulcers seen in Intermediate Care Services than previously.

A review of the network and place of residence for patients who developed a moderate harm pressure ulcer for January is as below with no evident themes.

Pressure Ulcer	**Developed in patients own home/network**	**Developed in residential/care home setting (name if known)**
Category 3	**4 West Network** **3 South Network** 1 **East Network**	0
Category 4	**1 East Network**	**1 East Network** at The Birches
Unstageable	**1 South Network** **2 East Network**	2 **West Network** 1 at Hilltop Residential Home 1 at Althorp Care Home **2 South Network** 1 at Cherry Tree House Residential Home 1 at the Valleys Residential Home **1 East Network** 1 at Castlethorpe Nursing Home 2 **Intermediate Care** 1 at Sir John Mason House 1 at Warley House

Over the past 24 months the division has reported a stagnant position in relation to pressure ulcers acquired on caseload. Current systems and process for managing pressure ulcer incidents, investigations and learning are not achieving any improvements in pressure ulcer prevalence.

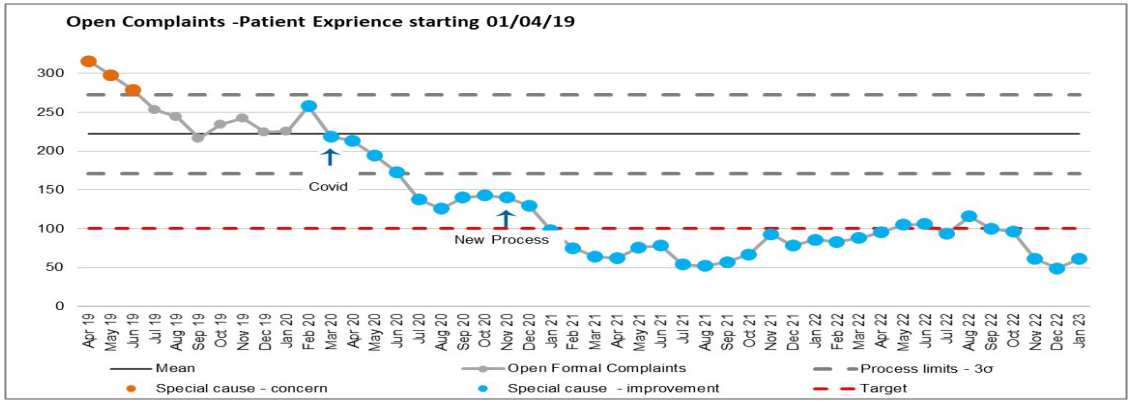
What have we done?

- Thematic review of PU incidents undertaken & identified recurrent themes & no new learning
- Tabletop exercise with ICB quality lead which reviewed all outstanding moderate harm PU incidents identified no new learning
- Proposal to transform the process by which moderate harm community pressure ulcers are reviewed in collaboration with ICB Quality lead in line with PSIRF approved and operationalised
- Improvement opportunity identified in relation to risk assessment for pressure damage and BRADEN to be implemented by end of Q4
- Increased education and training with dates scheduled for 2023 to ensure staff have received an update on pressure area management
- Weekly safe staffing review using a template based on the National CNSST which is due to be implemented this year. The weekly review focuses on the number of visits planned for the following week, a review of staffing and whether the capacity can meet the demand with actions taken to review staffing or move visits to where there is capacity

7.0 Patient Experience

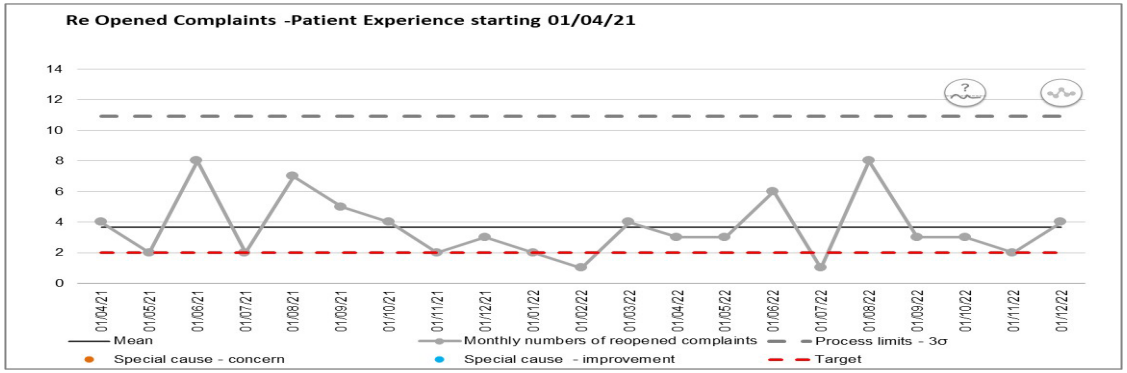
The changes to the complaint process, taken in November 2020, continues to be a sustained quality improvement area within the Trust, with QI methodology continuing in ongoing PDSA cycles. Work is currently being undertaken to improve the learning in complaints. Bespoke templates are being created with the Ulysses team which will enable increased divisional oversight and monitoring of learning and themes. This quality improvement is hoped to be a pivotal step in supporting a learning culture across the Trust.

New formal complaint numbers rose again in January to 29, after the usual seasonal reduction seen in December. At the end of January there was a 24% increase in open complaints, which relates partly to the increase in incoming complaints. This remains below the target and can be seen in graph A below which indicates a 24-month sustained picture:



Graph A

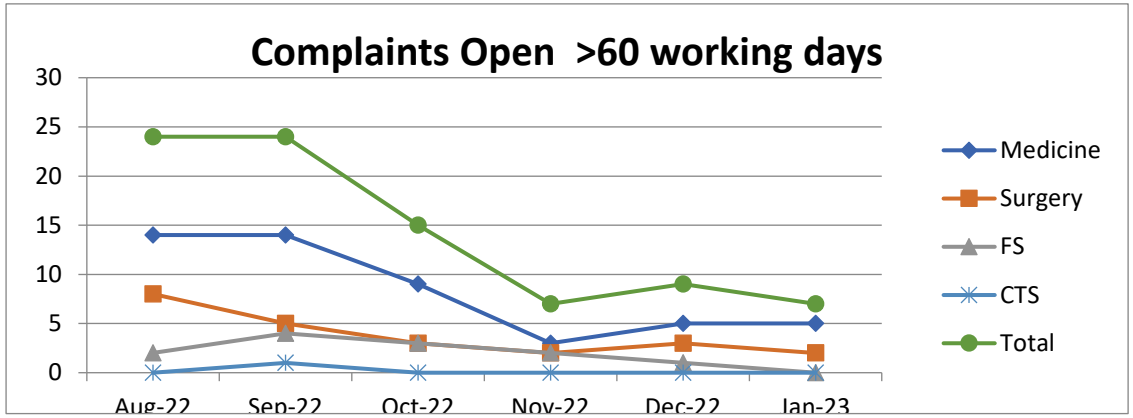
There were 4 reopened complaints in January as seen in graph B. The average over the course of 2022 was 3 per month and an initial target has been adjusted to 2. Re opened complaints predominantly come from bereaved families. We have already identified that the complaint process has a gap in the support of those are grieving who raise a complaint. This is something which requires further exploration across the wider patient experience network, and this will be undertaken in 2023.



Graph B

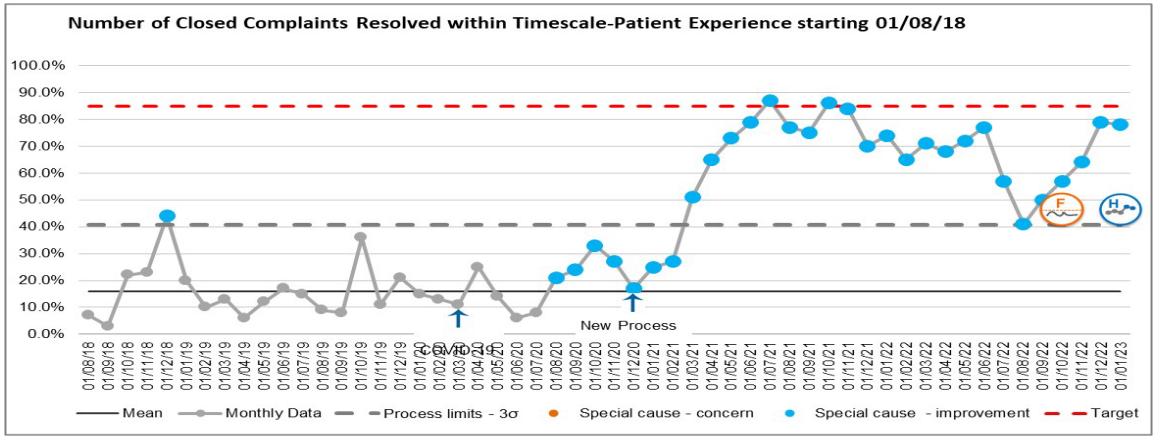
The reduction in complaints over 60 working days continued during January, with 7 being over timescale at the time of reporting, as seen in graph C:

Graph C



In January 25 complaints were closed, 78% were in timescale as seen in graph D.

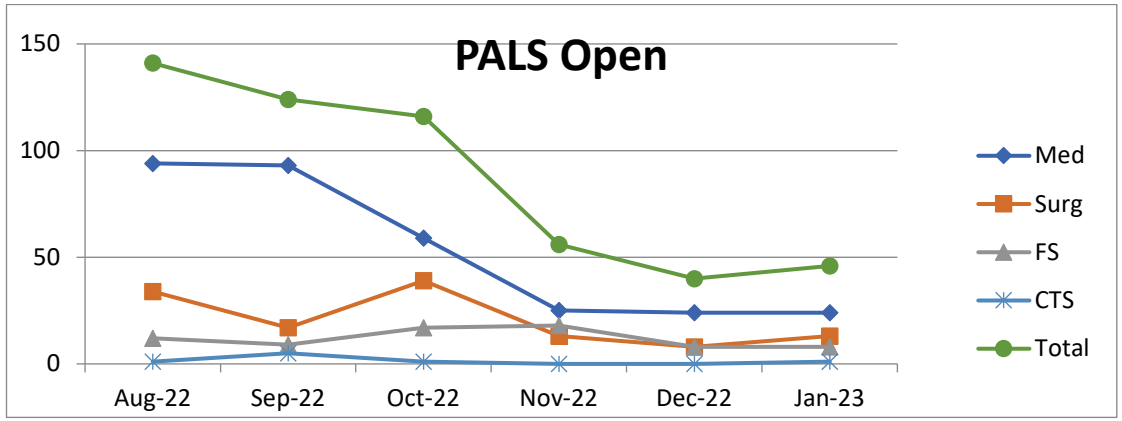
Graph D



Of those 6 that were out of timescale, 1 was over 100 days due to the quality of the information considered at DCN review and further investigation. 5 were over 70 days and 1 was between 61-69 days.

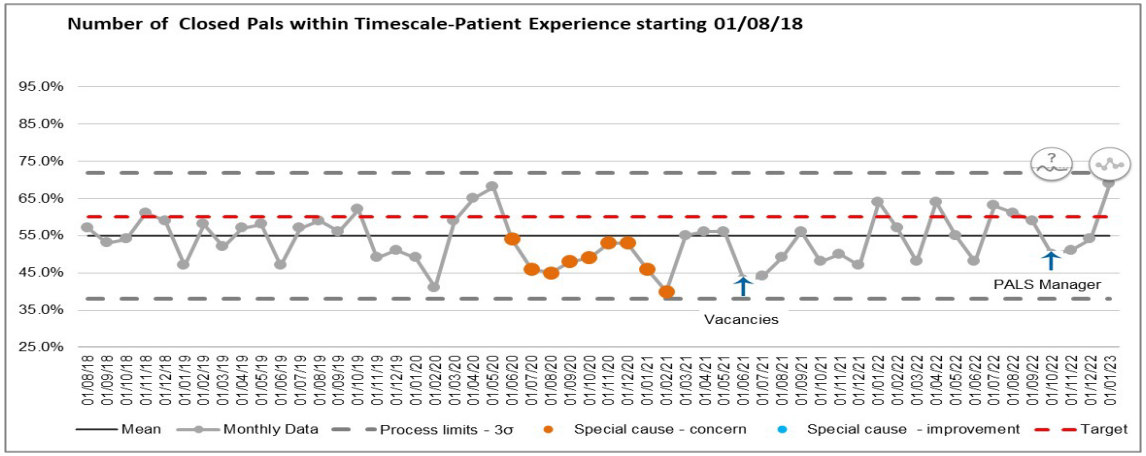
Trust wide the number of new PALs concerns received increased to 165. Open concerns still maintained a positive low position of 46 as seen below in Graph E. This is due to dividing PALS management from that of complaints which has given increased daily oversight,

intervention, and team support. As complexity in complaints increases this oversight also supports the changes seen in concerns, where issues can require more in-depth reviews, and therefore the 5-day target can be challenging. This role will finish March 31st, 2023.



Graph E

161 PALs concerns were closed in January. The KPI of 60% of PALs closed in timescale was recorded at a recorded high of 69% for January, this can be seen in graph F below. This reflects the hard work undertaken by the central PALS teams and divisions. The reduction in open concerns allows capacity to manage new concerns and it is hoped this improvement can be built on and sustained in coming months. With the loss of the temporary PALS Manager future management plans are being explored.



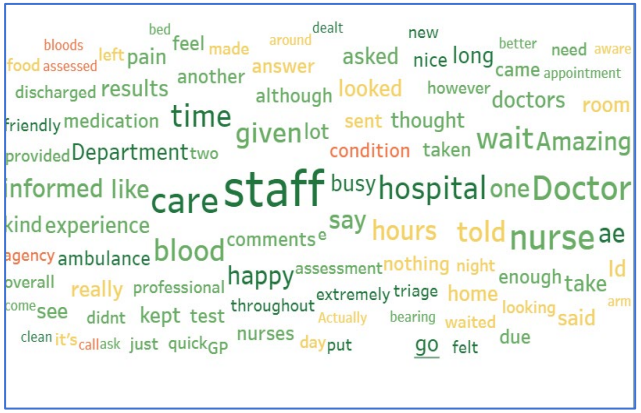
Graph F

January saw the seasonal reduction in patient feedback and a slight reduction in the overall organisational FFT response rate, 89% of those respondents rated they would recommend the Trust.

Performance Over Filtered Date Range	
% Positive	88.84%
% Negative	6.85%
Average 5 Star Score (all questions)	4.64
Review Count	1,183

The Patient Experience Manager has spent time reviewing the data in more depth and identified several data errors, these are being discussed with the current FFT provider. A further review of the survey is being undertaken to identify any barriers to completion, such as mandatory email address. This data and process quality work, which includes reviewing the whole trust hierarchy structure, is essential to creating a robust reporting platform. The temporary Patient Experience Manager continues to undertake staff engagement and is working at providing a first draft FFT report at divisional level for increased oversight.

As part of this work positive feedback will receive an increased focus. This is in combination with a full refresh of how compliments will be logged. Recognising the value to staff morale that the feedback can have the work to raise the profile of this will be an ongoing focus during the coming year



The Volunteering Manager continues to explore how the volunteering service could be further expanded through additional funding routes. Collaboration with HUTH is being explored in respect of their Young Health Champion volunteer programme. Numbers remain largely static, at around 100 active volunteers.

The Patient Experience Lead is working with other heads of patient experience across the North Yorkshire and Humber ICS as part of NHSE and Kings Fund project about integration. The project will look to create a patient experience charter across the ICS and will include engagement and co design of this as it progresses.

8.0 Mixed Sex Breaches

In January the Trust declared 9 mix sex breach between DPOW and SGH which involved 2 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
SGH	ICU	24/1/23	F	6	OPEL 4 on site, patient flow- unable to support step down- escalated at the time
SGH	ICU	24/1/23	M	6	OPEL 4 on site, patient flow- unable to support step down- escalated at the time
SGH	ICU	24/1/23	M	6	OPEL 4 on site, patient flow- unable to support step down- escalated at the time
SGH	ICU	24/1/23	M	6	OPEL 4 on site, patient flow- unable to support step down- escalated at the time
SGH	ICU	24/1/23	F	6	OPEL 4 on site, patient flow- unable to support step down- escalated at the time
SGH	ICU	24/1/23	F	6	OPEL 4 on site, patient flow- unable to support step down- escalated at the time
DPOW	HDU	26/1/23	F	3	OPEL 4 on site, capacity at DPOW and patient flow- unable to support step down- escalated at the time
DPOW	HDU	26/1/23	F	3	OPEL 4 on site, capacity at DPOW and patient flow- unable to support step down- escalated at the time
DPOW	HDU	26/1/23	M	3	OPEL 4 on site, capacity at DPOW and patient flow- unable to support step down- escalated at the time

9.0 15 Steps Challenge

Five 15 Steps Challenge visits and one mock assurance visit were completed during January 2023. As during previous schedules, no visits were planned during the first week of January to allow for increased pressures following the holiday period, freeing up staff and team members to support clinically.

Acute 15 Steps Challenge Visits			
Date of visit	Ward/ Department	Rating 22-23	Previous Rating
11/01/2023	Ward 22 **REVISIT**		
18/01/2023	Ward B6		
19/01/2023	Ward C1 Glover		
24/01/2023	ITU DPOW **REVISIT**		
26/01/2023	Discharge Lounge DPOW		N/A

Quarterly themes for areas of consideration/ action within the community and therapy schedule

	Themes	Actions
Standard 1: Observations	• Appropriate posters and signage to be in place. This is to include PALS poster, trust information posters, uniform posters	• Requests for posters to be displayed in relevant areas made to team
Standard 2: Documentation	• To ensure all staff await to limit use of abbreviations on medical records and not to use abbreviations when sent to external areas	• All staff emailed to remind and added to agenda of next team meeting • Record keeping audits to be completed
Standard 3: Patient Feedback	• To ensure patient that requested update was provided with this.	• Therapist contacted patient upon request to advise regarding outstanding equipment and timescale for availability
Standard 4: Staff Feedback	• To ensure all staff have access to mandatory training	• Two staff completing train the trainer for moving and handling and resus booked for 2023 for all staff to ensure maintained compliance

10.0 Infection, Prevention & Control

ALERT mandatory organisms

The Trust is performing within the expected parameters for mandatory organisms. It is unlikely that the case threshold for C. difficile will be met. Due to success of considerable reduction of cases in previous years, the trajectory for this year of 21 cases is extremely challenging, with a reported number of 19 cases so far. Through the PIR process, cases so far have been deemed unpreventable. The Trust is performing well in comparison to peer Trusts. C.difficile infection is one of the lowest in the country.
Hospital onset positive blood culture cases (gram-negatives, MSSA and MRSA) are in line with predicted numbers, and The Trust is performing well in comparison to peer Trusts. However, the case threshold has been exceeded for Pseudomonas aeruginosa. Again, due to success of considerable reduction of cases in previous years, a case threshold of 7 is challenging, with a reported number of 14 cases so far. There has been no case of hospital onset MRSA bacteremia for 24 months.

Respiratory Viruses

Winter was predicted and is proving 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. Currently we have patients across the sites with these illnesses, numbers are rising (especially on the SGH site), and we are seeing patients, young and old with dual viruses. Children's services have seen very high numbers of RSV cases for several months, and although the national picture shows it has reached peak, high numbers are still being seen in our hospitals.

Mitigation actions and controls remain in place to safeguard patients and staff safety. HEPA filtration units are in use on the wards. Isolation facilities are being increased using redirooms. C02 monitoring is being carried out regular in waiting areas and actions taken as appropriate.

Norovirus

Vomiting and diarrhoea can be caused by a number of viruses, the most common being rotavirus, which predominantly affects infants and young children, and the small round structured viruses (SRSVs) such as Norovirus which mainly affects older children and adults. Mode of Transmission Spread is by faecal-oral route and airborne transmission by droplets created during the process of vomiting when great numbers of virus particles are disseminated into the air. Anyone in the area at that time is at risk of acquiring the infection.

The Trust has experienced several wards closed at SGH and DPOW site due to confirmed Norovirus outbreaks.

Nationally this is the largest Norovirus outbreak for over a decade.

Mandatory alert organism

Overview 2022/23 YTD
Healthcare-associated cases

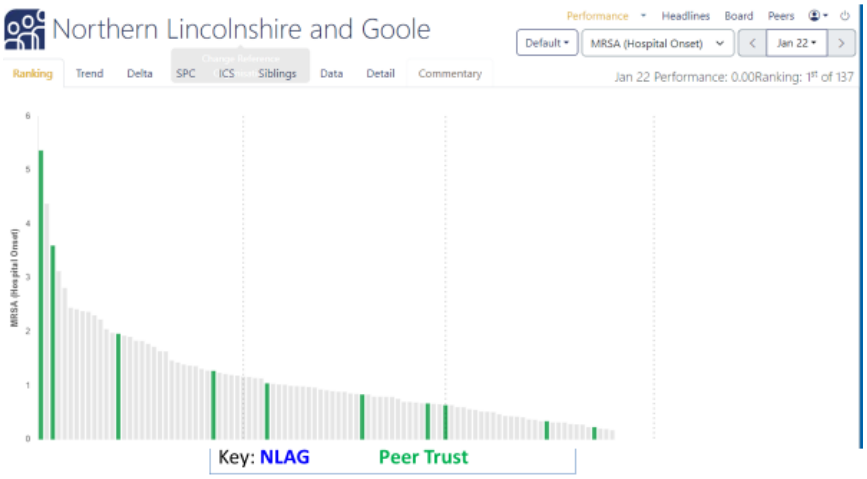
	April – January 2023					2021/22	
	PHE Trust-level Targets	Trust	DPOW	SGH	GDH	2021/22 Targets	2021/22 Actuals
C. difficile	21	19	13	6	0	33	20
MRSA	0	0	0	0	0	0	0
MSSA	No Target	16	9	4	3	No Target	21
E. coli	65	54	28	20	6	110	56
Klebsiella spp.	25	18	5	13	0	21	26
P. aeruginosa	7	14	8	6	0	16	12

Targets 2022/23

Healthcare-associated cases (HOHA and COHA)
Baseline dataset 12 months ending November 2021
C. difficile – Trusts with greater than 10 cases – target 1 less than count
Gram-negative bloodstream infections - Trusts with greater than 10 cases – target 5% less than count
https://www.england.nhs.uk/publication/minimising-clostridioides-difficile-and-gram-negative-bloodstream-infections/

MRSA Regional comparison

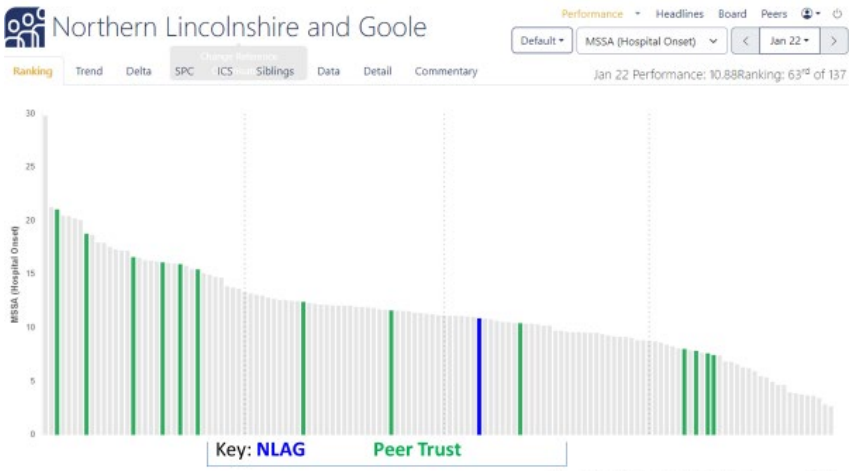
Northern Lincolnshire and Goole NHS Foundation Trust



https://publicview.health/Auth/Performance/RJL/1

MSSA Regional comparison

Northern Lincolnshire and Goole NHS Foundation Trust



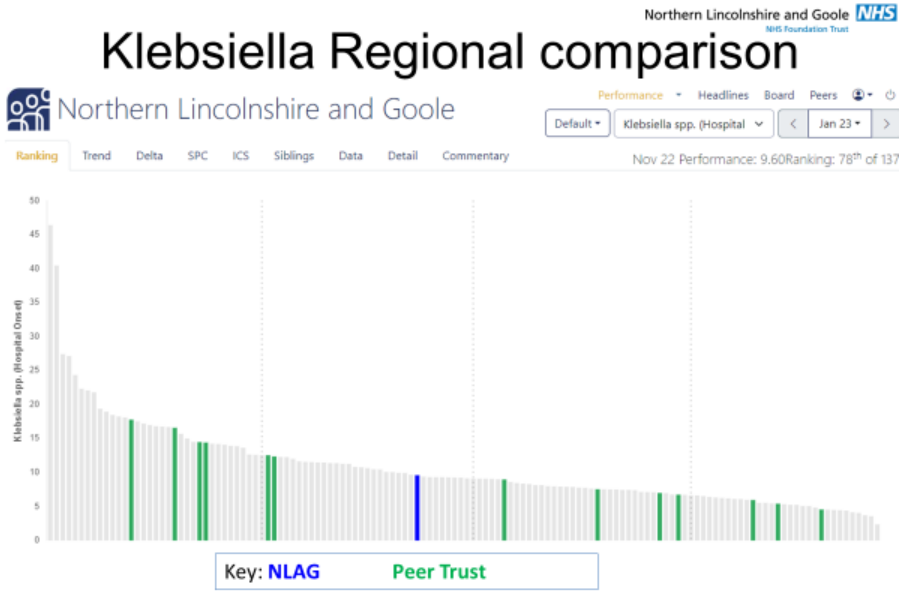
https://publicview.health/Auth/Performance/RJL/1

E. coli Regional comparison

Northern Lincolnshire and Goole NHS Foundation Trust

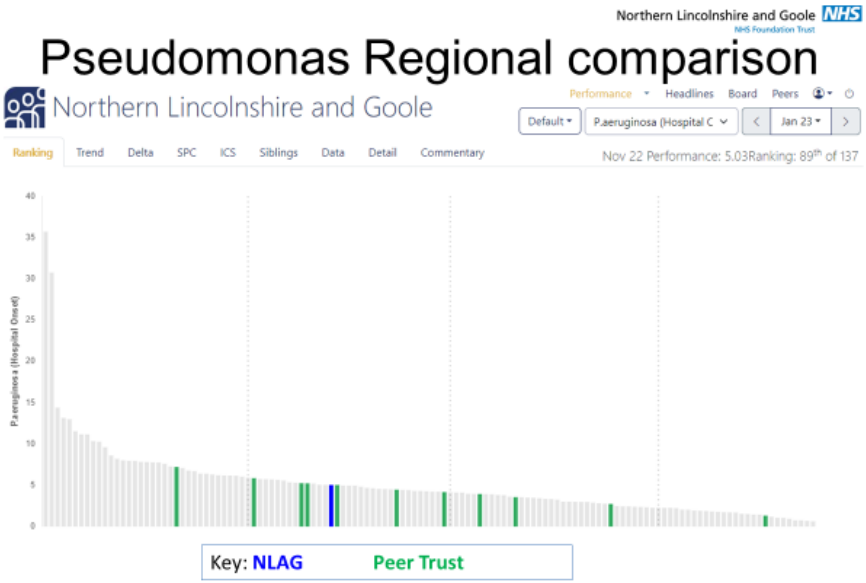
https://publicview.health/Auth/Performance/RJL/1

Klebsiella Regional comparison



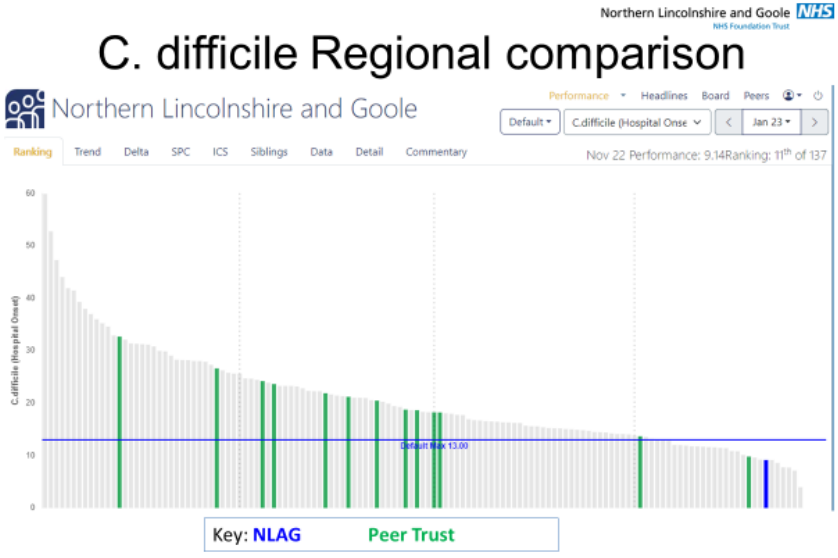
https://publicview.health/Auth/Performance/RJL/1

Pseudomonas Regional comparison



https://publicview.health/Auth/Performance/RJL/1

C. difficile Regional comparison



https://publicview.health/Auth/Performance/RJL/1

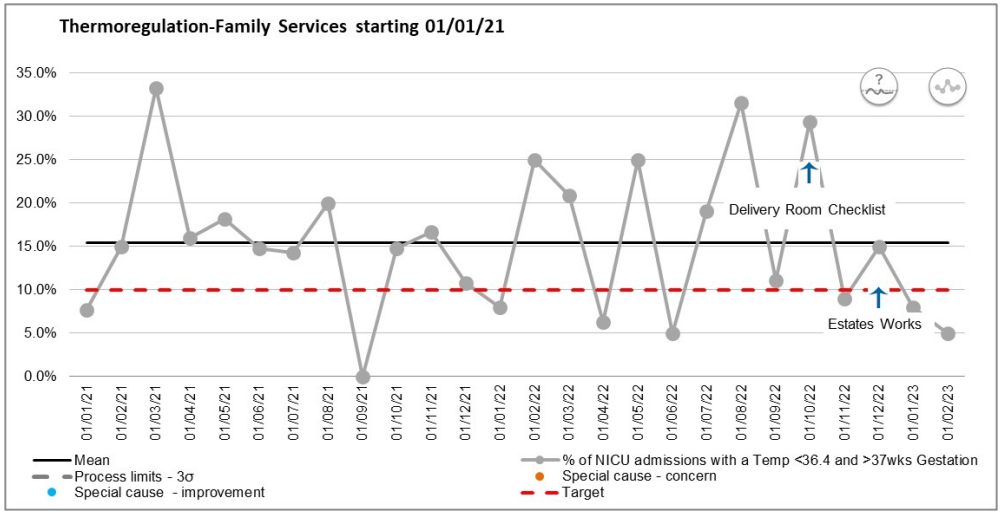
11.0 Quality Improvement

There are various QI projects in progress across the Trust. In focus this month are Improving Pain assessment and reassessment, Reducing Thermoregulation of new-born babies and Improving how we care for patients in their End of Life.

Improving Pain Assessment and Reassessment QI Collaborative has moved from the testing and developing phase where frontline teams were involved in developing an electronic tool that was easy to use and assess pain. This involved many iterations and developments of the tool within WebV. This new Pain Assessment tool has now gone live with 5 wards using it during March with positive feedback to date around its ease and intuitive use. Early indication show that the initial assessments are being done using this tool but there is still some work to do with regards to the reassessment element. Data will be reviewed at the end of March 2023 to review how successful the tool has been with these 5 ward areas.

Reducing Thermoregulation of new-born babies following birth are at risk of thermoregulation (loss of body temperature) which can lead to other health related issues requiring admission to NICU. This Quality Improvement projects aim is to have no more than 10% of NICU admissions as a result of babies with a temperature outside of the optimal limits (<36.4) for babies >37 week gestation by 31st March 2023 (based on a baseline mean of 16% Jan 2021 – Jan 2023 equating to 97 babies).

Whilst the baseline position is 16%, the SPC chart below shows the larger variation and impact from 0% up to 33% of babies > 37 weeks gestation been admitted to NICU with thermoregulation.



PDSA cycles commenced in October 2022 with focus on the room environments ensuring that the rooms were adequately heated, windows shut, fans off etc. This was followed up with estates working in December 2022 to fix broken / draughty windows and adjust heating settings in delivery rooms at DPOW. On the 14th February an educational / communication campaign was launched aimed at both staff and new parents and care givers to explain the importance of post birth temperature and what everyone can do to support correct thermoregulation.

Since commencement of the PDSA cycles we can see from the above SPC chart that there are 4 data points below the mean with 3 data points below the 10% target, showing potential signs of improvement. This data will continue to be monitored and reported to understand the effects of the PDSA cycles in particular the most recent educational / communication campaign which we are yet to see in this data.

An End of Life “Always Event” took place on the 9th March 2023 looking at how we can improve our processes and care for patients in End of Life. This event looked at the problem through the lens of what should we “Always do” from a patient perspective. The event was well attended with positive feedback received from attendees in regard to the conversations, engagement and direction. Themes around problems, challenges and potential ideas for testing were gathered and are currently being collated by the project group. The next stage is to prioritise these themes and change ideas prior to commencement of testing.

12.0 Conclusion

The overall CHPPD was 8.6 in January.The latest model hospital data for December 2022 indicates a provider value of 7.8 (quartile 2 mid-low 25%) against a peer median of 8.2 and provider median of 8.0. The overall fill rate was 99.6% however for each ward varies from 83.7% to 149.1%. Some of this high fill rate can be attributed to those wards that have unestablished escalation beds. Additional shifts are created to staff escalation beds which are filled by temporary staff which impacts on the overall fill rates.

In January 2023 the midwife to birth ratio was 25.4 at DPoW and 21.6 at SGH 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.

There is a total of 202.72 WTE (10.87%) registered and 106.77WTE (11.02%) unregistered nursing vacancies across the Trust. Recruitment and retention work remain a priority.

Three falls were reported at Grimsby with major harm in January 2023. Huddles were held within one working day of the falls and no lapses in care were identified in the huddles on Ward A1 and C1 Glover and the ICB agreed to de-log both incidents. The third fall on Ward C2 is being fully investigated as a serious incident due to lapses in care.

A further four falls with harm were reported in January 2023 and were within the Emergency Department. These incidents are not included within the in-patient data used within this report. Huddles were held promptly and a theme identified was that all the patients who fell were awaiting admission. Learning was identified and the Clinical Educators are delivering very focused training to the staff as well as purchasing additional equipment to support patients who are experiencing long waits in the department.

The number of pressure ulcer incidents reported in Acute and Community has increased significantly. The community caseload/visits has seen a rise from 12,414 in December 2022 to 13,818 in January 2023 which may be a contributory factor. All moderate harm pressure ulcers are reviewed weekly with no lapses in care identified in any of the cases.

The reduction in complaints over 60 working days continued during January, with 7 being over timescale.

Whilst PALs concerns increased to 165, open PALS remain very low at 46. This is due to dividing PALS management from that of complaints which has given increased daily oversight, intervention, and team support.

Five 15 Steps Challenge visits and one mock assurance visit were completed, which is a reduced number of assurance visits, however this allowed staff to support clinical areas.

It is over 2 years since the last hospital onset MRSA bacteraemia case. The Trust has reported 20 C.difficile onset cases since 1st April with a trajectory of 21 and continues to perform well against peer Trusts.

There are various QI projects in progress across the Trust. In focus this month are Improving Pain assessment and reassessment, Reducing Thermoregulation of new-born babies and Improving how we care for patients in their End of Life. An End of Life “Always Event” took place on the 9th March 2023 looking at how we can improve our processes and care for patients in End of Life. This event

looked at the problem through the lens of what should we “Always do” from a patient perspective. The next stage is to prioritise these themes and change ideas prior to commencement of testing.

Agenda Item: NLG(23)070

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	04 April 2023	
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 - January 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	The Workforce Committee Minutes from the meeting held on Tuesday 21 January 2023, and approved at its meeting on Tuesday 21 March 2023, 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, 31 January 2023 at 12:30 hours via Microsoft Teams

Present:

Susan Liburd	Non-Executive Director (Chair)
Linda Jackson	Vice Chair

In Attendance:

Abolfazl Abdi	Deputy Chief Operating Officer
Nico Batinica	Associate Director for Workforce Systems, Recruitment and Training
Paul Bunyan	Associate Director of Workforce Operations
Jenny Hinchliffe	Deputy Chief Nurse
Simon Nearney	Interim Director of People
Robert Pickersgill	Governor Observer
Fiona Osborne	Non-Executive Director
Karl Portz	Equality, Diversity, and Inclusion Lead (agenda items 9 and 10)
Wendy Stokes	Executive Personal Assistant to Director of People *(taking minutes)*

1 Welcome and apologies for absence

Apologies received from Sean Lyons, Peter Reading, Shaun Stacey, Kate Truscott, and Jennifer Granger.

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, 29 November 2022

The minutes from the previous meeting held on Tuesday, 29 November 2022 were accepted as a true and accurate record.

4 Matters arising from the previous minutes

Page 4, item 11, paragraph 2 - Derek Conlon confirmed the current figures for 2021/2022 job plans for consultants is at 97% and SAS doctors is at 62%. Currently, the Job Planning Committee is meeting fortnightly to expedite 2021/2022 and complete the 2022/2023 job plans. The Chair confirmed that the target was 100%.

4.1 Review of Action Log

Action 102 - Mandatory and Core Skills Training Review
It was agreed that Simon Nearney will speak to Nico Batinica outside of the meeting to hand this item over as Nico leaves the trust in February.
Action: Simon Nearney

Action 103 - Job Planning for SAS Doctors
Discussed previously under agenda item 4. It was agreed to remove this item from the action log.

Action 104 - Workforce Committee Terms of Reference
It was agreed to remove this item from the action log.

5 People Strategy Annual Delivery Plan 2022-2024 - Quarter 3 Update

Paul Bunyan presented key points from the Quarter 3 Update, available on SharePoint.

Fiona Osborne stated that the numbers of HCAs recruited is amazing and she asked if there is an issue trying to reduce the timescale from appointment to onboarding. Nico Batinica replied that other roles attend Care Camps and there are challenges in occupational health. The process has changed for clearances and the delays are less than they were.

Regarding ward managers, Fiona Osborne stated they have taken on some of the recruitment work and additional duties for procurement, she asked if that is a bottleneck. Nico Batinica stated he was not aware of that although that can be streamlined going forward. Jenny Hinchliffe added that over time some of the recruitment checks had gone to ward managers and they have not had any increase in allocated office time. Implementation of ESR Manager Self-service has also had an impact on the demands of ward managers. Jenny highlighted that because of the long recruitment period some people are looking for other opportunities, and that is a real concern.

Linda Jackson asked the following questions:

1. Does the trust offer bespoke help with e-processes to areas with specific challenges such as the emergency department and medicine who have a lot of long-term locum medics, they are trying to find permanent posts for? Paul Bunyan replied that the talent acquisition team run specific recruitment programmes for hard to fill roles. It is a very niche team and concept in the NHS, grown steadily over time and that can add benefit to support managers and source individuals. The issue is capacity within a very small team, every dept has an urgent need. Abolfazl Abdi felt there was a focus on short term planning and there needed to be better prospective planning.

2. The report highlights great things that are happening although the feedback is very different. Linda asked does recruitment canvas any views from its users around what they would like to see happen. Nico Batinica replied that for the last year recruitment have been sending out surveys, the results come back to the team and that forms part of their service development plan. Linda Jackson asked do conversations take place with medicine about locums moving to permanent positions. Nico Batinica added there are medics, healthcare, and nursing vacancies and to date they have looked at HCAs and nurse vacancies, they didn't want to spread the team too thinly. For Q4 they are starting to look at medics. Paul Bunyan highlighted that there had been some wins from long term agency members to staff using the star chamber programme and they are now looking at long term locums. Abolfazl Abdi felt the trust had gone some way with recruiting medics in acute medicine, but the challenge is

retention. Two years ago there were seven people providing on call and now there is 16, NLaG is still on that improvement journey. This has been impacted by the wider system, some trusts offer extremely high rates to medics, and some have resigned from their substantive posts to go to other hospitals to pick up locum shifts. It is important for the ICB to standardize the system.

3. Regarding new roles in vascular surgery at HUTH, conversations have taken place with clinicians around the interim clinical plan. Linda Jackson asked how we are capturing the need for new roles as part of the interim clinical plan discussions as part of our commitment to closer working together with HUTH going forward. Paul Bunyan felt it is about the connectivity and both NLaG and HUTH HRBPs having that conversation around each strand of the plan. The trust needs to listen more to staff and focus on the OD element. Simon Nearney highlighted that there is already a joint HR group, but to create new roles is difficult and takes time. Senior clinicians have to support and want to do it as they will ultimately be responsible for their training and development and how the new role works with the wider team. Linda Jackson stated that is a very strong message to the NLaG clinical body to agree the operating model and find the smoothest pathway for NLaG patients. Abolfazl Abdi felt that there is expertise in NLaG, and staff are enthusiastic and willing to take part across the Humber. Staff are also positive and enthusiastic about culture transformation and the leadership programme.

Simon Nearney observed that occupational health remains a severe risk. The manager (and deputy manager which is not public knowledge) are leaving the trust; the manager role has been advertised. He continued that there are positives as the length of time for onboarding has reduced, disciplinary cases/investigations in 2022 have reduced from 2021 by 92% mainly due to our 'just culture' approach and using the principle of accepted responsibility which avoids unnecessary investigations.

The staff survey highlight report will be presented at the next meeting, although there hasn't been much change. Simon Nearney to further discuss registered nurse vacancies with Paul Bunyan outside of the meeting.

Jenny Hinchcliffe stated that new roles, including the ACP programme, are part of her portfolio. There are concerns about turnover rates and it is about trying to determine the vision and strategy for new roles. People qualify, join the trust and staff are then leaving to go into primary care and this all links into the trust having a clear workforce plan. The Chair asked, is the pilot a selection of wards that have been chosen with challenges, or have you chosen easier options, and equally how will you know this is working. Paul Bunyan stated that the project is run by the Safe Staffing Group and design of wards and ward manager experience are taken into consideration. Some ward managers are engaged with their staff and more settled resulting in less vacancies and time to be able to manage their roster well.

6 People Strategy Deep Dive - Nursing

Nico Batinica presented key points from the People Strategy Deep Dive into Nursing, available on SharePoint. The main concern was that nationally there is a notable increase in nurses aged 55 years exercising their right to take early retirement. The trust needs to look at plans and have discussions with the workforce. Fiona Osborne commented from a quality and safety assurance point of view the plans for culture transformation are quite light and not clear about age profile. Fiona asked is there more information available to give that assurance for the future. Paul Bunyan replied that ICB and national conversations are taking place about how to engage the workforce overall, not just nursing staff that are due to retire. The pension reforms consultation ended

yesterday, staff can retire and return and still contribute to the pension scheme. The scheme is designed for people to be able to carry on working longer in the NHS. The trust needs to understand why people want to leave and translate that into actions over the next 12 months. A lot of work is being done around exit interviews and it is for HRBPs to have open conversations with nursing groups and to specifically ask staff what their intentions are. Actions being undertaken include career clinics, retire and return, relaunching retirement courses, part-time and flexible working initiatives for those able to retire early. In addition for new starters, pastoral support, listening clinics, enhanced training and development, career planning and feeling valued initiatives are being delivered. When recruiting newly qualified or international nurses, the trust needs senior people in CPD roles to train them. This is a very current conversation, linked to both the regional and national picture.

Linda Jackson stated that the trust has 23 leavers each month in nursing, meaning 35% of staff are absent at any point in time, due to vacancies, sickness, and maternity leave. Linda went on to ask what the trust is doing in one year to track unregistered leavers. Regarding the middle group, 3 to 5 years, which strands of management development is the trust using to improve that. It is good to have statistics for leavers, the more the trust can do to make staff stay with the trust is welcomed.

The Chair appreciated giving some consideration to the national picture however, she asked about local perspectives in terms of retention. There is lots of activity, how does the trust get people from the point of offer to being in post and how can that be supported locally. Jenny Hinchliffe reported starting from April, legacy mentoring funding has been received from NHS England for one post. They are looking at one or two wards and should have a proposal of what that might look like by the end of the year. Career clinics are up and running for nursing, support workers and therapists although not focused on people close to retirement. Good feedback has been received and there is evidence of people coming into the NHS who want to stay until the latter end of their careers.

Simon Nearney commented that NLaG is still an outlier although registered nursing and midwifery vacancy percentages had reduced. The Staff Survey results are below average and there is no short-term fix. The trust must rebuild a critical mass through cultural transformation and have conversations with senior managers and executives about putting managers into a better place, so they can put their staff into a better place. Simon suggested manager development sessions in the summer to progress those cultural and leadership issues which are linked to the staff survey results. Simon also stated that we need to get into schools and colleges to show that NHS jobs and careers are accessible to local people across all clinical areas. This is a massive programme that will take a lot of hard work and time to resolve. Staff must be listened to and cared for and the trust needs to take health and wellbeing, career structures and flexibility between family and work life balance to another level.

The Chair asked what is being done to integrate large inputs of staff into the trust and to disrupt the current culture. Nico Batinica reported that a lot of onboarding work has been done and Jenny Hinchcliffe's team are undertaking recruitment reviews. They are making good progress, but there is still more work to do. They are starting to onboard values-based questions around recruitment such as, are the right people in this organisation. Jenny Hinchcliffe added there is an additional challenge on SGH site wards in that they have vacancies but because of the skill mix, they cannot take any more international or newly qualified nurses. Wards are working through how many they can cope with this year, but there won't be enough to fill vacancies, leaving lots of challenges. Paul Bunyan added the trust needs to employ nurses on a cycle. There are 650 leaders across the organisation throughout different levels and there are new things in place such as leadership development.

Regarding age profile, and the trust seeing a different picture in twelve months' time, Fiona Osborne asked what the target is, where does the trust want to be in twelve months' time and what is being measured against what is expected, she felt that the assurance is missing from the report. The Chair asked what good looks like and is the trust clear about what the outcome is to assure the committee it is on a particular journey. Paul Bunyan replied the trust is sighted on good leaders in the organisation however, it is one thing to undertake leadership training, it is difficult to make that real for people you are responsible for. Fiona Osborne felt that information on where the trust wants to be, should be available in Finance and Performance Committee and she asked if HR is involved in substantive staff planning for the coming year. Paul Bunyan replied there is an operational plan, and when you start translating that into tangibles form leadership and culture, most divisions will not be able to say what that will look like in twelve months' time, it is very difficult. Simon Nearney questioned whether Fiona Osborne was asking for specifics such as, if nursing is at 12% now, that would be expected to be at 8% by the end of 2024, as well as giving more detail of other staff groups. Fiona Osborne replied absolutely, she would like to see a quantity value. Nico Batinica stated that HR are heavily involved in the process and that information should be available at the next Workforce Committee meeting as there will be identified frameworks. The trust is currently going through business planning rounds and will need to know what changes will look like. The first draft will be available from the middle of February and it is also due to go back to the ICB. It was agreed that the Chair of Workforce Committee will prepare a response to the Quality and Safety Committee.
Action: The Chair

Fiona Osborne felt it would be useful once the planning process was complete, to say what the numbers will be and what actions will get the Trust to that point.

Robert Pickersgill referred to Lee Bond's Monday morning message, and the significant problems with spend across medical and nursing. HUTH have better stats on agency spend, and the drivers may be sickness absence levels being covered. Jenny Hinchcliffe added that the trust knows there is a lot of temporary staffing spend due to more than one ward having extra escalation beds open. Establishment reviews are just being finalized. HUTH is in a different position with newly qualified nurses in September, which reduces their need for agency spend. Simon Nearney added there is still a lot of work to do on recruitment. HUTH registered nursing vacancy rate is 2% and that took millions of pounds of investment and work that started some five years ago. HUTH has been working closely with Hull University and NLaG doesn't have that partner on its doorstep.

7 Recruitment Plans 2022/2023 - Update on Delivery

Nico Batinica presented key points from the 'Recruitment Plans 2022/2023 - Update on Delivery' available on SharePoint. Linda Jackson asked what is happening in occupational health as she had heard there was a three-month wait for a health clearance appointment. Paul Bunyan reported that the Head and Deputy Head of occupational health are both leaving the trust. The demand on the team has grown considerably over the last three years. The trust is far better at recruiting people and the team cannot cope with the capacity. Covid health related issues have also created a delay. Over the last five months systems and processes have been made as lean as possible to prevent delays. From December people will be able to start work at the trust, pending an occupational health appointment within their first three months. The new Cority system will be used to lessen the administrative burden of the paper system. Managers will be able to make direct referrals straight into the system, reducing the time to process referrals. Occupational health is currently reviewing the backlog, and the SOP states that a clinical person isn't needed to clear everyone. The real risk is the Occupational Health Physician, there is currently a three-month waiting list. At present there are no other options, the trust is using HUTH and Lincoln as well as picking up locums when it can. HUTH is also very stretched. Paul Bunyan added he met

with occupational health and they have been supported for the last two months. At present clearances are taking on average twenty-eight days to process and previously they were taking seven weeks. On 07 February a good applicant is being interviewed for the Head of Occupational Health role and the deputy head has not actually handed her notice in yet.

8 BAF 2022-2023 - Quarter 3 Report

The BAF 2022-2023, Quarter 3 Report is available on SharePoint.

Fiona Osborne stated that the risk score for strategic objective 2 stands at 20. The trust is looking to reduce that to 12 by the end of 2022-2023, and to further reduce that to 4, by the end of March 2024, which she felt isn't realistic. Fiona can see all the completed actions in blue and asked what she should be worried about. The Chair and Simon Nearney agreed. Simon Nearney felt the committee could not sign up to the proposal of 12 by the end of March 2024. Simon proposed that the committee agree to keep the risk at 20. It is still a significant risk and Simon felt that the score would be around 16 by the end of March 2024 which remains a worry for the trust.

There are high numbers of staff vacancies and when you look at medics, over 60 out of 300 WTEs is a significant risk and that must be one of the top three objectives on the BAF. Regarding leadership, Simon Nearney felt the target should remain at 12, and the committee should not sign up to reducing the target to 8 by the end of 2022/2023 year. Linda Jackson agreed the trust needs something that is reasonable and challenging and suggested that Simon Nearney has 1:1s with Helen Harris prior to Workforce Committee meetings taking place to discuss the BAF.

9 Gender Pay Gap Annual Report

Karl Portz presented key points from the 'Gender Pay Gap Annual Report' available on SharePoint. The report is not dissimilar from last years in terms of numbers verified by payroll and workforce. Key highlights include 80% female staff, 80% male consultants and they have the biggest CEA awards. There is an action plan to cover any gaps and a lot of recruitment and equality work is taking place including looking at recruitment panels, how the trust recruit jobs, flexible working, and revamping the EDI assessment process. The trust has an ageing workforce and part of the engagement work includes a Menopause Working Group. A bigger piece of work is working with universities, medical schools, and ICBs.

Fiona Osborne stated that equality isn't about doing the same thing for everyone it is about adjusting outcomes for individuals. A female applicant is less likely to negotiate a higher pay rate and Fiona asked if that had been considered. Karl Portz had not experienced that in the NHS. Nico Batinica added that NHS terms and conditions are quite rigid, and the NHS doesn't tend to deviate from them, but any exceptions would be dealt with on a personal basis. Fiona Osborne went on to ask if it would be a set value rather than a scale. Nico Batinica explained that there is a bottom and top point on the scale, and it is about experience within that band.

Fiona Osborne asked if the trust had any strategies to reduce the gap and whether it was targeting highly paid female consultants to encourage them to come into the organisation. In the upper quartile female salaries had not changed and males had increased, can any lessons be learnt from that. Karl Portz confirmed it is only small numbers and they won't affect the quartile, and that can possibly be explored further. Fiona Osborne commented that the figures had only changed by one WTE. Paul Bunyan stated he would expect that recruiting to the current market that is prominently male. The trust hasn't done anything specific to target recruitment around female consultants within the last twelve months.

Simon Nearney added there are some green shoots, currently there are more female junior doctors in medical schools than males although it will take some time to train them to become consultants. The trust needs to make sure it has got leadership programmes for those doctors and make sure they are available to the female workforce. NLaG needs to create an environment that wants females to join and stay with the organization, so we need flexible working and compassionate leadership at its core.

The Chair stated she was disappointed; figures are going in the wrong direction. The Chair questioned how confident the trust is about everything it is doing, and can it say 100% that it has tried everything possible to address this and is not becoming complacent.

The Chair confirmed the Workforce Committee approved the Gender Pay Gap Annual Report for submission to Trust Board for final approval.

10 NLaG Modern Slavery Statement

The trust has a legal requirement to annually publish its NLaG Modern Slavery Statement. This requires sign off by the Workforce Committee and Trust Board.

The Chair confirmed the Workforce Committee approved the NLaG Modern Slavery Statement for submission to Trust Board for final approval.

11 CQC Update

Jennifer Granger had sent apologies for today's meeting and the Chair asked all to forward any questions to her via email.
Action: All

12 Quality and Safety Actions

Recruitment plans discussed under agenda item 7.

Pharmacy recruitment is on the national hard to fill roles list as there are challenges recruiting staff because of NHS pay scales. The talent acquisition team is working closely with pharmacy but there is still a lot of work to do around retention. Recruitment at HUTH have launched an initiative to work with local schools to futureproof supply for the future. The Chair stated that both pharmacy and occupational health are under immense pressure and she asked for an update to be given at the next meeting.
Action: Paul Bunyan

Nursing workforce discussed under agenda item 6.

13 Workforce Integrated Performance Report (IPR) - Trust and Directorate

To be presented at the next meeting.

14 Recruitment KPIs/Dashboard

Nico Batinica stated that the report is more sophisticated, the ownership is being put into divisions, that is being reviewed each quarter and will re-targeted as the position changes.

15 Trust Board Highlight Report

- Nursing Recruitment and Retention Strategy
- Health Care Support Workers and Medical Support Workers recruitment exemplar
- De-escalation of the Gastroenterology Programme Enhanced Monitoring Status
- Industrial Action
- Approval of:
    a) The Gender Pay Gap Annual Report
    b) NLaG Modern Slavery Statement

16 Items for information

See Appendix A.

17 Annual Workplan

To be presented at the next meeting.

18 Any Other Business

The Chair thanked Nico Batinica for his huge commitment to this committee and she wished him all the best and good luck in his new role.

18.1 Staff Survey

To be discussed at the next meeting.

18.2 Industrial Action

Paul Bunyan agreed to circulate a virtual response to the Committee.
Action: Paul Bunyan

19 Date, time, and venue of next meeting:

Tuesday, 21 March 2023 at 14:00 hours via Microsoft Teams

The meeting closed at 14:30 hours

Cumulative Record of Workforce Committee Attendance (2022/2023)

Attendee Name	Possible	Actual	Attendee Name	Possible	Actual
Michael Whitworth	3	2	Kate Truscott	2	1
Michael Proctor	2	1	Ellie Monkhouse	5	0
Fiona Osborne	3	3	Helen Harris	5	2
Sean Lyons	5	1	Jenny Hinchliffe	5	2
Linda Jackson	2	2	Diane Hughes	2	2
Peter Reading	5	1	Shaun Stacey	5	1
Christine Brereton	4	4	Robert Pickersgill	5	5
Maneesh Singh	3	1	Abolfazl Abdi	2	2
Susan Liburd	3	3	Aswathi Shanker	1	1
			Simon Nearney	1	1

NLG(23)071

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	04 April 2023	
Director Lead	Simon Nearney, Interim Director of People	
Contact Officer/Author	Liz Houchin, Freedom To Speak Up (FTSU) Guardian	
Title of the Report	**Freedom To Speak Up (FTSU) Guardian Q3 Report 2022-23**	
Purpose of the Report and Executive Summary (to include recommendations)	The Q3 Report gives an update from last board, an overview of number of concerns raised, national and regional updates, the proactive work undertaken by the Trust's FTSU Guardian, and future plans for FTSU. The report is 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.
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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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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 Q3 – Oct to Dec 2022

Liz Houchin
18th January 2023

Contents

1. Executive Summary

This paper provides an update regarding NLaG activity for Q3 2022-23 (which covers the period October–December 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

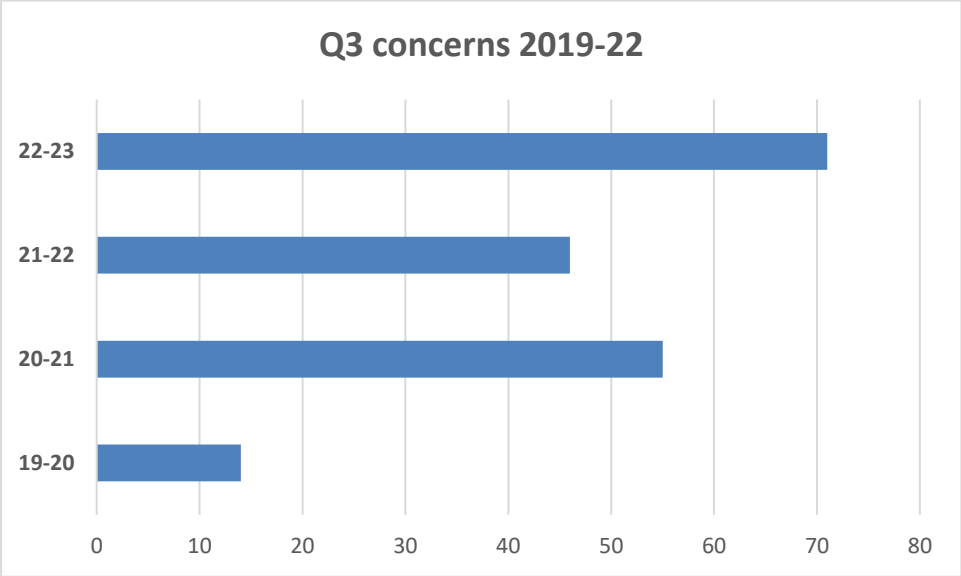
The paper is presented in a structured format to ensure compliance with the ''Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts'' published by the National Freedom to Speak Up Guardians Office and NHS Improvement. The presentation of this information is structured in 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 Q3 2022-23 the number of concerns received were 71, 15 of those were closed on the same day after giving advice or signposting to other services:

- 1 concern was raised anonymously in Q3.
- 11 concerns involved an element of patient safety. This puts the Trust in the mid-quartile nationally (12 month rolling average), the peer figure being 22 and the national median 23 (figures according to Model Hospital data)
- 1 concern involved an element of bullying and harassment which puts the Trust in the mid-quartile nationally (12 month rolling average), the peer figure being 13 and the national median being 22.

4.2 The Q3 figure of 71 is the highest number in the current reporting year. Q3 is usually the highest quarter due to the nation 'Speak Up' campaign in October (please see graph below for previous Q3 numbers). There have also been concerns raised by groups of staff which are now counted as individual concerns.



4.3 The main themes raised were around worker safety, behaviours and process.

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. FTSU data is now being included in the 15 Steps Challenge.

Q2. 2022-2023 (July- September 2022)			Q3. 2022-2023 (October-December 2022)
Concerns		**50**	**71**
Themes	Behaviour / relationships	20	28
	Bullying & Harassment	3	1
	Culture	0	13
	Leadership	1	0
	Patient Safety	10	24
	Process/Systems	18	26
	Personal Grievance	1	0
	Worker Safety	10	29
How Raised	Openly	10	25
	Confidentially	38	45
	Anonymously	2	1
Perceived detriment		1	0

NB - Please note some concerns may have more than 1 element.

Report Breakdown by Division and Role

Q2.2022-2023 (July-September)			Q3. 2022-2023 (October - December 2022)		
Role	**Division**	**Number**	**Role**	**Division**	**Number**
Doctor/ Dentist	1x Medicine 1 x S&CC	2	Doctor/ Dentist	1x S&CC 3 x Medicine	4
Nurse/ Midwife	4 x Medicine 2 x S&CC 1 x C&T 8 x W&C 1 x Chief Nurse	16	Nurse/ Midwife	6 x Medicine 2 x C&T 19 x W&C 1 x Chief Nurse	28
HCA	Medicine	1	HCA	2 x Medicine 2 x S&CC 1 x COO	5
Admin	1 x Medicine 6 x S&CC 5 x C&T 5 x CIO	17	Admin	1 x Medicine 3 x C&T 9 x Trust Secretary 1 x S&CC 1 x CIO 4 x COO 1 x Medical Director	20
AHP	1 x Medicine 1 x S&CC 3 x C&T	5	AHP	4 x S&CC 1 x Medicine 1 x C&T	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	Other	4 x C&T 1 x People 2 x COO 1 x E&F 1 x W&C 1 x Medicine 2 x unknown	12

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	15	15
Q4		

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

- ***I felt it helped get the senior team to see what I was seeing on the shop floor***

- ***I was talked through how things worked and was comfortable to talk openly, thank you Liz. Your work is very important.***

- ***Thank you again Liz for all you help. For respecting my wishes and for being honest and confidential safe space. I would absolutely encourage staff to come to you. You have helped me so much.***

- ***I found Liz very helpful and understanding, she spent time listening to our concerns and was able to pinpoint the underlying issue. Liz outlined her role and gave us opportunity to decide our chosen course of action. The role is extremely useful in achieving a desired outcome.***

4.7 Case Study

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

The FTSUG received an email from a colleague raising concerns that transfer and slide sheets were not being used in an area. These improve both patient and worker safety. Training had been given to all colleagues but the use of them was still low. The FTSUG contacted the area's management team and also the Lead Safety Trainer to inform them of this concern. The Lead Safety Trainer is going to support the area to improve uptake and the management team are going to use the safety huddles to highlight the importance of using the sheets and will carry out audits and checks to monitor the situation providing additional training where required. This outcome was shared with the colleague that raised this.

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). Concerns where poor/inappropriate behaviour is a factor now represents a third of concerns reported nationally and is something that is mirrored in Trust.

Q3 data for 2022-23 will be submitted to the NGO by the Guardian when the portal opens.

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. Recent discussions included timeframes for organisations adopting the new National Policy, what Guardians can expect when being interviewed by the CQC and how organisations are responding to media stories and investigations.

6.0 Proactive work of the FTSUG during Q3

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at Health & Wellbeing Steering Group
- Speak Up Awareness activities during October
- Attendance at all network meetings
- Board reflection and planning tool completed
- Adoption of National Speaking Up Policy

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: 18th January 2023

NLG(23)072

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	4 April 2023	
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.	
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
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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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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 January 2023

Contents

1. Executive Summary

Exception reports for the quarter 1st October 2022 to 31st December 2022 saw a significant increase from 74 to 107 exception reports. The majority of the exception reports submitted were in connection with working hours, with some 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. The first training session was recently undertaken, and this work is ongoing.

Current numbers of Doctors in Training within NLaG is as follows:

Number of Training Posts (WTE)	302.74
Number of Doctors/Dentists in Training (WTE)	262.32
Number of Less than full time (LTFT) Trainees (Headcount)	20
Number of Training post vacancies (WTE)	40.42
Total number of trainees: SGH	155.74
Total number of trainees: DPOW	147
Total number of trainees: GDH	0

Source Finance data

During the period of this quarterly report (1st October 2022 to 31st December 2022) there have been a total of 107 exception reports submitted through the allocate exception report system.

This showed an increase of 33 exception reports from the last quarter (1st July 2022 to 30th September 2022).

Of the 107 exception reports submitted, 78 were linked to hours. This showed an increase of 24 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). They have all been closed successfully.

The below table is a breakdown of the exception reports over the last quarter (October 2022 – December 2022)

Exception Reports Open (ER) between 1st October 2022 – 31st December2022	
Total number of exception reports received	107
Number relating to hours of work	78
Number relating to pattern of work	3
Number relating to educational opportunities	3
Number relating to service support available to the Doctor	23
Number initially relating to immediate patient safety concerns	19

*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 October 2022 and 31st December 2022	
Total number of exception reports resolved as at 31/12/2022*	120
Total number of exception reports unresolved as at 31/12/2022*	0
Total number of exception reports where TOIL was granted	37
Total number of exception reports where overtime was paid	45
Total number of exception reports resulting in a work schedule review	1
Total number of exception reports resulting in no further action	18
Total number of exception reports resulting in fines	TBC

"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 19 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.

This quarter has demonstrated a significant increase in the number of immediate safety concerns received. All of these reports were due to issues with staffing in medicine in DPOW. This was at both a junior and senior level, and across a variety of medical specialties. This increase in immediate safety concerns was escalated to the medical director, and a meeting was held with various stakeholders in the management and staffing of medicine. An action plan was created and several interim solutions were found. The level of immediate safety concern reporting has greatly reduced since these interventions.

3. Work Schedule Reviews

During this quarter there was one work schedule review undertaken in Gastroenterology in DPOW. This has highlighted the need for increased staffing at a junior level. An interim solution has been put in place pending an establishment review.

4. Trend in Exception Reporting

There has been a significant increase in exception reports received this quarter. This is likely to reflect high operational pressures in the medical departments, coupled with high levels of sickness within the departments at all levels. Improved engagement with the doctors during induction has embedded the culture of exception reporting well among the doctors in training, particularly at a foundation level, which has meant that this system is being used appropriately to highlight staffing issues.

5. Fines Levied against Departments this quarter

There has been at least one fine this quarter. This was for missed breaks in Scunthorpe, and has been calculated as £432.40. These funds will be discussed with the junior doctors forum and a plan made as to how to spend this money. There will more likely than not be more fines for persistent hours breeches in medicine in DPOW owing to the frequency of exception reports, however the guidance about how and when to fine is very unclear. Clarification has been sought from NHS England and the BMA regarding this matter, and an update will be provided in the next quarterly report.

6. Communication and Engagement

Work continues regarding 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. This is usually run by the guardian of safe working, but several times a year is a joint session with PGME or the Freedom to Speak Up Guardian. In addition there is a regular quarterly newsletter which is circulated via e-mail. Information pertaining to the 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 a significant increase compared with the previous quarter. This is likely to be due to high operational pressures, coupled with high levels of staff sickness. The high levels of exception reporting were coupled with a high level of immediate safety concerns. This situation was escalated to the medical director, and action was taken to ensure that the staffing on the ward was safe. The rate of exception reporting reduced following this intervention.

Continued engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to resolve most issues as and when they arise. We will ensure that we continue with this work, as it provides real-time information about the situation on the wards, in addition to being a contractual obligation.

Engagement of the Educational Supervisors still remains an issue which needs improvement- this will ensure a timely response to exception reports, in addition to providing improved support to the doctors in training, and contributing to our efforts to make the training experience at NLaG a positive one.

Dr Liz Evans - Guardian of Safe Working

Date: 1st January 2023

NLG(23)073

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	4 April 2023	
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 24 November 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Audit, Risk & Governance Committee held on 24 November 2022 and approved at its meeting on 23 February 2023.	
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 ✓ 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.
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MINUTES

MEETING: Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**

DATE: **24 November 2022** via MS Teams

PRESENT:	Simon Parkes	Chair of ARG Committee / Non-Executive Director
	Gill Ponder	Non-Executive Director (*From item 7.1 due to IT issues*)
	Kate Truscott	Non-Executive Director
IN ATTENDANCE:	Helen Harris	Director of Corporate Governance
	Chris Boyne	Deputy Director, 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
	Simon Tighe	Deputy Director of Estates and Facilities (For item 11.1)
	Ivan Pannell	Head of Procurement (For items 11.6 & 11.7)
	Mick Chomyn	Director of Pathology (For item 11.2)
	Kishore Sasapu	Consultant (For item 11.3)
	Sue Meakin	Data Protection Officer (For item 11.5)
	Lauren Short	Finance Directorate Administrator / PA to CFO (Minutes)

Item 1 11/22 **Apologies for Absence:**

1.1 Simon Parkes welcomed Kate Truscott as the Trust's new Non-Executive Director and a member of this Committee, as well as Lauren Short who would now be the admin support and minute taker for the Committee following Anne Sprason's retirement. Simon Parkes advised that the meeting was being recorded for transcription purposes and the recording would be deleted once the draft minutes were approved.

Kate Truscott introduced herself and gave a background of the work and roles she had previously undertaken and noted that she had been a member of various Audit Committees throughout her career.

1.2 Apologies received from Lee Bond.

Item 2 11/22 **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 11/22 **Minutes of Previous Meetings**

3.1 The minutes from the public meeting held on 27 July 2022 were agreed as an accurate record.

3.2 The Public Highlight Report from 27 July 2022 had been provided and noted.

3.3 The minutes from the private meeting held on 27 July 2022 were agreed as an accurate record.

3.4 The Private Highlight Report from 27 July 2022 had been provided and noted.

Item 4 11/22 **Matters Arising/Review of Action Log**

The action log was reviewed and the following noted:

- 9 (24.2.22) – High Level Risk Register – Helen Harris advised now incorporated into the BAF. **Closed**.
- 7.1 (21.4.22) – Assurance Map – Helen Harris had supplied the draft document to Simon Parkes for review.
- 7.4 (21.4.22) – Data Quality Reviews – Danielle Hodson confirmed this was now included in the Internal Audit programme. **Closed**.
- 12.7 (21.4.22) – Declarations of Interest – Scheduled agenda item. **Closed**.
- 6.4 (27.7.22) – HFMA Financial Governance Checklist – additional ARG meeting not necessary. **Closed**.
- 8 (27.7.22) – BAF Finance Risks – Review under BAF agenda item. **Closed**.
- 10.1 (27.7.22) - Mortuary and Body Store Assurance – Scheduled agenda item.
- 11.5 (27.7.22) – RATS Highlight Report & Action Log – Simon Parkes discussing issue of assurance received at ARG.

Nicola Parker joined the meeting.

Item 5 11/22 **External Audit**

5.1 Update on Position with External Audit Service Tender

Sally Stevenson informed the Committee that the second tender exercise closed on 9.11.22 with one bid received, and a tender evaluation panel meeting was arranged for 2.12.23. Sally Stevenson was therefore hopeful to be able to report good news on appointing a new External Auditor shortly thereafter.

The Committee was asked to refer to Appendix 1 of the paper which showed External Audit Fees benchmarking data provided by NHSE, recognising there were now nationwide issues attracting and retaining External Auditors. It was interesting to note where the Trust sat in the data, and it was apparent that the Trust had been paying quite low fees. It was therefore expected that the Trust would see an increased fee with the new External Auditor service.

Simon Parkes agreed and explained how the External Audit market, and not just in the NHS sector, had broken down due to a combination of factors in play, including Auditors being under a lot more pressure from the Regulator, pricing their risk as you would expect them to, being much more careful of the sectors they're involved with and firms struggling trying to get their trainees qualified, resulting in less capacity. Ultimately the Trust must have an External Auditor and the Trust will go through the tender process accordingly, hoping to attain the required quality standards but recognising the pricing situation and accepting the likely increase in fees.

Robert Pickersgill raised an issue which was relevant to the Governors and referred to the last External Audit opinion which he stated was somewhat constrained around areas, for example, value for money. Robert asked if there were anything the Trust could do in terms of the specification, although recognised it was governed by procurement rules so probably not. Robert Pickersgill questioned the source of the constraint and asked if there was anything to loosen the terms in future.

Simon Parkes stated that the Trust do not place any constraints or additional expectations on the External Auditor through the process. Sally Stevenson confirmed that the Trust do not govern the value for money opinion, it is determined through national guidance and the National Audit Office and not something the Trust has any control over. Simon Parkes added that the reason for External Auditors modifying the

value for money opinion was effectively due to the Trust being in double special measures. He expected to receive a different opinion once the Trust exits special measures. This would be the same for any other External Auditor as they all work to the same guidance.

Robert Pickersgill. questioned whether the Trusts professional staff agreed with this view stating that it did not seem fair for Trusts in special measures to not have value for money work completed by External Auditors. Simon Parkes suggested that this could be picked up and discussed at the next Governors Assurance Group, and also potentially picked up next week at the tender evaluation panel meeting as part of appointing the auditors.

Action: Simon Parkes

Simon Parkes thanked Sally Stevenson for the positive update on the appointment of a new External Auditor.

Item 6 11/22 **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 five reports had been finalised since the last report and another two were at draft report stage with all other audits either under way or in the planning stage. The five finalised reports, and their assurance ratings, were as follows:

- National Cost Collection 2022 (Significant assurance)
- Cyber Security – Phishing Exercise (Advisory assurance)
- Business Continuity and EPRR (Significant assurance)
- Covid-19 Costs (High assurance)
- HFMA Checklist – Improving NHS Financial Sustainability (Advisory assurance)

The following four changes to the 2022/23 Internal Audit plan were highlighted by the auditors and approved by the Committee:

- Improving NHS Financial Sustainability - Additional 15 days obtained through reducing other budgets and use of contingency days.
- The merging of the Gifts, Interests and Hospitality and the Declarations of Interest reviews, as they are very similar and made sense to do together.
- An additional review added into the plan (Data Quality Review) –as per the Committee's request and would be conducted in Q4.
- Information Asset Register to be moved from Q3 to Q4 due to a new IT Asset Register being implemented.

Simon Parkes commented that there had been little choice about conducting the HFMA work, but it was noted that this did not affect the overall audit days for the year, in line with the guidance for this particular piece of work.

Danielle Hodson reported 95 days undertaken to date with the overall plan days standing at 205. Kate Truscott referred to the gap between the total number of days allocated, and the total number of days completed, and queried whether there was some back loading of audit activity for Q3 and Q4. Danielle Hodson reassured the Committee that this was a reasonable position to be in for this time of the year and not out of the norm, with certain audits having to be undertaken in Q3 and Q4 e.g. DSPT Toolkit.

It was agreed by the Committee that the audit reports were generally strong audits with a high level of assurance and nothing of concern. In terms of recommendations made there appeared to be reasonable timescales for implementation and should not be overly difficult for the Trust to achieve. There were no concerns to escalate to the Board.

Simon Parkes thanked the Internal Auditors for a detailed report and noted Kate Truscott's query with regards to the audit days being backloaded but was content at this stage, adding that he would not expect any slippage.

Helen Harris advised that Gill Ponder was experiencing IT issues joining the meeting but would hopefully join the meeting shortly.

6.2 IA Recommendations Follow-up – Status Report

Danielle Hodson confirmed that the introduction of the new monthly Excel spreadsheets to Directors regarding overdue recommendations in their areas was helping to facilitate the support needed to clear recommendations. Danielle Hodson highlighted that there were currently eight overdue recommendations (0 major, 7 moderate, and 1 minor) but with rationale for the delays, and hence could provide assurance that recommendations are being continually monitored and progressed.

Simon Parkes asked Internal Auditor whether there were any particular areas they were worried about or where the Committee needed to pay particular attention to. Danielle Hodson stated no, she was happy with how the audit recommendations were progressing this year and that engagement had improved, reassuring the Committee of regular meetings which take place with Sally Stevenson to highlight any issues if necessary. Simon Parkes acknowledged the challenges faced by Managers but was pleased that engagement had improved in terms of progressing recommendations.

6.3 Insight Technical Updates Report

The latest Insight Technical Updates Report was provided by Internal Audit for information and therefore taken as read, although it was noted that there was a revised Code of Governance issued by NHSE for NHS provider Trusts. There were no questions from the Committee.

6.4 Internal Audit Report on Outcome of HFMA Financial Governance Self-Assessment Checklist

Danielle Hodson advised that this paper should be read in conjunction with the next item on the agenda, and reminded the Committee of the background to this piece of work and presented an overview of the Internal Audit report which reviewed the Trust's completed HFMA Financial Governance Self-Assessment Checklist of the 72 questions. The review found that appropriate evidence was provided by the Trust to support the self-assessment score for each of the 12 NHSE-specified questions. No recommendations had been made for further evidence to be provided. Three recommendations had been agreed in relation to formally monitoring the improvement actions identified by the Trust, to further develop a current process (B13) and develop an action plan for a low scoring question (H1). Danielle Hodson commented that it had been a very interesting piece of work to undertake.

Simon Parkes stated that his general conclusion was that this piece of work had been completed properly and carefully by the Trust, with a degree of honesty.

6.5 NLAG HFMA Checklist and HFMA Checklist Scores Benchmarking Report

Sally Stevenson confirmed that the checklist had been completed honestly and informed the Committee that the Finance management team met over two sessions and studied all questions carefully, with the exercise being interesting and useful to undertake. It had been recognised that there were some areas for improvement, with the view that nothing is ever perfect which was reflected within the scores.

A session will be arranged between NLAG and HUTH to review both sets of scores, to identify differences in scores and understand why that may be. The Trust will also be working to ensure all actions are complete, as far as possible, by 31 January 2023 and the status of actions will be reported back to the February 2023 Committee meeting.

Sally Stevenson referred to the benchmarking results provided by Audit Yorkshire, for the local ICS results and also the 103 other organisations which are audited by NHS Internal Audit consortia highlighting that NLAG's score was showing middle of the range across those 103 organisations. Chris Boyne commented it was a good score for NLAG and that the senior finance team had worked hard to complete this work, pulling the evidence together, etc. Internal Audit will be carrying out more benchmarking and will be looking into examples of best practice of those Trusts who scored high in certain areas and how these can be shared with everyone.

Kate Truscott asked Sally Stevenson as to which action the senior finance team felt was the most concerning in terms of being able to deliver it. Sally Stevenson advised that it was the one highlighted in the paper about ensuring that the tone from the top was right, adding this was something Lee Bond was very keen to work on, understanding and acknowledging that it is very difficult for Executive colleagues to always have finance at the forefront of their minds because of their other competing priorities in terms of patient safety and quality, etc.

Kate Truscott stated that this would be particularly important to reinforce during the business planning period and informed the Committee of a trend she had noticed from sitting on the Quality and Safety Committee around the number of reports received which stated '…if the Trust had more positions and/or more equipment it would solve the problems…'. Kate Truscott added the Trust has to understand that it must live within a funding envelope. Nicola Parker emphasised that the Trust is currently overspent and there is a tone from the top that the Trust needs to manage this spend. Unfortunately, we are not in a position to have additional posts and equipment, etc.

Simon Parkes commented that he was not surprised that the Trust came out reasonably well in this HFMA exercise but was surprised that the Trust seemed to be further adrift from some other Trusts. Simon Parkes added that when he considers the things which demonstrate a Trust that is working well in terms of financial management, e.g. the ability to produce the financial statements quickly at the end of the year, for those to go through the annual audit process with minimal modification or adjustment, etc. demonstrates a Trust which has got a good grip of financial management. As a Trust although in special measures and under significant pressure, colleagues need to understand that this does not excuse the fact that we must manage our finances with proper discipline and rigor, as things will deteriorate if the Trust loses control of financial management. If the Trust can get out of special measures showing strong discipline things will improve and the Committee confirmed their commitment to work with Lee Bond to make sure the balance is properly understood.

Nicola Parker highlighted that there were a few areas on the HFMA checklist where the Trust will not be able to score 5, e.g. discussing budgets with budget holders due to the timeframe of closedown and also external reporting requirements. The Committee

agreed and understood that certain activity and reports are generated during the course of a month.

Robert Pickersgill queried how much emphasis is placed on the analysis of variances within budgetary control system. Simon Parkes confirmed that a monthly finance report is rigorously scrutinised at the Finance and Performance Committee. Nicola Parker reiterated this advising there is a detailed analysis of variances in the Finance report, along with risks and mitigation. Furthermore, a variance analysis has to be reported to NHSE on a monthly basis with our PFR returns. Simon Parkes also stated that since being a member of the Finance and Performance Committee he was impressed with the analysis of the operational impact of the differing mitigations being put forward.

Nicola Parker left the meeting.

Item 7 11/22 **Counter Fraud**

7.1 LCFS Progress Report

Nicki Foley highlighted the following key points to note from the latest progress report:

- A new Government counter fraud body – the Public Sector Fraud Authority - will coordinate all counter fraud activity across the public sector, including the NHS, with an aim to look at modernising the approach to fraud.
- The Trust's Portfolio Governance Board agreed for Fraud Awareness training to be made mandatory through an e-Learning module, however agreement now needs to be sought from the Workforce Committee which will feature on their agenda for approval on 29.11.22.
- The Fraud fact sheet will now be included within the budget holder training slides provided by the Finance team.
- Two new NHSCFA Fraud Prevention Notices received; relating to phishing emails to obtain access to emails and NHS IT Systems; and a successful urgent payment made at another Trust due to a CFO's email account being hacked.
- Seven new fraud referrals had been received since the last meeting, with relevant enquiries at different stages.

Simon Parkes, along with members of the Committee expressed frustration with the recurrent problem of staff working elsewhere while off sick. Nicki Foley stated that every case is considered on its own merits with the appropriate action undertaken, and if not suitable for a criminal investigation then it would be referred to Human Resources for possible disciplinary investigation/action.

Gill Ponder joined the meeting following IT issues.

Kate Truscott supported the fraud investigation work and, where criminal routes could not be pursued, using robust HR sanctions to deal with such employees. Nicki Foley advised that she has a really good relationship with the HR team, who often refer things to her, and they work together to progress cases as necessary.

Sally Stevenson informed the Committee that the issue of staff working elsewhere whilst off sick is not unique to NLAG, it is a nationwide issue and unfortunately with the cost of living crisis, it is likely that there may be an increase in this type of fraud as staff try to find other ways of earning extra income, which may not always result in them being honest and truthful about when they are performing additional jobs. Simon Parkes concurred and agreed that the Trust needs to keep publicising the issues and risks. The Committee agreed that the Trust needs to be a flexible and approachable organisation to try and help staff through these unprecedented times to avoid them resorting to fraudulent activities.

Helen Harris assured the Committee that work is taking place to encourage staff to complete declarations of interest and secondary employment forms, advising that when Nicki Foley does a piece of awareness work Helen is inundated with declaration of interest forms. Helen Harris added that she is continuing to address gaps in respect of declarations of interest and would be discussing it again at the Executive team meeting the following week. Helen Harris and Nicki Foley to discuss other potential awareness avenues outside of the meeting.

Action: Helen Harris / Nicki Foley

Nicki Foley also highlighted to the Committee that the National Fraud Initiative (NFI) is due, being done every two years, with relevant data matches due in January 2023.

Simon Parkes thanked Nicki Foley for the update, commenting that there was a lot of good work going on.

Item 8 11/22 **Board Assurance Framework and Strategic Risk Register – Q2**

Helen Harris highlighted the following points from the paper:

- 3.1 and 3.2 of the BAF has been thoroughly reviewed by Lee Bond and Ivan McConnell. The target risk and current risk ratings have been increased due to the current financial situation the Trust faces.
- The planned actions have been colour coded as part of Internal Audit recommendations, and will support and aid Board committees to see where actions are at with progress.
- The high-level risk register is now included, although is difficult to format. It now also goes to all Board committees for oversight of high-level risks, to be able to provide appropriate challenge.
- Assurance mapping exercise has taken place with the Executive Directors for each strategic risk, looking at controls and that assurance is coming through on the controls and that they are effective. The BAF Internal Audit report is due to feature on the Trust Board agenda in December 2022 when they plan to go through each recommendation in detail, etc. to ensure that the risk appetite is fit for purpose.

Simon Parkes welcomed the circulation of the high-level risk register saying it was step in the right direction and was very helpful and noted the Committee's specific responsibility for the BAF strategic object 1.1. Gill Ponder confirmed there was nothing that stood out to her as an issue, everything made sense and triangulated with other sources.

The Committee was assured that the BAF is creating discussions and helping Board committees have honest discussions, however there were no assurance that this is leading to improvements within the metrics that the Trust is judged against. This is due to a whole range of issues, however it was acknowledged that the Executive Directors and their teams are following the advice given by the committees.

Gill Ponder explained that the committees feel they are doing all that they can do and that the debate needs to happen at Trust Board level, however she was not convinced there was much more the Trust Board could do either until some of the bigger problems are solved.

Robert Pickersgill questioned whether radical outside of the box thinking was required. It was stated that this is already the case, with the Trust being extremely innovative and radical (e.g. virtual wards, rehabilitation beds) however the issue seemed out of the Trust's control with people still coming through the front door whilst there is a lack

of access to alternative healthcare, and is a wider system problem. Kate Truscott commented that the Trust can exert some control over elective care but it cannot control emergency care as its 24/7, and national issues with social care need to be sorted. Kate Truscott agreed it was a system issue.

Kate Truscott left the meeting at this point for a pre-existing commitment.

Item 9 11/22 **Losses and Compensations Report**

Sally Stevenson highlighted the loss of patient property of a ring amounting to nearly £4k. This was due to Trust procedures not being followed which fed into the Committee's previous concerns on this, with an Internal Audit already commissioned for 2022/23. Simon Parkes stated this was frustrating and no doubt upsetting for the family with likely sentimental value.

Simon Tighe joined the meeting.

Gill Ponder expressed concern and noted a theme which seemed to be emerging around jewellery. Sally Stevenson advised that the incidents of loss/theft should be reported via the Ulysses incident reporting system and referred to the Trust's Local Security Management Specialist (LSMS) who deal with thefts, etc. and likely to be joining the dots on such issues. Sally Stevenson offered to speak to the LSMS and establish further information for the Committee. Simon Parkes referred to the fact that there is also an Internal Audit review scheduled in this area during the year.

In terms of patients' valuables, Helen Harris raised whether more focus should be put into the letters which are sent to patients to remind them to not bring valuables in with them. The Committee agreed to wait to see the findings of the Internal Audit report before taking any further action.

Simon Parkes also noted his concern with the amount of pharmacy waste due to an open fridge door and felt this reflected his concerns at a 15 steps visit around controls not being what they should be. It was agreed to refer to this matter in the Highlight Report to the Board.

Post meeting note: Due to an oversight, the pharmacy waste issue was omitted from the Highlight Report to the Board at its December 2022 meeting.

Item 10 11/22 **Management Reports for Assurance – Items for Approval**

There were no reports to approve.

Item 11 11/22 **Management Reports for Assurance**

11.1 Medical Gas Oversight and Assurance

Simon Tighe apologised for not presenting a formal paper today, and stated that there were a number actions for a number of committees that he needs to meet with operational colleagues and Simon Priestley with to get assurance on the action plans through the Medical Gases Committee and then come back to the Committee with what needs doing and when it will be done. Simon Tighe stated that he wanted to build the information into business as usual reports rather than create new ones, and therefore requested to come back to the next meeting having joined all the dots. Simon Tighe assured the Committee that the work was being done in the background, but this was now about reporting on that work, and confirmed there was no risk exposure as a result

of not presenting anything today. The Committee agreed to Simon Tighe returning in February 2023.

Simon Tighe left the meeting. The Committee broke for a short comfort break.

Mr Kishor Sasapu joined the meeting. The next two agenda items were taken out of sequence.

11.3 Risk Management Strategy Development Plan Update

Mr Sasapu advised the Committee that the Trust had appointed a new Associate Director of Quality and Governance who is due to join the Trust in January 2023. Mr Sasapu highlighted that a review by NHSE had resulted in recommendations in three key areas:

- Risk maturity.
- Capacity building – specifically governance within the divisions.
- Reporting and oversight – through the Risk Management Group.

With support from NHSE an action plan has been created to track and monitor these areas with oversight from the Risk Management Group. Mr Sasapu stated most of the actions are complete, and those shown as amber are around how to incorporate regular training for managers to understand risks. Mr Sasapu will be discussing this with the new Associate Director to see how they track this. Mr Sasapu also outlined plans for making sure there was more clinical representation in the meetings, adding that he also now chairs the Risk Management Group.

Sue Meakin and Mick Chomyn joined the meeting.

Simon Parkes stated that good progress was being made, however emphasised a recurring challenge across a number of areas as being the capacity for training and clear understanding of what and when that training needs to take place. It was positive to hear that there was more clinical engagement taking place.

Mr Sasapu informed the Committee that the new incident reporting system (Ulysees) is much more user friendly and that tracking of incidents is more robust. Additionally, there is a better understanding that reporting incidents is not about blaming people, it's about raising awareness of incidents to understand issues and effect change. Mr Sasapu agreed to feed the issue of training back to the new Associate Director of Quality and Governance.

Ivan Pannell joined the meeting.

Mr Sasapu left the meeting.

11.2 Mortuary and Body Store Assurance

Simon Parkes commented that he thought this matter was close to coming to a close. Mick Chomyn explained that the long-term plan had been to close the body store down and source a local funeral director to collect the deceased directly from the ward, however funeral directors approached all said no to providing this service. The other option would be to transfer the deceased from Goole to the Scunthorpe mortuary using the Trust's own transport services. This option would not be available until the Scunthorpe mortuary had increased the storage capacity. A capital programme project is currently underway to expand the Scunthorpe mortuary which should be within the next 2-3 months, and this issue can be revisited.

Mick Chomyn raised his concerns regarding the deceased needing to be collected within a 4-hour timeframe which would require a 24/7/365 service. It was confirmed that Mick Chomyn and Ant Rosevear, who now has managerial responsibility for the Goole site, are currently working on an options paper as to the feasibility of the transport arrangements versus keeping the body store in operation and taking all other requirements into consideration.

Simon Parkes asked for confirmation that the key weakness was the adequacy of audit of CCTV and swipe card access at Goole. Mick Chomyn didn't feel it was much of a weakness and advised that Ant Rosevear was developing an SOP. Simon Parkes requested confirmation that the arrangements are actually in place at Goole, and then the question is a financial one based on the option appraisal being developed.

Gill Ponder asked for clarification on the options now being discussed when they simply didn't appear viable options. It was clarified that all options are being considered to find a practical alternative, but in the interim deliver the service robustly and securely. Gill Ponder shared her apprehensions regarding the lack of providers willing to provide this service, if any could be found.

A further update to be provided to the February 2023 ARG Committee meeting. Mick Chomyn was thanked for the update and left the meeting.

Action: Mick Chomyn

11.4 Document Control Report

Helen Harris presented the report and highlighted 98.5% of controlled documents were in date, which is good, however compliance needs to be increased to 100%. Work is ongoing to ensure the clinical divisions keep documents up to date, however Helen Harris recommended the Committee add this to the Highlight Report to the Trust Board to assist with strengthening divisional compliance.

The Committee noted a generally improving trend, however acknowledged the high to moderate risk overdue documents needed urgent attention to avoid the potential for any adverse outcomes. Simon Parkes requested that following this meeting a list of the high and medium risk stratified overdue documents needs to be sent to the relevant Executive Directors for urgent action.

Action: Helen Harris

11.5 IG Steering Group Highlight Report

Sue Meakin took the report as read and Simon Parkes asked whether Committee members wanted to raise any questions.

Gill Ponder highlighted her disappointment of the Trust not reaching 95% for IG training as it is something which she believed is within the control of the Trust and can be achieved, adding it only takes around 40 minutes to do although recognised the pressure staff were under but still felt it was achievable. Sue Meakin agreed, particularly when the Trust achieved 95% during Covid. Sue Meakin explained all the various ways in which staff can complete this training and that she was having a meeting with HR later that week to discuss what else could be done as they were willing to do anything they could to improve compliance rates.

The Committee also discussed the level of incidents and the key themes, but Sue Meakin advised that they were still working on getting robust reports from the new Ulysees system.
Sue Meakin left the meeting.

11.6 Waiving of Standard Orders Report

Ivan Pannell highlighted the small number of Waivers in this report and was happy to take any questions.

Robert Pickersgill queried the percentage of Waivers raised against the number of orders raised and total value of orders. Ivan Pannell stated that he did not have the answer to hand, although it was something they could work out if necessary, adding that it would be a very low percentage given the overall level of spend against the number of Waivers. Ivan Pannell confirmed that 21 Waivers had been processed within the last 3 months with an average of 150 purchase orders daily, illustrating the low number of Waivers.

Gill Ponder queried the reasons for Waivers. Ivan Pannell confirmed that the typical reasons for Waivers are for standardisation purposes, only one supplier in the market or an extension for a short period of time, etc. Gill Ponder asked for confirmation that controls were not bypassed as a result of doing a Waiver. Ivan Pannell confirmed no processes were being bypassed and explained that a purchase order is always raised alongside a Waiver which must be approved by the budget holder, divisional finance manager and the Chief Financial Officer. A Waiver would also only be completed upon advice from the Procurement department.

Simon Parkes commented that there were no Waiver rejections detailed and Ivan Pannell confirmed that there should never be any rejections as either there was a valid reason for requesting a Waiver or there wasn't and therefore the procurement process should be applied, so effectively the Waiver rejection category is a redundant option.

Robert Pickersgill asked how the Procurement team was coping with inflation and checking supplier invoices for pricing issues. Ivan Pannell shared a few supply issues which the Procurement team has mitigated and continue to monitor the supply and demand. The Procurement team regularly update prices within the Trust's electronic catalogues, however suppliers are now increasing their prices more often and routinely increasing them between 5%-10% which is understandable in the current climate. Ivan Pannell concluded that as a result of their actions there should be no issues with invoices mis-matching with orders in relation to prices.

11.7 Procurement KPI Data Report

Ivan Pannell asked the Committee not to underestimate the level of cultural change of implementing the electronic requisitioning system within the Trust, it has been a huge task to undertake with over 800 active users. Overall, it had been a successful implementation with positive feedback from stakeholders, clearly there were some teething troubles as with any new large-scale system implementation. Ivan Pannell stated the process has improved (safer, more robust, quicker) with responsibility now placed on the requisitioner to GRN their orders once received. Feedback from other Trust's using it indicates that on average it takes up to one year for users to feel comfortable using this system. The Procurement department continue to offer training.

Ivan Pannell left the meeting.

11.8 Salary Overpayments Report

Sally Stevenson shared her disappointment regarding an increase in salary overpayments for Q2, noting a total of seven overpayments during Q2 amounting to

approximately £43k. Action is in place to recover these overpayments with some already recovered.

Sally Stevenson also updated the Committee that the Payroll and Pensions team is now collaborating closely with HUTH and as a result is now being managed by Richard Horner, Payroll and Pensions Manager at HUTH. The NLAG Payroll and Pensions Manager left in October 2022 at which point Richard Horner took over management arrangements and two payrolls have been processed since that time with Richard Horner very pleased with the way things had been going.

Simon Parkes noted that the number and value of Payroll department errors was quite high and wondered whether there was any particular reasoning behind this. It was confirmed that there were several salary advances that were processed and had not been recovered from the following month's pay. The Pay Clerk was aware of the mistake and the necessary action has been undertaken to ensure this does not happen again.

11.9 Declarations of Interests Report

Helen Harris was pleased to inform the Committee of the positive progress being made regarding declarations of interests but noted that the new electronic system still required some minor improvements. Unfortunately, the software developer involved has recently left the Trust and therefore there was a slight delay getting the minor system adjustments finalised.

Helen Harris also advised that herself and Alison Hurley were undertaking lots of awareness work and attending meetings, etc. to discuss making the required declarations. Further focus is needed on ensuring 'Decision Making Staff' make the necessary declarations, including nil declarations, and she had discussed this with the Chief Executive earlier that day and would be raising it at the Exec team meeting the following week. Helen Harris also wanted to note that work is ongoing with the E Job planning for Consultants to tighten up the process.

Sally Stevenson raised an issue with how the system was showing each part of the declaration process, as she had submitted her declarations as necessary but it was showing as 'in progress' as it had not been through the line managers part of the process. Helen Harris acknowledged that this was an issue and something they were looking to fix.

Item 12 11/22 **Action Logs and Highlight Reports from other Sub-committees.**

The following action logs and Highlight reports were provided and noted:

12.1 Finance & Performance Committee
12.2 Quality & Safety Committee
12.3 Workforce Committee
12.4 Health Tree Foundation Committee
12.5 RATS Committee - not received.
12.6 Strategic Development Committee

Item 13 11/22 **Private Agenda Items**

There were no private items to discuss.

Item 14 11/22 **Any Other Business**

14.1 ARG Terms of Reference – Minor Amendments

Helen Harris advised that as a result of an Internal Audit recommendation, a minor wording amendment was being made to all Board Committee Terms of Reference to ensure consistent references to the High-Level Risk Register. The Committee approved the amendment prior to final ratification by the Trust Board.

14.2 ARG Committee Schedule of Meeting Dates 2023

The Committee was notified of the change to the July 2023 meeting being moved a week earlier at the suggestion of Helen Harris, and was now due to take place on Thursday 20 July 2023.

14.3 Any Other Urgent Business?

There was no urgent business raised.

Item 15 11/22 **Matters for Escalation to the Trust Board**

All issues for escalation were agreed throughout the meeting.

Action: Sally Stevenson / Simon Parkes

Item 16 11/22 **Matters to Highlight to other Trust Board Assurance Committees**

There were no issues to highlight to other Trust Board Assurance Committees.

Item 17 11/22 **Review of ARG Committee Workplan**

The ARG Committee workplan was noted.

Item 18 11/22 **Review of the Meeting.**

Members of the Committee were happy with how the meeting was undertaken and agreed with all the items being highlighted to the Trust Board, noting some recurring themes which needed nudging in the right direction.

Item 19 11/22 **Date and Time of the next full meeting**

Thursday 12 February 2023 – 9.30am – 12.30pm via Microsoft Teams.

NLG(23)074

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	4 April 2023
Director Lead	Simon Parkes, NED / Chair of Audit, Risk and Governance Committee
Contact Officer/Author	Simon Parkes
Title of the Report	**Results of Audit, Risk & Governance Committee Annual Self-Assessment Exercise 2023**
Purpose of the Report and Executive Summary (to include recommendations)	The annual self-assessment exercise has been conducted by the Audit, Risk and Governance Committee. The updated draft self-assessment document for 2023 was reviewed by the following, with comments/suggestions duly incorporated as necessary: 1. Simon Parkes– NED / ARGC Chair 2. Kate Truscott – NED 3. Gill Ponder - NED 4. Lee Bond – Chief Financial Officer 5. Helen Harris – Director of Corporate Governance 6. Sally Stevenson – Assistant Director of Finance – Compliance and Counter Fraud 7. Chris Boyne – Deputy Director, Internal Audit, Audit Yorkshire 8. Danielle Hodson – Interim Internal Audit Manager, Audit Yorkshire The results of the 2023 self-assessment exercise are recorded on the attached checklist. No deficiencies were identified in the review of the Committee's processes. The Committee use the HFMA NHS Audit Committee Handbook (2018) self-assessment checklist for this annual exercise. The HFMA have advised that a full updated Handbook is due sometime in 2023. **The Trust Board is asked to note the results of the latest self-assessment exercise performed by the Audit, Risk and Governance Committee in February 2023.**
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk & Governance Committee Agenda Papers – 23 February 2023
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ✓ 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 ☐ 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

Audit, Risk and Governance Committee

Self-Assessment Review of Committee Processes - HFMA NHS Audit Committee Handbook, 2018

23 February 2023

Area/ Question	Yes	No	Comments/Action
Composition, establishment and duties			
Does the audit committee have written terms of reference and have they been approved by the governing body?	√		Latest version freely available on the Trust intranet. Last approved by the Trust Board in February 2023 (7.2.23). Minor revisions proposed as part of annual review at February 2023 ARG Committee. Proposed revisions going to April 2023 Trust Board for approval.
Are the terms of reference reviewed annually?	√		Part of the Committee's annual work plan, but also adjusted as necessary in the intervening period. Last reviewed and updated by the Committee in November 2022 to reflect a recommendation arising from an Internal Audit review of the Board Assurance Framework – section 5.9.6 of the ARG ToR. Submitted to February 2023 Trust Board for ratification. Minor revisions proposed as part of annual review at February 2023 ARG Committee, and being submitted to April 2023 Trust Board for approval.
Has the committee formally considered how it integrates with other committees that are reviewing risk?	√		The Committee's ToR specifically refers to how it integrates with other Trust Board Assurance sub-committees. This is achieved by reviewing their work, specifically in terms of the management of risks, through the routine receipt of action logs and highlight reports at each meeting of the Committee, and identifying any issues that the Committee feel further assurance is required on. Additionally, there is formal ARG Committee member representation on each of the other Board assurance sub-committees.
Are committee members independent of the management team?	√		The Committee's membership comprises 3 Non-Executive Directors.

Area/ Question	Yes	No	Comments/Action
Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?	√		Minutes and highlight reports submitted to Trust Board. Chair of ARG Committee presents highlight report at TB (as do all other sub-committee Chairs). Highlight reports also submitted to the Governor Assurance Group (GAG) for oversight and assurance and the Lead Governor prepares a Highlight Report from the GAG to the Council of Governors (CoG).
Does the committee prepare an annual report on its work and performance for the governing body?	√		Annual report submitted to the Trust Board and CoG for information.
Has the committee established a plan of matters to be dealt with across the year?	√		Formal work plan first adopted in 2012, reviewed annually thereafter and any ad-hoc changes made as necessary in between. Rolling twelve month work plan adopted in July 2020. Latest annual review conducted at February 2023 ARG Committee meeting.
Are committee papers distributed in sufficient time for members to give them due consideration?	√		In line with ARG ToR – 7 calendar days before each meeting.
Has the committee been quorate for each meeting this year?	√		Five scheduled meetings during 22/23 (Feb/Apr/June/Jul/Nov) and all were quorate.
Internal control and risk management			
Has the committee reviewed the effectiveness of the organisation's assurance framework?	√		Through Internal Audit annual review. The Committee also routinely receives and reviews the quarterly BAF and Strategic Risk Register report at each meeting.
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?	√		Through minutes from other Board sub-committees. As from April 2017 the Committee has received a quarterly report on the BAF and Strategic Risk Register for oversight and scrutiny purposes.
Has the committee reviewed the accuracy of the draft annual governance statement?	√		ARG Committee minutes will evidence this.

Area/ Question	Yes	No	Comments/Action
Has the committee reviewed key data against the data quality dimensions?	√		***New question in 2018*** - The Trust's Data Quality Strategy was refreshed and submitted to the July 2019 meeting of the ARG Committee for review/comment. External audit review performance indicators as directed by NHSI as part of their year-end audit work, and report the results accordingly to the Committee. The Committee also receives reports from Internal Audit on the outcome of reviews of targeted KPI's as part of the IA annual plan. Specific data quality audits have been added to the Internal Audit work plan during 2022/23 and these will continue to be included each year on a cyclical basis.
Annual report and accounts and disclosure statements			
Does the committee receive and review a draft of the organisation's annual report and accounts?	√		Annual Report and Accounts. The Committee receives the draft accounts for review prior to submission to the External Auditor. The Committee also receives the audited accounts for approval prior to submission to NHSE, under formal delegated authority from the Trust Board. A paper proposing delegated authority is submitted to the February Trust Board for consideration and approval each year.
Does the committee specifically review: • The going concern assessment • Changes in accounting policies • Changes in accounting practice due to changes in accounting standards • Changes in estimation techniques • Significant judgements made in preparing the accounts • Significant adjustments resulting from the audit • Explanations for any significant variances?	√		Facilitated as necessary through reports from Finance / External Auditor and discussion at Committee meetings.

Area/ Question	Yes	No	Comments/Action
Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?	√		In June, prior to submission to NHSE.
Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?	√		Robust discussions involving annual accounts. The Audit Completion Report includes explanations for any areas of non-adjustment. None identified in the 21/22 audit.
Internal audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?	√		Formal Internal Audit Charter and Internal Audit Working Protocol with Internal Audit Provider (currently Audit Yorkshire).
Does the committee review and approve the internal audit plan, and any changes to the plan?	√		Annual and strategic plans are approved prior to the beginning of each financial year. Changes are documented and approved through IA progress reports to each ARG Committee meeting as necessary.
Is the committee confident that the audit plan is derived from a clear risk assessment process?	√		Plan derived from Internal Audit's individual discussions with Trust Executive Directors, followed by discussion of the draft plan at an Executive Team meeting(s) and then submission to ARG Committee for review and final approval. Additionally, the Committee will suggest items for inclusion in the annual internal audit plan, for example this year cyclical data quality audits has been added.
Does the committee receive periodic progress reports from the head of internal audit?	√		At each meeting.
Does the committee effectively monitor the implementation of management actions arising from internal audit reports?	√		At each meeting.
Does the head of internal audit have a right of access to the committee and its chair at any time?	√		Specifically referred to in ARG ToR.

Area/ Question	Yes	No	Comments/Action
Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?	√		Could be raised at the annual private meeting between the auditors and the Committee (June – Audited Accounts meeting), or by calling an ad-hoc private meeting at any time or during Committee meetings if such an issue arose.
Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*?	√		Audit Yorkshire's work is undertaken in accordance with their detailed Internal Audit Quality Assurance Manual which ensures a consistent approach and compliance with all relevant regulatory standards. In addition, they use an Internal Audit Quality Assessment Framework biennially and an external review every five years to objectively assess the quality of their service. Audit Yorkshire agreed with their Board to perform a self-assessment in 2019/20 to confirm compliance for the organisation, with an external review planned for 2020. This external review was duly undertaken by CIPFA in February 2020 with the following outcome: *'It is our opinion that Audit Yorkshire's self-assessment is accurate and, as such, we conclude that Audit Yorkshire FULLY CONFORMS to the requirements of the Public Sector Internal Audit Standards.'*
Does the committee receive and review the head of internal audit's annual opinion?	√		ARG Committee minutes will evidence this.
External audit			
Do the external auditors present their audit plan to the committee for agreement and approval?	√		ARG Committee minutes will evidence this. Received at the February 2022 meeting.
Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?	√		ARG Committee minutes will evidence this.

Area/ Question	Yes	No	Comments/Action
Does the committee review the external auditor's value for money conclusion?	√		ARG Committee minutes will evidence this.
Does the committee review the external auditor's opinion on the quality account when necessary? **[Note: this question is not relevant for CCGs]**	√		No longer a requirement for external audit independent review.
Does the committee hold periodic private discussions with the external auditors?	√		Once a year (June – Audited Accounts meeting) or at any other meeting if requested in advance by the auditors.
Does the committee assess the performance of external audit?	√		Formalised approach adopted in July 2020 with a paper to ARGC providing a formal annual evaluation of External Audit performance . Last undertaken in July 2022. Issues in the intervening period would be addressed as necessary.
Does the committee require assurance from external audit about its policies for ensuring independence?	√		Formal confirmation in audit strategy/fee documentation.
Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?	√		Policy for Engagement of External Auditors on Non-Audit Work devised and approved in February 2015 and subject to annual review. Revised January 2019 to reflect new NAO guidance on this area and reviewed annually thereafter. Latest review at February 2023 meeting. Details of non-audit work included in the annual ISA260 report from the External Auditor. Value of non-audit work also identified separately in the annual accounts.
Area/ Question	**Yes**	**No**	**Comments/Action**
Clinical audit [Note: this section is only relevant for providers]			
If the committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?	√		The Quality & Safety (Q&S) Committee are responsible for monitoring delivery of clinical audit activity. Q&S Committee minutes received by ARGC. 2022/23 Clinical audit annual plan received by ARGC in July 2022 for information.

Area/ Question	Yes	No	Comments/Action
If the committee is responsible for monitoring clinical audit has it: • Reviewed an annual clinical audit plan? • Received regular progress reports? • Monitored the implementation of management actions? • Received a report over the quality assurance processes covered by clinical audit activity?	N/A	N/A	See above.
Counter fraud			
Does the committee review and approve the counter fraud work plans, and any changes to the plans?	√		Plan agreed with Chief Financial Officer and received by the ARG Committee for review.
Is the committee satisfied that the work plan is derived an appropriate risk assessment and that coverage is adequate?	√		Counter fraud work plan informed by register of fraud risks, internal audit, NFI, NHS Counter Fraud Authority (NHS CFA) intelligence reports, etc. Work plan areas based on national provider standards established by the NHS CFA / Cabinet Office.
Does the audit committee receive periodic reports about counter fraud activity?	√		Standing agenda item for written counter fraud progress reports from the Local Counter Fraud Specialist (LCFS) at each ARGC meeting. LCFS in attendance at each meeting.
Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?	√		ARG Committee minutes will evidence this where appropriate.
Do those working on counter fraud activity have a right of direct access to the committee and its chair?	√		Contained within ARG ToR in relation to the LCFS. The LCFS also meets with the ARG Chair annually.
Does the committee receive and review an annual report on counter fraud activity?	√		This has always been the case in relation to counter fraud work since 2000.
Does the committee receive and discuss reports arising from quality inspections by NHSCFA?	√		ARG Committee minutes will evidence this where appropriate.

NLG(23)075

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	4/4/2023	
Director Lead	Adrian Beddow, Associate Director of Communications	
Contact Officer/Author	Charlie Grinhaff, Communications Manager	
Title of the Report	**Communications Round up**	
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 January and February 2023 and includes an overview of team plans and progress. The Trust Board is recommended to note the report.	
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.

*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

Communications Team update

April 2023

Kindness • Courage • Respect

Report period: January to February 2023

Contents

Headlines

3,938+ (+0.56%) Members of the staff Facebook group

257 Ask Peter questions asked

872 Opens of the new manager email

85 FOIs received in one month (a new record)

98% Of media coverage was positive or neutral

This report covers May and June 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 • Reviewed the content on our website, and that on the NHS website for our Trust • Introduced regular infographics on maternity stats, A&E stats and more recently patient feedback	**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 • Added the Trust Twitter feed to the home page of the Hub so staff not on social media can see our celebrating success content • Introduced a new managers email so we can target manager specific messages
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** • Working with senior leaders on their approach to engagement and communication • Supporting the People division with the Health and Wellbeing and Culture Transformation work. • Bringing back the annual staff awards ceremony, Our Stars 2023 • Reviewing Ask Peter

Supporting the Trust's priorities

Trust Priority 1 – Our People
We launched our first dedicated managers email in February. The monthly newsletter will be a one stop tool which covers the latest news, updates, policy changes and some myth busters to help our managers in their roles. We've already had positive feedback: "This email is so very helpful – thanks for putting it together and sending 😊"

It was sent to 566 managers and opened 1479 times.

Annual leave carry over campaign
We've been encouraging staff to think of their health and wellbeing and get some rest by booking any unused leave. Staff have been informed across all of our channels to apply to carry over any unused leave.

Schwartz Rounds
We held our first Schwartz Round in February with 62 colleagues joining the session. Feedback from attendees included:
"I'm surprised how emotional I feel as it has made me think about some of my own experiences."
"It has been great to take the time out from our roles to listen to these stories. It just goes to show that we need to support each other.

Supporting the Trust's priorities

Trust Priority 2 – Quality and Safety
We have created a new infographic to highlight the positive feedback from the Friends and Family Test and to encourage more people to share their experiences via the iWantGreatCare platform

Trust Priority 3 – Restoring Services
The Trust featured in a national playbook on the NHS E website focusing on the successful rollout of digital letters. https://transform.england.nhs.uk/key-tools-and-info/digital-playbooks/workforce-digital-playbook/digitisation-of-out-patient-letters/

Trust Priority 4 – Reducing health inequalities
The Alcohol Care team now has a presence for the service on the website and Hub.

We continue to work with system partners to support and promote the Tobacco Dependency Service – both the public and staff offer.

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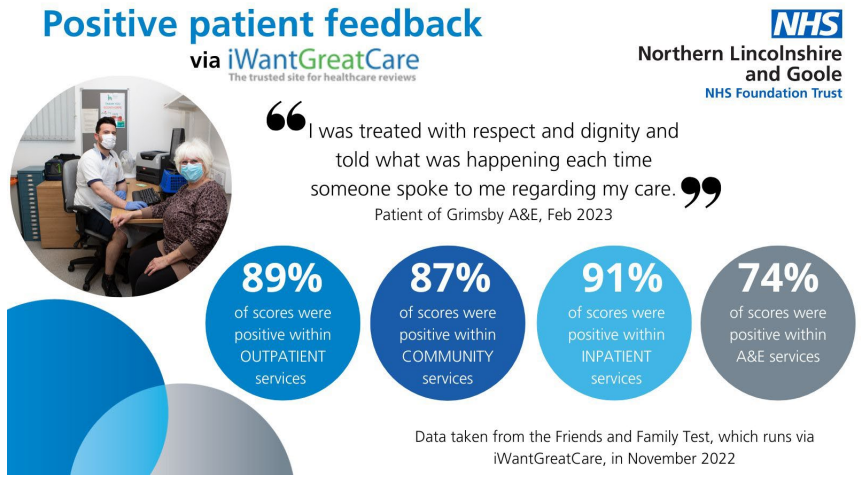


Supporting the Trust's priorities

Trust Priority 8 – Capital Investment - During the first two months of this year, the main focus of our Capital communications has been on our internal audience. We've covered everything from the final stages of the construction and takeover of the Scunthorpe Emergency Department to work getting underway on new Changing Places facilities, and updates on the numerous other improvements being made to our facilities across the Trust.
In terms of reach, there have been some changes in the data we have available to us. We can now measure how many times our weekly Building Our Future emails are opened. However, we have lost the ability to see how many visitors there have been to our Hub sites. During January and February, the Building Our Future email was opened a total of **41,656 times** and our estimated total audience was **63,013.**

Trust Priority 9 – Digital – Unsurprisingly, given the reach and scope of this programme of work, the main focus of our Digital comms has been on the implementation of Lorenzo – our new Patient Administration System.

The Monday Message on the topic from Shauna generated 65 click throughs to the Smartcard Hub Site.

Other topics covered include BadgerNet, Multi Factor Authentication, cyber security, and Single Sign On.

Trust Priority 10 – The NHS Green agenda
We continue to promote our sustainability work including a number of green initiatives. Keith Fowler, Associate Director of Facilities and Sustainability, presented at Team Brief Live and spoke about all the great work we're doing across the Trust. The work we're doing to reduce our waste is being highlighted by Greener NHS. They will be sharing our story on their website and social media.

Campaigns and awareness weeks

Can’t make it? Cancel it!

We ran a social media and website campaign from mid Jan to mid Feb to support the Trust in reducing the number of DNAs (did not attend). Whilst the campaign can’t take full credit the Trust DNA rate did fall during this period. On social media we posted 16 times and generated 14,927 post impressions and 314 engagements and 5 comments. During the campaign we signposted people to the website to two specific pages – 1. the rearrange or cancel your appointment form which had 685 visits – and 2. the SAT team contact details page – which had 349 visits.

Blue Monday draw

We supported the Lottery Committee with a campaign and prize draw to help staff during January. The ‘Not so Blue Monday’ prize draw saw 100 members of staff win a £100 shopping voucher. We came up with the look and feel of the campaign, created the artwork, ran the draw in partnership with the OD team and helped with distribution of the vouchers to winners.

Feedback from staff included: “Amazing thank you so much”, “That is great news”, “It certainly did brighten my day.” “Thank you so much! This has made my morning 😊” and “Oh wow thanks very much.”

Campaigns and awareness weeks

Other campaigns

External campaigns include promoting bowel cancer screening, letting patient know they can now access information about their outpatient appointments via the NHS app. Internally we promoted the winter incentives and we have also updated our guidance around wearing masks for staff.

Health Tree Foundation

Kris Weavill raised more than £1,000 from his 24-hour video gaming stream fundraiser at Scunthorpe hospital. Kris live streamed himself playing Minecraft and Surgeon Simulator 2 to raise money to improve the experience of patients having an MRI. We also arranged for him to be interviewed live on BBC Radio Humberside. It was also the most covered press release in this period.

THE HEALTH TREE FOUNDATION
Your hospital charity

Improving staff morale and engagement

Keeping staff informed

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.

Each week we see between 5,700 and 7,200 opens of the Wednesday Weekly News.

The most popular Monday Message during this time was Peter’s ‘Be The Change’ Monday Message on the 16th January with 7,435 opens.

Staff App

There were 605 downloads of the staff app during this period.
The main thing staff use the app for is accessing eroster.

This report covers Jan and Feb 2023

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.

January's session focused on Health and Wellbeing support and featured an update from the Health Tree Foundation. In February sustainability/the green agenda and QI were in the spotlight.

70 staff attended in Jan and 28 in Feb (with nearly 300 views of the video afterwards on the Facebook group)

"Some fantastic things being done. Really enjoyed both presentations - thank you."

Team Brief Live

NHS Northern Lincolnshire and Goole NHS Foundation Trust

We each have a voice that counts

Senior Leadership Briefing

75 senior leaders attended the SLC briefing in January. 102 joined in February. A new 'sharing success' slot appears to be going down well and generating stories for the team to follow up on.

102 Senior leaders attended the last SLC briefing

Improving staff morale and engagement

Giving staff a voice

Ask Peter
An extremely popular forum for staff to raise concerns and ask questions about absolutely anything. We received 135 questions in January (down from 148 in 2022), and 122 in February (up from 95 in 2022) – totaling 257 across the two months! During this period, we have removed seven and redacted seven.

Hot topics include: #buttergate; face masks; parking; incentives; training; cages on corridors.

257
Ask Peter questions

Staff Thank You
Since the 'Thank you' system launched in January last year staff have sent more than 1,000 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 have recently created a new page on the Hub where people can view all the Thank You messages shared with the comms team

"Thank you for being so kind, caring and supportive towards me, i know you say its doing your job, but to me its more, you go above your job to make sure everyone is ok and i am grateful for that especially in the tough times i have had, i have upmost respect for you and your role, but without your support and guidance i would have struggled, so i just wanted you to know i am grateful for everything you do.."

Improving reputation through external communications

Media coverage

There were 52 stories about the Trust in the media during this period. 98% of media coverage was positive or neutral in tone. 79% of coverage was in print or online media.

We categorise the media coverage into themes – in this period 'pressures' was the top theme, which is not surprising given the significant operational pressures the Trust has experienced.

We issued 5 proactive news releases and the most covered was the 24-hour video gaming stream to raise money for the MRI appeal. Medicine have had the most positive media coverage in this period

98%
Of media coverage was positive or neutral

Media enquiries

49 media enquiries were handled in this time, 94% were dealt with within the requested timescale.
The majority of requests, 43%, came from TV outlets.

The top theme for media enquiries was 'pressures'. The main reason journalists got in touch was to put in an information request. 9 reactive statements were issued in this period.

94%
Of media enquiries dealt with on deadline

Videos produced

The first in our 'everything you need to know about' series was on the topic of parking. It has so far had 640 views on Facebook, 235 on Twitter and 268 on YouTube.

Improving reputation through external communications

External website – www.nlg.nhs.uk

Key stats:

- 53,643 users
- 85,442 visits
- 217,325 page views
- 76% of visitors were new users
- Safari was the top browser used to access the site followed by Chrome. IOS was the top operating system
- 84% of people came to the website via a search, 13% direct, 1.6% from social media (mainly Facebook) and 1.1% from other websites
- Most visited page: Grimsby hospital home page, which had more than 13,000 views followed by the staff page which had just under 13,000.

217,000
Page views on our website

The top three news releases viewed on the website were a plea to for people to return medical equipment, an advertisement for healthcare assistant open days and text reminders being introduced to reduce wasted hospital appointments. It's worth noting none of these media releases were issued in this time period, highlighting the search function on the website is bringing up relevant content for users.

Website accessibility rating: We moved up five places on the Silktide Accessibility rating for the whole of the NHS - from 118th to 113th

Social media activity

Social media overview

Followers update for the Trust's corporate accounts:

- 14,105 on the Trust's Facebook page
- 5,473 followers on Twitter (56 new followers in this period)
- 5,027 followers on LinkedIn (290 new)
- 616 subscribers on YouTube

We shared 13 #ThankYouNHS posts and 15#ThumbsUpFriday posts in this period. Since we switched to using #ThankYouNHS we have sent 125 posts, with 270,000+ Impressions generating more than 400 comments.

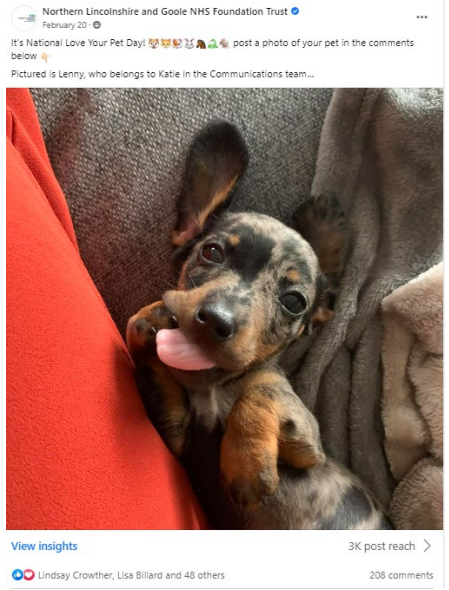
Staff Facebook group

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 3,938 staff members on there and popular topics included National Pet Day, feedback for a Porter and five stars for some of our cleaners.

Facebook group stats
3,938 members
388 posts in this period
4,570 comments
12,576 reactions

The team keep a close eye on the group and are spending more time moderating the group. 13 posts/comments were deleted during this period. Facebook now allows members to approve anonymously, subject to approval. In this period the team approved more than 80 anonymous posts and declined 7.

During this time, a lot work has been done to ensure accuracy membership of the group.



Social media activity - Facebook

Facebook page
The Facebook post with the highest engagement was the post about the 15 steps certificates, consistent with our top tweet in this period.

Top three posts in Jan

January 13, 2023 02:00pm

How lovely is this Theo and Oliver popped into our A&E at Grimsby recently with their parents. After seeing the pressures staff are working under on the news they wanted to find a way to treat staff - and treat them they did! They presented the team with a large selection of treats, as pictured. Staff have now written

Post Clicks	Reactions	Impressions	Reach	Eng. Rate
1,597	321	13,858	10,066	13.93%

January 17, 2023 10:56am

Even when our Emergency Departments A&Es are busy, our staff still make sure you receive the care you need. This is what happened when Amanda attended Grimsby recently with her husband. She said: "He was triaged quickly and saw a doctor who arranged to have him admitted for intravenous antibiotics. The staff are

Post Clicks	Reactions	Impressions	Reach	Eng. Rate
1,226	195	9,570	9,145	15.04%

January 5, 2023 06:00pm

Driving to your hospital appointment Did you know blue badge holders can park for free Register by emailing nlg-tr.parking@nhs.net with a copy of your blue badge and your vehicle registration number.

Post Clicks	Reactions	Impressions	Reach	Eng. Rate
401	14	7,389	6,924	5.87%

Top three posts in Feb

February 3, 2023 02:00pm

Congratulations to all our areas that have recently received their Outstanding and Good 15 Steps certificates to celebrate the high standard of care they're delivering to our patients! 15 Steps is a continuous audit cycle that allows us to observe the environments from which we deliver care, review our documentation

Post Clicks	Reactions	Impressions	Reach	Eng. Rate
2,268	97	10,158	7,876	23.34%

February 21, 2023 10:00am

It's important to us you feel relaxed and comfortable when coming into our hospitals for a procedure. This is the experience Susan had recently at Scunthorpe. She said: "I attended the Endoscopy department for a colonoscopy. What a wonderful team of caring and reassuring staff. I was put at ease and everything was

Post Clicks	Reactions	Impressions	Reach	Eng. Rate
611	78	5,760	5,648	12.07%

February 3, 2023 11:00am

There have been incidents recently at Grimsby hospital of vehicles driving incorrectly around the site. Vehicles have been driving through the no-entry sign near A&E and driving past the clock tower and workshops. This is clearly signposted. Please make sure you're driving responsibly around our sites.

Post Clicks	Reactions	Impressions	Reach	Eng. Rate
374	4	5,608	5,434	6.94%

Social media activity - Twitter

Twitter
Our top tweet, (by impressions) was a celebratory post about wards receiving their 15 steps certificates and our top mention (by engagement) was a patient thanking staff for looking after them during a four day stint in Scunthorpe hospital

JAN 2023 SUMMARY

Tweets 30	Tweet impressions 25.3K
Profile visits 2,036	Mentions 72
New followers 27	

FEB 2023 SUMMARY

Tweets 54	Tweet impressions 23.7K
Profile visits 2,207	Mentions 126
New followers 29	

Top tweet Jan

Jan 2023 • 31 days

TWEET HIGHLIGHTS

Top Tweet earned 1,186 impressions

In December we saw 13,317 patients in our emergency departments - that was up by 20% from 11,057 attendances in 2021.

Thank you our staff who are working incredibly hard to see and treat people as quickly as they can.
pic.twitter.com/2Y9OiQxndR

3 5 7

View Tweet activity View all Tweet activity

Top tweet Feb

Feb 2023 • 28 days

TWEET HIGHLIGHTS

Top Tweet earned 1,605 impressions

Congratulations to all our areas that have recently received their Outstanding and Good 15 Steps certificates to celebrate the high standard of care they're delivering to our patients! #ThumbsUpFriday
pic.twitter.com/qs6w3b9eLV

3 2 23

View Tweet activity View all Tweet activity

Top mention Jan

Top mention earned 688 engagements

Becki Thomas
@BeckiThomas05 · Jan 4

Finally home after spending 4 days in hospital with double pneumonia. I can't thank the nurses, doctors and all the staff at Scunthorpe General Hospital and the A&E Department enough @NHSNLaG. Back home and recovering after a pretty traumatic health scare. pic.twitter.com/Tq9ak3VX19

22 2 76

View Tweet

Top mention Feb

Top mention earned 141 engagements

Gill Hunt
@gill_hunt · Feb 1

Great day visiting @NHSNLaG today, thank you so much to @ellie_nursing and colleagues for such a warm welcome. Continuous improvement ethos is evident in absolute bucketloads @NHSNEY

1 2 27

View Tweet

Top media tweet

Top media Tweet earned 1,029 impressions

We're helping to rewrite the futures of 5 young people as part of DFN Project Search. They've joined the Estates and Facilities team at Diana, Princess of Wales Hospital, Grimsby, on 1 yr placements. Find out more: buff.ly/3legrMh
pic.twitter.com/lbi4pMF5aQ

2 6

This report covers Jan and Feb 2023

Social media activity – Linkedin and YouTube

LinkedIn

Stats

1,283 page views
519unique visitors
293 reactions
11 comments
62 reposts

Content

A post about Schwartz rounds being introduced provided the most engaging content.

You Tube

January	February
12 NEW SUBSCRIBERS	**13** NEW SUBSCRIBERS
3,970 TOTAL VIEWS	**4,141** TOTAL VIEWS
6,478 MINUTES WATCHED	**15.3K** MINUTES WATCHED

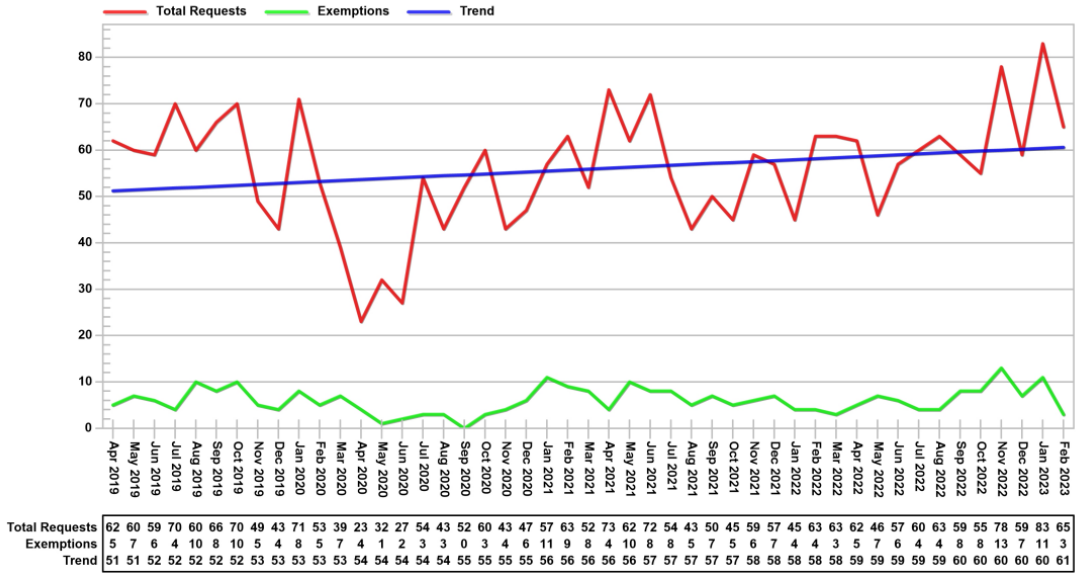
Content

Our top video was an instructional video on bottle feeding from 2018 – it had 2,777 views

Enquiries and information requests

Freedom of Information requests (FOIs)

The number of FOIs the Trust receives is increasing month on month and in January the Trust received the most in one month ever with 85 submitted. 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 104 submitted in this period – of these 91 are closed, 10 are still in progress and 3 are awaiting a response from the requester. The chart to the right shows the upward trend in FOI's received since 2019.



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023
Total Requests	62	60	59	70	60	66	70	49	43	71	53	39	23	32	27	54	43	52	60	43	47	57	63	52	73	62	72	54	43	50	45	59	57	45	63	63	62	46	57	60	63	59	55	78	59	83	65
Exemptions	5	7	6	4	10	8	10	5	4	8	5	7	4	1	2	3	3	0	3	4	6	11	9	8	4	10	8	8	5	7	5	6	7	4	4	3	5	7	6	4	4	8	8	13	7	11	3
Trend	51	51	52	52	52	52	52	53	53	53	53	53	54	54	54	54	54	55	55	55	55	56	56	56	56	56	57	57	57	57	57	58	58	58	58	58	59	59	59	59	59	60	60	60	60	60	61

General enquiries

The team receives general enquiries via a form on the Trust website. In this period, 159 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. The main themes during this period were accessing services, appointments, recruitment and patient and clinical information.

104
FOIs received

159
General enquiries dealt with

This report covers Jan and Feb 2023

NLG(23)076

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	4 April 2023	
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 (February 2023 – NLG(23)034).	
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 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

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**
-	----	-

Action Required

The Trust Board is asked to note the report.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(23)077

Name of the Meeting	**Trust Board - Public**	
Date of the Meeting	4 April 2023	
Director Lead	Dr Peter Reading, Chief Executive	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	**Director Statutory and Regulatory Roles of the Executive Directors**	
Purpose of the Report and Executive Summary (to include recommendations)	To present to Trust Board the Statutory & Regulatory Roles of the Executive Directors. Amendments made: Maternity and Neonatal Board Level Safety Champion (previously worded as: Maternity Champion (Board Level). Medical Director changed to Chief Medical Officer. Food Standards (National Standards for Hospital Food and Food Safety 2023), Authorised Person added as Jug Johal – Director of Estates and Facilities.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Dr Peter Reading
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:**

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Northern Lincolnshire and Goole NHS Foundation Trust

TRUST BOARD – EXECUTIVE DIRECTOR STATUTORY & REGULATORY ROLES

TRUST BOARD - EXECUTIVE DIRECTOR STATUTORY & REGULATORY ROLES			
AREA	**EXECUTIVE LEAD**	**EXECUTIVE ROLE**	**REFERENCE**
Overall Responsibility for the Trust	Chief Executive	Accountable Officer	NHS Act 2006
	Chief Executive	Accounting Officer	NHS Act 2006
Emergency Preparedness	Chief Operating Officer	Accountable Officer for Emergency Preparedness	Emergency Preparedness Resilience and Response (EPRR), NHS England
Medical Devices	Chief Operating Officer	Medical Devices Lead	Medical Devices Handbook
Finance	Chief Financial Officer	Counter Fraud, Bribery and Corruption Board Lead	Health and Social Care Act 2012 – Service Condition 24 of the NHS Standard Contract / Government Functional Standard GovS 013: Counter Fraud
Information Management / Governance	Chief Medical Officer	Caldicott Guardian	HSC1999/012
	Chief Information Officer	Senior Information Risk Officer (SIRO)	Data Security & Protection Toolkit (includes UK GDPR, Cyber Security, & Data Protection Act)
Health & Safety	Director of Estates and Facilities	Lead Executive for Health & Safety	Health & Safety at Work Act 1974
	Director of Estates and Facilities	Medical Gases Executive	Health Technical Memorandum (HTM) 02-01
	Director of Estates and Facilities	Heating & Ventilation designated Person	HTM 03-01
	Director of Estates and Facilities	Water Designated Person	HTM 04-01
	Director of Estates and Facilities	Electrical LV Designated Person	HTM 06-02

	Director of Estates and Facilities	Electrical HV Designated Person	HTM 06-03
	Director of Estates and Facilities	Specialist Services (Lifts) Designated Person	HTM 08-02
	Director of Estates and Facilities	Environment & Sustainability Responsible Person	HTM 07-02
	Director of Estates and Facilities	Fire Board Level Director	Fire Safety (Regulatory Reform) Order 1985 HTM 05-01
	Director of Estates and Facilities	Security Management Director	NHS Commissioning Contract
	Chief Operating Officer	Radiation Protection Advisor	Ionising Radiation Regulations 1999
Food Standards	Director of Estates and Facilities	Authorised Person	National Standards for Hospital Food and Food Safety 2023
Infection Control	Chief Nurse	Director of Infection Prevention & Control (DIPC)	Health & Social Care Act 2008 Code of Practice on Control of Infection
	Chief Operating Officer	Decontamination Lead	Health & Social Care Act 2008 Code of Practice on Control of Infection
Safeguarding	Chief Nurse	Safeguarding Executive Lead	Safeguarding Accountability Assurance Framework NHS Standard Contract
Freedom of Information Act	Associate Director of Communications	Freedom of Information Act Lead	Freedom of Information Act
Freedom to Speak Up	Director of People	Freedom to Speak Up Guardian	NHSE Requirement & requirement of NHS Standard Contract
Quality / Patient Safety	Chief Medical Officer	Quality Executive Lead	Francis Inquiry
	Chief Medical Officer	Executive Lead for End of Life Care	More Care, Less Care Report 2013
	Chief Nurse	Responsible Person for Compliance with Complaints Regulations	NHS Complaints Regulations

	Chief Medical Officer	Guardian of Safe Working Hours	NHS Employers
	Chief Medical Officer	Responsible Officer	General Medical Council
	Chief Medical Officer	Mortality Lead	Learning From Deaths Report 2017; NHS England
	Chief Operating Officer	Cancer Lead	• Achieving world class outcomes for Cancer (A Strategy For England 2015 - 2020 - One Year On 2015-16) • The quality (peer review) annual programme – QSIS • NHS Long Term Plan (nhs-long-term-plan) • Cancer Waiting Times constitutional standards
	Chief Operating Officer	Mental Health Champion	• Mental Health Act 1983 and Mental Health Act amendment 2007 • Section 136, Section 2, Section 3, Section 5 (2), Section 140 • Psychiatric Liaison Accreditation Network Standards • Child and Adolescent Mental Health Services • CQC guide Ligature Risks
	Chief Nurse	Maternity and Neonatal Board Level Safety Champion	Ockenden Report 2021
Human Tissue Authority	Chief Medical Officer	Designated Individual	Human Tissue Authority Act
Care Quality Commission	Chief Medical Officer	CQC Registered Manager	Health & Social Care Act 2014
Sustainability	Director of Estates and Facilities	Trust Board Lead (Executive)	Delivery A Net Zero National Health Service, October 2020
Equality & Diversity	Director of People	Board Executive Lead	Equality Act 2010
	Director of Estates and Facilities	Executive Board Lead for Tackling Inequality	NHS England, Phase 3 of the Covid response https://www.england.nhs.uk/wp-content/uploads/2020/08/implementing-phase-3-of-the-nhs-response-to-covid-19.pdf

SENIOR MANAGER ROLES		
SENIOR MANAGER LEAD	**ROLE**	**REFERENCE**
Chief Pharmacist	Accountable Officer for the Destruction of Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373)
Chief Pharmacist	Accountable Officer for Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373)
Medicines Safety Officer	Medicines Safety Officer	Patient Safety Alert NHS/PSA/D/2014/005
Chief Pharmacist	Non-Medical Prescribing Lead	NMC Code of Conduct
Head of Medical Engineering	Medicines Devices Safety Officer	Patient Safety Alert NHS/PSA/D/2014/006
Organ Donation Lead	Organ Donation	NHS Blood Transfusion 2008
Medical Examiner	Lead Medical Examiner	Dept of Health & Social Care's Death Certification reforms programme for England (part of the National Patient Safety Strategy 2020)
Associate Director of Clinical Quality Governance	Patient Safety Specialist	NHS England Patient Safety Strategy identifying-patient-safety-specialists
Associate Director of Safety & Statutory Compliance	Health & Safety Advisor Fire Safety Manager	Management of Health & Safety at Work Regulations HTM 05-01 – Managing Healthcare Fire Safety
Chief Nurse & Allied Health Professional Information Officer	Clinical Safety Officer	NHS Service Standard - Make your service clinically safe - NHS digital service manual (service-manual.nhs.uk)

The Senior Manager Lead Roles are to support Executive Directors in their statutory duties

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Name of the Meeting	**Trust Board – Public**	
Date of the Meeting	4 April 2023	
Director Lead	Helen Harris, Director of Corporate Governance	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	**Non-Executive Director Allocation and NED Champion Roles**	
Purpose of the Report and Executive Summary (to include recommendations)	The report provides the updated schedule of Non-Executive Director allocation and the Champion roles assigned to NEDs following review. The key change is to the role of Simon Parkes who is now the NED Deputy Chair of the Strategic Development Committee. The Board is asked to note the report.	
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	
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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Non-Executive Director (NED) Allocation and NED Champion Roles

As at 21 February 2023

NED	NED Chair of Trust Meetings & Board Sub-Committees	Deputy Chair and / or Member	NED Champion Role *	COG Subgroups
Sean Lyons Trust Chair	Chair of the Council of Governors (CoG) Chair of the Trust Board Chair of the Remuneration and Terms of Service Committee			Appointment & Remuneration Committee for Non-Executive Directors
Linda Jackson Vice Chair	Chair of the Strategic Development Committee	Member of Remuneration and Terms of Service Committee Member of Workforce Committee Member of Humber Acute Services Development Committee	FTSU NED Champion	Governor Assurance Group Appointment & Remuneration Committee for NEDs
Fiona Osborne NED	Chair of the Quality &Safety Committee (including statutory requirements that fall within the remit of the Committee's Terms of Reference (TOR))	Deputy Chair of Finance and Performance Committee Member of Remuneration and Terms of Service Committee	Digital Transformation NED Champion	Governor Assurance Group
Simon Parkes NED	Chair of the Audit, Risk & Governance Committee (including statutory requirements that fall within the remit of the Committee's TOR)	Member of Remuneration and Terms of Service Committee Deputy Chair of Strategic Development Committee Member of Finance and Performance Committee		Governor Assurance Group
Gillian Ponder NED, Senior Independent Director	Chair of the Finance and Performance Committee (including statutory requirements that fall within the remit of the Committee's TOR)	Deputy Chair of Audit Risk and Governance Committee Member of Remuneration and Terms of Service Committee	Security Management NED Champion	Governor Assurance Group

NED	NED Chair of Trust Meetings & Board Sub-Committees	Deputy Chair and / or Member	NED Champion Role *	COG Subgroups
		Trustee of Health Tree Foundation Trustees Committee		
Sue Liburd NED	Chair of the Workforce Committee (including statutory requirements that fall within the remit of the Committee's TOR)	Member of Quality and Safety Committee Trustee of Health Tree Foundation Trustees Committee Member of Remuneration and Terms of Service Committee	Maternity Board Safety Champion** NED on the Cultural Transformation Board	Governor Assurance Group
Kate Truscott Associate NED		Deputy Chair of Quality and Safety Committee Deputy Chair of Workforce Committee Member of Strategic Development Committee Member of Audit Risk and Governance Committee Member of Remuneration and Terms of Service Committee	NED Wellbeing Guardian	
Stuart Hall Associate NED and Vice Chair at HUTH		Member of Humber Acute Services Development Committee		
Neil Gammon	Independent Chair of Health Tree Foundation Trustees Committee			

Doctors Disciplinary NED Champion - Any NED can be called upon to be involved in an MHPS investigation. The Chair of Workforce Committee will hold a quarterly meeting with the Director of People to look at trends, lessons to be learnt

** NED Champion roles are in line with the "Enhancing board oversight – A new approach to non – executive director champion roles" document from NHSEI version 1, December 2021 except for the digital transformation NED Champion – which is NLaG specific*

***Role of the NED Safety Champion:* B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf (england.nhs.uk)

NLG(23)087

Name of the Meeting	**Trust Board - Public**	
Date of the Meeting	4 April 2023	
Director Lead	Helen Harris, Director of Corporate Governance	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	**Trust Board – Business Reporting Framework 2023-24**	
Purpose of the Report and Executive Summary (to include recommendations)	The Trust Board is asked to note the Trust Board – Business Reporting Framework 2023-24.	
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	
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

Trust Board - Business Reporting Framework

REPORTING YEAR					2023 / 24					
Agenda Item	**Committee Oversight**	**Lead**	**Frequency**	**Action**	**April**	**June**	**August**	**October**	**December**	**February**
Business Items										
Declarations of Interest	N/A	Chair	Bi-monthly							
Chair's Opening Remarks	N/A	Chair	Bi-monthly							
Chair's Briefing	N/A	Chair	Bi-monthly	Noting						
Chief Executive's Briefing (to include Trust Priorities)	N/A	Chair	Bi-monthly	Noting						
Minutes of the Previous Meeting	N/A	Chair	Bi-monthly							
Trust Board Action Log	N/A	Chair	Bi-monthly							
Patient Story	N/A	Chief Nurse	Bi-monthly	Noting						
Integrated Performance Report	All Committees	Chief Information Officer	Bi-monthly	Noting						
Trust Board - Business Reporting Framework	N/A	Director of Corporate Goverance	Bi-monthly	Noting						
Register of Directors Interest and Fit & Proper Persons	N/A	Chair	Annual	Approval						
Trust Strategy	N/A	Chief Executive	3 Yearly	Noting						
Strategic Objective 1 - To Give Great Care										
F&PC Highight Report & Board Challenge	F&PC	NED Chair of F&PC	Bi-Monthly	Assurance						
Q&SC Highlight Report & Board Challenge	Q&SC	NED Chair of Q&SC	Bi-Monthly	Assurance						
Annual Establishment Review of Safe Staffing	Q&SC	Chief Nurse	Bi-annual	Approval						
Annual Quality Account	Q&SC	Chief Medical Officer	Annual	Approval						
Annual Review of Mental Health Strategy	Q&SC	Chief Operating Officer	3 yearly	Assurance						
Delivery of Mixed Sex Accommodation - Annual Declaration of Compliance to Trust Board	Q&SC	Chief Nurse	Annual	Approval						
Strategic Objective 2 - To Be a Good Employer & Strategic Objective 5 - To Provide Good Leadership										
WC Highlight Report & Board Challenge	WC	NED Chair of WC	Bi-monthly	Assurance						
Freedom to Speak Up Guardian Report	WC	Freedom to Speak Up Guardian	Biannual	Assurance						
Freedom to Speak Up Self Assessment	WC	Director of People	Annual	Noting						
Gender Pay Gap Report	WC	Director of People	Annual	Approval						
Modern Slavery Statement	WC	Director of People	Annual	Approval						
Staff Survey	WC	Director of People	Annual	Noting						
Workforce Equality Disability Standards (WDES)	WC	Director of People	Annual	Approval						
Workforce Equality Standards Annual Report (WRES)	WC	Director of People	Annual	Approval						
Freedom to Speak Up Self Assessment	WC	Director of People	Annual	Noting						
Equality & Diversity Strategy	WC	Director of People	3 yearly	Approval						
People Strategy	WC	Director of People	3 yearly	Approval						

Agenda Item	Committee Oversight	Lead	Frequency	Action	April	June	August	October	December	February
Strategic Objective 3 - To Live Within Our Means										
Executive Report - Finance	F&PC	Chief Financial Officer	Bi-monthly	Noting						
F&PC Highight Report & Board Challenge	F&PC	NED Chair F&PC	Bi-monthly	Assurance						
Operational & Financial Plan	F&PC	Chief Operating Officer	Annual	Approval						
Business Planning / CIP Timetable	F&PC	Chief Financial Officer	Annual	Noting						
Major Capital / Overarching Capital	F&PC	Chief Financial Officer	Annual	Noting						
Winter Plan	F&PC	Chief Operating Officer	Annual	Assurance						
Annual Accounts - Delegation of Authority	AR&GC	Chief Financial Officer	Annual	Approval						
Digital Strategy	SDC	Chief Information Officer	3 yearly	Approval						
Estates Strategy	SDC	Director of Estates & Facilities	5 yearly	Approval						
Strategic Objective 4 - To Work More Collaboratively										
Executive Report - Strategic & Transformation	TBC	Director of Strategic Development	Bi-monthly	Assurance						
HTFC Highlight Report & Board Challenge	HTFC	Chair of HTFC	Bi-monthly	Assurance						
SDC Highlight Report & Board Challenge	SDC	Chair of SDC	Monthly	Assurance						
Clinical Strategy	F&PC	Director of Strategic Development	3 yearly	Assurance						
Governance										
AR&GC Highlight Report & Board Challenge	AR&GC	NED Chair of the AR&GC	Quarterly	Assurance						
Annual Accounts / Going Concern / Audit Letter / Annual Report & Annual Governance Statement	AR&GC	Various	Annual	Approval						
Audit Committee Annual Report	AR&GC	NED Chair of AR&GC	Annual	Approval						
Board Assurance Framework (BAF) and High Level Risk Register	All Committees	Director of Corporate Goverance	Quarterly	Assurance						
Emergency Preparedness, Resilience & Response Annual Report	AR&GC	Chief Operating Officer	Annual	Noting						
Fire Annual Report	AR&GC	Director of Estates & Facilities	Annual	Approval						
Health & Safety Policy Statement	AR&GC	Director of Estates & Facilities	Annual	Approval						
LSMS Annual Report and Workplan and Security Annual Report	AR&GC	Director of Estates & Facilities	Annual	Approval						
Protocol for Matters Reserved for Private Meetings	N/A	Director of Corporate Goverance	Annual	Approval						
Risk Appetite Statement	N/A	Director of Corporate Goverance	Annual	Approval						
Risk Management Strategy	AR&GC	Chief Medical Officer	3 Yearly (next 2024)	Approval						
Trust Constitution & Standing Orders	Trust Board & COG	Director of Corporate Goverance	3 yearly	Approval						
Trust Board - NHS Provider Self-Certification	N/A	Chair	Annual	Assurance						

Agenda Item	Committee Oversight	Lead	Frequency	Action	April	June	August	October	December	February
Trust Board, Board Committees & approval of changes to Terms of Reference	All Committees	Committee Chairs	Annual	Approval						
Trust Board & Board Committee Meetings Timetable	All Committees	Director of Corporate Goverance	Annual	Approval						
Trust Board and Board Committees Performance & Effectiveness	N/A	Chair	Annual	Noting						
Trust Board Development Programme	N/A	Chair	Annual	Noting						
Trust Scheme of Delegation and Powers Reserved for the Trust Board / Standing Financial Instructions	AR&GC	Chief Financial Officer	3 yearly	Approval						
Items for Information										
Communications Report	N/A	Associate Director of Communications	Bi-monthly	Noting						
Committee Minutes - Public & Private	All Committees	NED Chairs	Bi-monthly	Noting						
Deviations from NICE guidance	Q&SC	NED Chair	Ad-hoc	Noting						
15 Steps Annual Report	Q&SC	Chief Nurse	Annual	Noting						
Nursing Assurance Report (includes same sex accomodation)	Q&SC	Chief Nurse	Bi-monthly	Assurance						
Guardian of Safe Working Hours	WC	Chief Medical Officer	Quarterly	Assurance	Q3	Q4	Q1		Q2	
Patient Experience Report incorporating Annual inpatient survey result & action	Q&SC	Chief Nurse	Quarterly	Assurance	Q3	Q4	Q1		Q2	
Documents Signed Under Seal	N/A	Director of Corporate Goverance	Quarterly	Noting	Q4			Q2		
Executive & NED Statutory & Other Lead Roles	N/A	Vice Chair / Director of Corporate Governance	Annual	Noting						
Annual Complaints Report	Q&SC	Chief Nurse	Annual	Assurance						
Medical Appraisal & Revalidation Annual Report (AOA)	WC	Chief Medical Officer	Annual	Assurance						
Infection Control Annual Report	Q&SC	Chief Nurse	Annual	Assurance						
Safeguarding & Vulnerabilities Annual Report	Q&SC	Chief Nurse	Annual	Assurance						

Items for Trust Boards - Guidance for Papers

Title	Description	Frequency	Source	Action
Adult & Child Safeguarding Annual Report	The purpose of the report is to provides assurance that Trust is compliant with safeguarding duties. To update the Trust Board on safeguarding activity, issues and risks	Annual	There are multiple sources but the link below is fairly comprehensive. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper	Assurance
Annual Emergency Planning Position & Plan - EPRR Self-Assessment Assurance Report	The purpose of this document is to provide guidance to organisations completing the EPRR annual assurance process by: providing an overview of the Core Standards for EPRR outlining roles and responsibilities of the organisations involved defining the participating organisations setting out the EPRR annual assurance process. The Civil Contingencies Act 2004 and the NHS EPRR Framework requires NHS Acute organisations to plan for, respond to and recover from major incidents. The purpose of this paper is for information purposes detailing the work of the Emergency Planning Team	Annual	Annually, NHS England issues a set of EPRR Core Standards on which the trust has to complete a self assessment. https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-annual-assurance-guidance-v1.pdf	Incorporated within the Annual Report
Annual Plan / Draft Operational & Financial Plan	NHS Operational Planning and Contracting Requirements	Annual	See NHS Operational Planning and Contracting Guidance 2021/22 https://www.england.nhs.uk/operational-planning-and-contracting/	Approval
Annual Quality Account	Improving quality in organisations: All organisations should implement plans to improve quality of care, particularly for organisations in special measures; drawing on the NQB's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services; and participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare. To formally adopt the Quality Account in public session	Annual	See page 7 of https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmwrk.pdf	Assurance
Annual Report and Accounts including Annual Governance Statement and Quality Report	The Department of Health and Social Care (DHSC)'s Group Accounting Manual (GAM) requires NHS trusts to include an annual governance statement (AGS) in their annual report	Annual	https://improvement.nhs.uk/resources/nhs-foundation-trust-annual-reporting-manual/ https://improvement.nhs.uk/resources/quality-accounts-requirements/	Assurance
Annual Report from the Director of Infection Prevention and Control	The purpose of this report is to inform and provide assurance to the trust Board, patients, public and staff of the processes in place at NLAG to prevent and control healthcare associated infections (HCAI). To provide an update on the Trust's Infection Prevention & Control activities and information on actions in place	Annual	Health and Social Care Act (2008) : Code of Practice for the NHS on prevention and control of healthcare related guidance. https://www.nice.org.uk/guidance/ph36/chapter/Quality-improvement-statement-1-Board-level-leadership-to-prevent-HCAIs	Assurance
Audit Committee Annual Report	To provide assurance to the Trust Board that the Audit Committee is functioning in accordance with its Terms of Reference and in line with the requirements of the NHS Audit Committee Handbook	Annual	In line with the requirements of the NHS Audit Committee Handbook (HFMA) and contributes to the Annual Governance Statement	Approval
Caldicott Guardian Annual Repo	To advise the Board of work undertaken by and in support of the Caldicott Guardian during the preceding year	Annual	The Caldicott Guardian is appointed by the Trust Board and The Caldicott Guardian has a key role in ensuring that the Trust achieves the highest practical standards for handling patient information. This includes representing and championing confidentiality requirements and issues at Board Level, and wherever appropriate within the Trust's overall governance framework	Assurance
Delivering a Net Zero Health Service	The Publication of the Delivering a Net Zero Health Service for NHS in October 2020 set a mandatory framework for NHS organisations. This includes sustainability indicators reported nationally through systems, such as the Greener NHS Dashboard and produce a Green Plan to be approved byt the Board along with an annual summary of progress towards net zero	Annual	Carbon Reduction forms part of Annual Report and Accounts. Annual sustainability reporting is now mandated for clinical commissioning groups (CCGs) and trusts by the NHS Standard Contract (Service Condition 18) See Page 45 of this link. https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf	Assurance
Flu Vaccination Information	In order to ensure your organisation is doing everything possible as an employer to protect patients and staff from seasonal flu we ask that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of 2018	Annual		Noting
Freedom to Speak up Guardian Reports including Annual Report	The report provides an update from the Trusts Freedom to Speak Up Guardian in relation to any national or local developments relating to Raising Concerns or Whistleblowing. To provide thematic reporting to the Board on the themes and issues that are being reported to the FTSUG. The Trust Board is responsible for setting the culture and tone of the organization and in line with the Trust's values of openness, compassion and learning	Bi-annual	Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts https://improvement.nhs.uk/documents/2468/Freedom_to_speak_up_guidance_May2018.pdf The requirement for NHS organisations to establish a Freedom to Speak Up Guardian (F2SUG) arose from the recommendations made by Sir Robert Francis in his report into failings at Mid Staffordshire Hospitals NHS Foundation Trust. There is also an expectation that the F2SUG will report directly to the Chief Executive Officer and the Trust Board on the issues that are being reported to them	Approval
Health and Safety Risk Management Annual Report	HSE Gudance sets out an agenda for the effective leadership of health and safety. It is designed for use by all directors, governors, trustees, officers and their equivalents in the private, public and third sectors. Provided primarily for assurance given the overall responsibility of the Trust Board for Health & Safety in the organisation and the potential individual and corporate consequences of health and safety breaches	Annual	Various requirements See link https://www.hse.gov.uk/pubns/indg417.pdf	Assurance
High Level Risk Register	To inform the Board of the Trust's highest rated risks which are currently logged on the Corporate Risk Register	Three times per year	This quarterly report is included as part of the Board reporting framework	Assurance

Title	Description	Frequency	Source	Action
Information Governance/Cyber Security reporting	Data Security and Protection Toolkit. Information Governance is a key component of the Trust's governance framework and has regulatory consequences if requirements are not adhered to	Annual	Some general reference to the Board but does not include specifc board reporting requirements https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit	Assurance
Medical Appraisal and Revalidation Annual Report - Annual Organisational Audit	This Report provides information about the medical appraisal and revalidation system and processes over the year, highlighting key issues and action being taken to respond to them. Revalidation is a statutory obligation with which the Trust must comply. Reports provide assurance that requirements are being met and that governance arrangements are robust	Annual	A Framework of Quality Assurance for Responsible Officers and Revalidation https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/04/fqa.pdf	Assurance
Mortality (SHMI and HSMR) Update	Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals" This was reinforced by the recent findings of the Care Quality Commission (CQC) report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning Understanding and tackling this issue will not be easy, but it is the right thing to do. There will be legitimate debates about deciding which deaths to review, how the reviews are conducted, the time and team resource required to do it properly, the degree of avoidability and how executive teams and boards should use the findings This first edition of National Guidance on Learning from Deaths aims to kickstart a national endeavour on this front. Its purpose is to help initiate a standardised approach, which will evolve as we learn. Following the Learning from Deaths conference on 21st March 2017 we will update this guidance to reflect the collective	Various	National Guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These add new mandatory disclosure requirements relating to 'Learning From Deaths' to quality accounts from 2017/18 onwards. These new regulations and the explanatory memorandum are available at http://www.legislation.gov.uk/uksi/2017/744/introduction/made	Noting
NHS Provider Licence Self-Certification	NHS foundation trusts and trusts must self-certify that they can meet the obligations set out in the NHS provider licence. The licence includes requirements to comply with NHS acts and constitution, and with governance requirements. NHS foundation trusts designated to provide commissioner requested services are also required to complete a self-certification on the availability of resources to deliver those services	Annual	The NHS Provider Licence https://improvement.nhs.uk/resources/self-certification-guidance-nhs-foundation-trusts-and-nhs-trusts/ NHS foundation trusts and trusts must self-certify that they can meet the obligations set out in the NHS provider licence. The licence includes requirements to comply with NHS acts and constitution, and with governance requirements. NHS foundation trusts designated to provide commissioner requested services are also required to complete a self-certification on the availability of resources to deliver those services	Assurance
NHS Resolution Maternity Incentive Scheme	Self Declaration	Annual	https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf	Assurance
NHS Staff Survey Report and Action Plan	Provides an overview of the annual NHS National Staff Survey. The report is to provide assurance regarding engagement, quality and people management matters across the Trust	Annual		Noting
Ockenden	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	Quarterly to Q&SC & Trust Board	https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf	Assurance
Patient Experience Report incorporating Annual inpatient survey result and action, and Annual Complaints Report	Quarterly reports collating the various sources of patient feedback are produced by the Patient Experience Team	Three times per year & Annual report	Patient experience information supports the CCG in making decisions about local health services The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 statutory instrument 309 requires NHS bodies to provide an annual report on its complaints handling, which must be available to the public. To provide the Board with oversight around the management of complaints following the report of the Chief Inspector of Hospitals Inspection	Assurance
Quarterly Report from the Guardian of Safe Working Hours – This is a requirement of the Junior Doctors contract	The 2016 junior doctors contract (Schedule 6, para 11) requires the Guardian of Safe Working an overview and assurance of the trusts compliance with safe working hours for doctors across the trust and to highlight and detail any areas of concern. The report is to demonstrate the work of the Guardian in championing safe working hours in the trust to ensure the protection of patients and doctors	Quarterly	See Page 35 https://www.nhsemployers.org/-/media/Employers/Documents/Need-to-know/Terms-and-Conditions-of-Service-for-NHS-Doctors-and-Dentists-in-Training-England-2016-Version-2--30-March-2017.pdf	Assurance
Research and Development Ann	Sets out the strategic objectives, how the strategy is delivered, benchmarking data and provides commentary around income and future developments	Annual	Research, development and innovation are fundamental to excellence in healthcare which is one of the guiding principles of the NHS as set out in the NHS Constitution. The Trust is required to demonstrate adherence to national guidance and current legislation	Noting
Risk Management Strategy	To approve Strategy Updates	Annual	The management of risk underpins all strategies, processes and activities that lead to the achievement of the aims and objectives of the Trust	Approval

Title	Description	Frequency	Source	Action
Safer Staffing and Expectations relating to nursing, midwifery and care staffing capacity and capability	It is an expectation set out in the National Quality Board that Boards take full responsibility for the quality of care provided to patients, and, as a key determinant of quality, take full responsibility for nursing, midwifery and care staffing capacity and capability Boards are actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made. Boards monitor staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift-to-shift basis, versus planned staffing levels. They examine trends in the context of key quality and outcome measures. They ask about the recruitment, training and management of nurses, midwives and care staff and give authority to the Director of Nursing to oversee and report on this at Board level	Bi-annual	NQB guidance published in November 2013 (http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf) - page 7 It is a national requirement that a staffing assessment is submitted twice a year in order that the Board is aware of the Trust's position against national guidance and can take action where appropriate	Approval
Timetable of Board and Committ	To approve the annual timetable of Board and Committee meetings for the year ahead	Annual	As part of the overall governance structure for the organisation	Noting
Workforce Race Equality Standard (WRES) Action Plan & Workforce Disability Equality Standard (WDES)	To enable organisations to compare their performance with others in their region and those providing similar services, with the aim of encouraging improvement by learning and sharing good practice.To provide a national picture of WRES in practice, to colleagues, organisations and the public on the developments in the workforce race equality agenda. To inform the Board of the work of Equality and Diversity throughout the Trust and progress in relation to the actions in the Equality and Diversity System2	Annual	The Trust is required, by the Equality Act 2010, to eliminate discrimination, victimisation and harassment, advance equality of opportunity and foster good relations between different groups and required to publish Equality. To ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the work place - aligned to the strategic objective to be an employer of choice	Assurance

Update Reports shared through Executive and Non-Executive Director Highlight Reports to the Trust Board			
Committee & Report Update	**Frequency**	**Update included within Executive Report**	**Update included within NED Chair Report**
Quality & Safety Committee			
CQC Update (to include costs when required)	Ad-hoc	X	
Mental Health Strategy Progress Update	Annual	X	
Mortality Update	Quarterly	X	
Quality Improvement Update	Bi-annual	X	
Serious Incident Report	Quarterly	X	
CNST & Ockenden (maternity)	Quarterly		X
Complaints Report	Annual		X
Delivery of Mixed Sex Accommodation - Annual Declaration of Compliance to Trust Board	Annual		X
Deviations from NICE guidance	Ad-hoc		X
Medicines Management Report	Annual		X
Infection Control Annual Report	Annual		X
Quality Account	Annual		X
Research and Development Report	Annual		X
Safeguarding & Vulnerabilities Report	Annual		X
Workforce Committee			
Self Assessment Review - Health Education England		X	
People Strategy Progress Update	Annual	X	
Equality & Diversity Progress Update	Annual	X	
Annual Organisational Audit (AOA)			X
Flu Vaccination Self-Assessment			X
Flu Vaccination Update Rates			X
Medical Appraisal and Revalidation Annual Report (AOA)	Annual		X
Freedom to Speak Up Strategy			
Audit, Risk & Governance Committee			
Information Governance/Cyber Security Reporting (IG Toolkit)	Annual	X	
Caldicott Report	Annual		X
Local Counter Fraud Specialist Annual Report (private board - information item)	Annual		X
Risk Management Strategy Progress Update	Annual	X	
Strategic Development Committee			
Digital Strategy Progress Update	Annual	X	
Chief Executive Reporting			
Approval of CQC Statement of Purpose		X	
Trust Strategy Progress Update	Annual	X	
Finance & Performance Committee			
Estates Strategy Progress Update	Annual	X	
Other			
Clinical Strategy Progress Update	Ad-hoc	X	
High Level Risk Register	3 times per year	X	
Trust Constitution & Standing Orders	Ad-hoc	X	

Agenda item: NLG(23)088

Name of the Meeting	**Board of Directors**
Date of the Meeting	4 April 2023
Director Lead	Dr Kate Wood, Chief Medical Officer & CQC Registered Manager
Contact Officer/Author	Belle Baron-Medlam, Acting Head of Compliance and Assurance Richard Dickinson, Associate Director of Quality Governance
Title of the Report	**Review and Recommended Amendments to the Trust's CQC Statement of Purpose**
Purpose of the Report and Executive Summary (to include recommendations)	Updating and provision of a Statement of Purpose (SoP) is part of CQC regulations, with a regular review of the SoP planned annually and on this occasion several changes are required due to the model of care provision and service changes. This updated version has been reviewed by the Trust Management Board on 20 March 2023. The changes in this revision include: • Several updates to services on each site made • A number of changes to language, grammar and sentence flow and structure • Key clinical updates - aims and objectives section - Changes to Surgical Assessment Unit process description - Emergency/acute paediatric services provision updated - Oncology Services transfer to HUTH - Family Services provision language clarified and updated - Update to pharmacy provision at GDH The update CQC SoP has highlighted text, as preferred by the CQC to illustrate the changes made. Recommendations: • Identify any further updates that may be required to the Trust's CQC Statement of Purpose • Note and ratify all updates included within this report • Approve the Statement of Purpose dated March 2023 for submission to the CQC
Background Information and/or Supporting Document(s) (if applicable)	1. Review and Recommended Amendments to the Trust's CQC Statement of Purpose 2. Statement of Purpose March 2023 DRAFT 3. CQC website guidance for providers: https://www.cqc.org.uk/sites/default/files/20180807_100456_guidance_for_providers-statement_of_purpose_v4.pdf
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)	None	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	No negative impacts identified	
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

Chief Medical Officer's Directorate

Review and Recommended Amendments to the Trust's CQC Statement of Purpose

March 2023

1. Background

The Trust has a requirement as part of the Care Quality Commission (Registration) Regulations 2009 Regulation 12: Statement of purpose to notify CQC of any changes to their statement of purpose and ensure it is kept under review and notify CQC when there are any changes to the information.

The guidance states:
"A statement of purpose is a legally required document that includes a standard set of information about a provider's service. Statements must describe:

- *The provider's aims and objectives in providing the service*
- *Details of the services provided including the service types*
- *The health or care needs the service sets out to meet*
- *The provider's and any registered managers' full name(s), business address(es), telephone number(s) and (where available) email address(es)*
- *Details about the legal status of the provider*
- *The address CQC must use to send formal documents to registered providers and managers*
- *All of the locations where regulated activities are actually provided*
- *The information in statements of purpose must always be accurate and up to date."*

2. Trust Review Process

- Periodically the Trust is notified of required changes to the Statement of Purpose (SoP) for a number of reasons however it is good practice to review the SoP on a regular basis.
- As part of this review, the SoP has been sent to all Divisions including Pharmacy and Path Links for review and a number of updates were recommended. In addition, the aims and objectives section has been updated slightly to be more in line with how our aims, objectives and values are displayed within the NLaG Strategic Framework 2019-2024.
- The CQC require the updated SoP to be highlighted where any changes have been made and these have been included in this report for ease of reference.
- TMB is the designated committee to which all changes to the Statement of Purpose must be agreed

3. Recommended Update / Amendments for Approval

Summary of Changes is included below however please note that several minor amendments were made in relation to grammar and sentence structure and flow which are not included here.

Page number	Update / Amendment
Page 5	Aims and objectives - NLaG Strategic Framework 2019-2024
Page 10	Inclusion of: 'In addition, the redevelopment of the Emergency Care Centre was completed in October 2022'
Page 10	Inclusion of 'Patients requiring admission are admitted to IAAU and streamlined to a speciality ward dependent on capacity. Some emergency mobile emergency patients, if they meet a set criteria, are streamed up to Same Day Emergency Care Unit' To replace 'The surgical floor of the hospital has a Surgical Assessment Unit with 26 beds and a 6 chaired ambulatory care areas and a Short Stay Ward dedicated to the assessment and care of acute surgical emergency'
Page 11	Inclusion of: 'Our breast imaging and diagnostic service is run from our dedicated unit called the Pink Rose Suite which is based at Grimsby hospital.'
Page 11	Inclusion of: 'Complementary to this is the community midwifery service that operates across a number of satellite locations in North East Lincolnshire we provide encompassing care to women and their families throughout the area and including East Lindsey.'
Page 11	Inclusion of: 'Emergency/acute paediatric services are provided through the Emergency/acute paediatric services are provided through the dedicated Paediatric Area within the ED and the Paediatric Assessment Unit located in the Paediatric Ward.' To replace: 'Emergency/acute paediatric services are provided through the dedicated Paediatric Assessment and Observation Unit co-located in the Emergency Care Centre'
Page 11	Inclusion of: 'Neurology Service transfer was fully implemented with HUTH from April 2022.'
Page 12	Clarity that there is no confirmed date as yet for the service transfer for Haematology
Page 12	Clarity that the Dermatology Service transfer was fully implemented with HUTH
Page 12	Inclusion of: 'The Oncology service from Northern Lincolnshire and Goole NHS FT (NLaG) is expected to transfer over to Hull University Teaching Hospitals NHS Trust (HUTH) in 2023-24, date of full transfer not yet determined, When this occurs, all Oncology patients will be transferred onto the HUTH patient tracking list (PTL) and the service will be managed by HUTH.

	The transition of the NLaG Oncology service over to HUTH will be undertaken in a phased approach starting with non-elective inpatient care (target date 3/4/2023) followed by outpatient care and day case treatment. If required on clinical grounds, the transfer of specific cohorts of patients will be expedited according to diagnosis/tumour site in a phased approach. There will be no change to the delivery location of clinician-led outpatient appointments. Outpatient reviews for patients in the five main cancer tumour site groups (breast, lung, colorectal, upper gastrointestinal and urology) will remain in Diana Princess of Wales Hospital (DPoW) , Grimsby and the Queen's Centre at Castle Hill Hospital, however the care and management will be under HUTH. There will be no change to chemotherapy delivery, with continuation in both DPoW, Scunthorpe General Hospital and also the Queen's Centre at Castle Hill Hospital. All acute inpatient care relating to, or resulting from a patients Oncology treatment or Oncological care will occur in the Queen's Centre. No provision for this will be at either DPoW or SGH The consultant body will remain the same (as HUTH currently provide the consultants for the NLaG activity) and NLaG will continue to employ Clinical Nurse Specialists who will continue to support services at both NLAG and HUTH hospital sites under the service management of HUTH. Care closer to home is key to the service model of care, and as such required imaging, pathology and pharmacy will continue using NLaG services.'
Page 13	Removal of: • Hospice services (HPS) • Community-based services for people with a learning disability (LDC) Inclusion of: • Doctors consultation service (DCS) • Doctors treatment service (DTS) • Mobile doctor service (MBS)
Page 17	Surgical specialities on site updated
Page 17	Inclusion of: 'There is work ongoing to incorporate a CT scanner into the new ED.' To replace: 'Schemes currently under construction or in development include a new CT suite'
Page 18	Inclusion of: 'The Oncology service from Northern Lincolnshire and Goole NHS FT (NLaG) is expected to transfer over to Hull University Teaching Hospitals NHS Trust (HUTH) in 2023-24, date of full transfer not yet determined, When this occurs, all Oncology patients will be transferred

	onto the HUTH patient tracking list (PTL) and the service will be managed by HUTH. The transition of the NLaG Oncology service over to HUTH will be undertaken in a phased approach starting with non-elective inpatient care (target date 3/4/2023) followed by outpatient care and day case treatment. If required on clinical grounds, the transfer of specific cohorts of patients will be expedited according to diagnosis/tumour site in a phased approach. There will be no change to the delivery location of clinician-led outpatient appointments. Outpatient reviews for patients in the five main cancer tumour site groups (breast, lung, colorectal, upper gastrointestinal and urology) will remain in Diana Princess of Wales Hospital (DPoW) , Grimsby and the Queen's Centre at Castle Hill Hospital, however the care and management will be under HUTH. There will be no change to chemotherapy delivery, with continuation in both DPoW, Scunthorpe General Hospital and also the Queen's Centre at Castle Hill Hospital. All acute inpatient care relating to, or resulting from a patients Oncology treatment or Oncological care will occur in the Queen's Centre. No provision for this will be at either DPoW or SGH The consultant body will remain the same (as HUTH currently provide the consultants for the NLaG activity) and NLaG will continue to employ Clinical Nurse Specialists who will continue to support services at both NLAG and HUTH hospital sites under the service management of HUTH. Care closer to home is key to the service model of care, and as such required imaging, pathology and pharmacy will continue using NLaG services.'
Page 19	Removal of: • Hospice services (HPS)
Page 23	Section updated: 'Family Services provide outpatient consultant led gynaecology clinics, colposcopy services, hysteroscopy services and a midwifery-led 'Home from Home' unit for low risk deliveries. A Consultant Led Clinic for Obstetrics is also provided with sonographer input. Consultant led paediatric outpatient activity is also delivered from Goole, to try and provide care closer to home.'
Page 23	Removal of: 'in-patient pharmacy service' at Goole hospital
Page 24	Removal of: • Hospice services (HPS) • Long-term conditions services (LTC)
NA	Removal of 'The development of 3 Care Networks, which is being led by North Lincolnshire CCG, is now well established in terms of integrating community health and social care provision for the adult population of

	North Lincolnshire.’
NA	Removal of: ‘The Trust no longer provides the 0-19 nursing (health visiting and school nursing) service for children of North Lincolnshire after a re-procurement exercise by the commissioner (North Lincs Council).’
NA	Removal of: Orthodontics from both SGH and DPOW
NA	Removal of: Pain services from GDH
NA	Removal of: ‘from clinicians homes’ in reference to the outpatient clinics being run virtually

4. Recommendations

The Board of Directors are requested to:

- Identify any further updates that may be required to the Trust’s CQC Statement of Purpose
- Note and ratify all updates included within this report
- Approve the Statement of Purpose dated March 2023 for submission to the CQC

Statement of purpose

Health and Social Care Act 2008

Part 1

The provider's name, legal status, address and other contact details

Including address for service of notices and other documents

Please first read the guidance document *Statement of purpose: Guidance for providers*

Statement of purpose, Part 1

Health and Social Care Act 2008, Regulation 12, schedule 3

The provider's business contact details, including address for service of notices and other documents, in accordance with Sections 93 and 94 of the Health and Social Care Act 2008

1. Provider's name and legal status							
Full name[1]	Northern Lincolnshire and Goole NHS Foundation Trust						
CQC provider ID	RJL						
Legal status[1]	Individual	☐	Partnership	☐	Organisation	☒	

2. Provider's address, including for service of notices and other documents	
Business address[2]	Diana, Princess of Wales Hospital Scartho Road
Town/city	Grimsby
County	North East Lincolnshire
Post code	DN33 2BA
Business telephone	(01472) 874111
Electronic mail (email)[3]	kate.wood5@nhs.net

By submitting this statement of purpose you are confirming your willingness for CQC to use the **email address** supplied at Section 2 above for service of documents and for sending all other correspondence to you. Email ensures fast and efficient delivery of important information. If you do not want to receive documents by email please check or tick the box below. We will not share this email address with anyone else.

I/we do **NOT** wish to receive notices and other documents from CQC by email	☐

[1] Where the provider is a partnership please fill in the partnership's name at 'Full name' in Section 1 above. Where the partnership does not have a name, please fill in the names of all the partners at Section 3 below

[2] Where you do not agree to service of notices and other documents by email they will be sent by post to the business address shown in Section 2. This includes draft and final inspection reports. This postal business address will be included on the CQC website.

[3] Where you agree to service of notices and other documents by email your copies will be sent to the email address shown in Section 2. This includes draft and final inspection reports.

Please note: CQC can deem notices sent to the email or postal address for service you supply in your statement of purpose as having been served as described in Sections 93 and 94 of the Health and Social Care Act 2008. The address supplied must therefore be accurate, up to date, and able to ensure prompt delivery of these important documents.

3. The full names of all the partners in a partnership	
Names:	Not Applicable

Statement of purpose

Health and Social Care Act 2008

Part 2

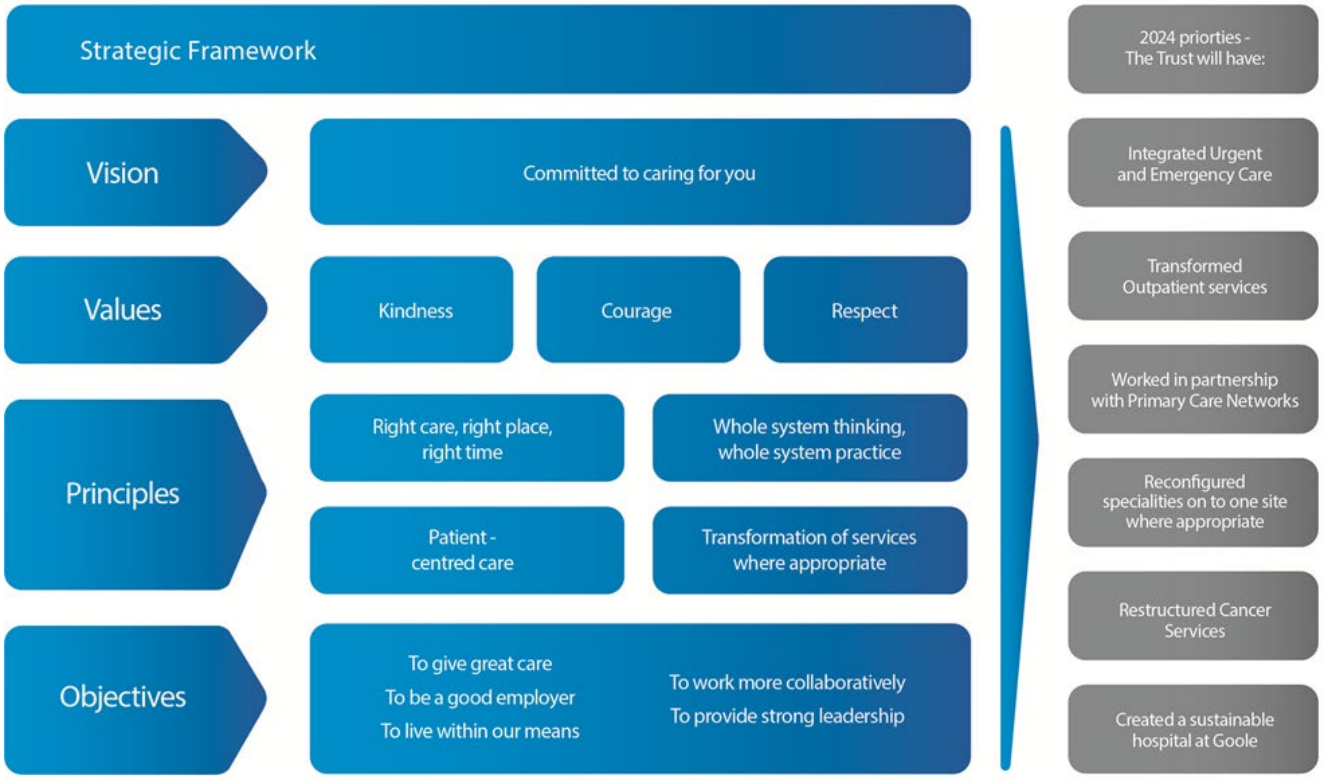
Aims and objectives

Please read the guidance document *Statement of purpose: Guidance for providers*.

Aims and objectives
What are your aims and objectives in providing the regulated activities and locations shown in part 3 of this statement of purpose

Northern Lincolnshire & Goole NHS Foundation Trust aims to provide the very best accessible healthcare to our local population. We aspire to do this through delivery of our values of - Kindness, Courage, Respect - which were crafted by staff at all levels from within the organisation. These values, recently launched, form the central part of our organisation's commitment to be the best and deliver services in line with these values.

Our strategic framework is set out in the graphic below. It provides, on one page, what the Trust is setting out to achieve in the next five years – our objectives and 2024 priorities – as well as how we want to do it, through our revised and updated Values and Behaviours.



Kindness: We believe kindness is shown by caring as we would care for our loved ones
- I will be compassionate, courteous and helpful at all times
- I will be empathetic, giving my full and undivided attention
- I will show I care by being calm, professional and considerate at all times.

Courage: We believe courage is the strength to do things differently and stand up for what's right
- I will be positively involved in doing things differently to improve our services
- I will challenge poor behaviour when I see it, hear it or feel it
- I will speak up when I see anything which concerns me.

Respect: We believe respect is having due regard for the feelings, contribution and achievements of others

• I will be open and honest and do what I say
• I will listen to and involve others so we can be the best we can be
• I will celebrate and appreciate the successes of others.

Strategic Plan 2019-2024: Principles

Right care, right place, right time

Patients are very clear they want, wherever possible, services which are close to them and their homes. Whilst this is not always possible – because of the lack of specialist staff, for example – it is something which the Trust is committed to achieving as much as it can. To make this happen the Trust will be looking at how technology can help to provide services in a different way. Specifically the Trust will be working on the basis that:

- Staff travel to treat the patient where clinically appropriate
- Treatments for some conditions at specialist hospitals

Use virtual technology

More and more use of technology for patient appointments to save coming to hospital. Whole system thinking, whole system practice This principle is all about making sure all the different organisations offering healthcare in the Northern Lincolnshire and Goole areas, as well as across the Humber and wider where appropriate, work together so patients only tell their story once and information about them can be viewed by anyone who needs to see them. It also means making sure patients, wherever they live and whatever they need, get the same service and level of care. This means the Trust aims to make sure:

- Work together with other organisations so patients get what they need every time
- Patients get the same service and care wherever they are seen.

Patient Centred Care

All the evidence shows patients like to be involved and communicated with so they know what is happening to them and why. It helps them to understand their condition, what treatment they are receiving and often means they recover more quickly. Making sure this happens every time the Trust needs to involve patients and their families and carers when it is making decisions to change services or provide them in a different way. Sometimes Trust staff think they are working on things which they think are important to patients when actually the patients want them to spend time doing something else. To stop this happening, and to make sure we really do focus on our patients' needs, the Trust will:

- Listen to feedback from our patients to improve what we do
- Do our best to provide what is important to patients
- Learn lessons and make changes from complaints and incidents
- Involve patients, carers and families in future service changes

Transformation of services where appropriate

Given the challenges the Trust faces, it is clear we cannot continue to do what we have been doing. We do not have the staff or infrastructure (in terms of buildings and equipment) to do that. Accessing the sums of money needed to put this right, which totals more than £50 million, is very unlikely. Even if we got the money we would not have the staff available to run services because of the national shortage of doctors and nurses. This means we need to work with other hospitals and partners to create services which, together, do have the specialist staff to offer safe and effective services. We also need to learn from other Trusts on better ways to run services to improve the outcomes for patients. If we do all of this we can create three vibrant and sustainable hospitals offering high quality services to our communities. This can only be achieved if we:

- Reshape the workforce
- Work in a different way so we use the specialist skills of each member of staff effectively
- Learn from others what improves services and make those changes in our hospitals

- Maximise the use of new technologies – for patient care, service delivery and staff development
- Benchmark and adopt best practice
- Be outward looking and learn from the best

Strategic Plan 2019-2024: Objectives

To give great care

We want to offer high quality, safe services which are stable and are not reliant on just one or two members of staff. We want to make sure we have a culture of continuous improvement and we learn from incidents and other hospitals. We want to make sure we focus on patients and their needs. So, to provide great care we will work and make decisions where we:

- Never compromise on safety
- Give care which works and is clinically proven
- Work on what matters to patients
- Always seek to learn and make improvements.

To be a good employer

Our staff are, without question, our most important asset. We need to do everything we can to offer great jobs and career progression in an environment where everyone feels supported, appreciated and invested in. We want our staff to feel they can raise concerns and ideas and know they will be listened to. Only by doing these things will we begin to attract and retain the numbers of staff we need to run our services. We will therefore look to:

- Develop a skilled and motivated workforce
- Promote staff wellbeing
- Create a safe and nurturing environment
- Listen to the concerns and ideas of staff

To live within our means

For many years the Trust has spent more money than it gets in. It is for this reason it was put into Financial Special Measures. We need to be better at financial planning and managing our scarce financial resources. Reporting a deficit very year is not something the Trust can do forever. In the next five years we need to make sure every pound we receive is spent in the right way and we make sure we live within our means. So we will be aiming to:

- Deliver value for money
- Work to eliminate the deficit
- Spend every pound wisely
- Innovate and educate to save
- Secure more investment.

To work more collaboratively

The Trust is not in a position to offer high quality services to everyone who needs them. Some patients' needs are too complex for us to treat as we don't have the specialist skills and knowledge to do that. Other patients need the support and help of mental health specialist teams which we do not have. For the local health providers to do the best for every single person in our communities we are going to have to work together. This means, for example, thinking about new ways to attract staff who might work for a number of organisations. To make sure we collaborate more the Trust will:

- Work with others to provide sustainable services
- Develop talent for the health community
- Use resources in the best way we can

To provide strong leadership

This strategy can only be successful if all the Trust's staff are committed to making it happen. That commitment comes from making sure they have the tools, knowledge and equipment they need to provide the care they strive to. It also means they have managers who show a similar commitment to make sure their teams are working effectively and everyone knows what they need to do and how they are going to do it. Our leaders need to be role models for all that is best in the NHS and in the Trust. By doing this they will create ambitious, motivated and successful teams. As such we see strong leaders to be those who:

- Ensure professional standards
- Be ambitious and aspirational
- Role model values and behaviours
- Develop skills and knowledge
- Strengthen team working.

Statement of purpose

Health and Social Care Act 2008

Part 3

Location(s),
and

- the people who use the service there
- their service type(s)
- their regulated activity(ies)

Fill in a separate part 3 for each location

The information below is for location no.:	1	of a total of:	3	locations

Name of location	Diana Princess of Wales Hospital
Address	Scartho Road Grimsby North East Lincolnshire
Postcode	DN33 2BA
Telephone	(01472) 874111
Email	kate.wood5@nhs.net

Description of the location

(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

Based in Grimsby, the Hospital is situated on a single site. Built in 1983, it has undergone considerable expansion since then. Projects completed over recent years have provided a centralised fully integrated Operations Centre, Theatres reconfiguration, new CT machine, new MRI, Acute Assessment Unit full refurbishment of two medical wards, new build of key worker accommodation comprising of 220 student rooms and self-contained flats. In addition, the redevelopment of the Emergency Care Centre was completed in October 2022.

Diana Princess of Wales Hospital provides the full range of district general hospital services, including emergency care, medicine, surgery and critical care, paediatrics, obstetrics, gynaecology, outpatients, diagnostics and therapy services. The hospital has 415 beds of which 109 are for surgery and critical care patients, 198 are for medical patients, 84 are for women & children's patients.

Medical specialties onsite include the emergency department, Same Day Emergency Care (SDEC), Integrated Acute Assessment Unit, frail elderly assessment services, diabetes and endocrinology, cardiology (including angiography, cardiac catheterisation, cardiac devices and permanent pacing facilities provided from a purpose build Cardiology Day Case Unit), respiratory medicine, elderly care, haematology and gastroenterology, stroke services and rheumatology. Oncology, outpatient cardiothoracic surgery and plastic surgery and renal medicine are provided by visiting consultants from Hull University Teaching Hospitals NHS Trust (HUTH).

Surgical specialties on site include trauma and orthopaedics, anaesthetics, critical care, general surgery, urology, ophthalmology, ENT and maxillo-facial. The theatre suite provides eight fully equipped theatres each with its own anaesthetic room, two theatres dedicated to orthopaedic use (both with ultra clean air facilities). One theatre is dedicated to emergency work and staffed at all times. A separate session is reserved each day for acute trauma cases, including weekends. Patients requiring admission are admitted to IAAU and streamlined to a speciality ward dependent on capacity. Some emergency mobile emergency patients, if they meet a set criteria, are streamed up to Same Day Emergency Care Unit.

Family Services provide maternity services and paediatric services within an estate comprising of maternity wards, gynaecology ward, dedicated obstetric theatres within the maternity unit, Paediatric and Neonatal in-patient areas, and the Child Development Centre. Our breast imaging and diagnostic service is run from our dedicated unit called the Pink Rose Suite which is based at Grimsby hospital.

Complementary to this is the community midwifery service that operates across a number of satellite locations in North East Lincolnshire we provide encompassing care to women and their families throughout the area and including East Lindsey. Emergency/acute paediatric services are provided through the Emergency/acute paediatric services are provided through the dedicated Paediatric Area within the ED and the Paediatric Assessment Unit located in the Paediatric Ward. This is supported by a neonatal unit and children's ward, caring for medical and surgical patients. Four designated beds are provided for babies requiring transitional care within the maternity unit.

We have a range of outpatient clinics, providing general paediatric clinics to specialist paediatric clinics. During the Covid-19 pandemic, some outpatient clinics were run virtually and this continues. The pathway is continued through the delivery of community paediatrics, ensuring children are provided appropriate care at an appropriate setting.

All the diagnostic and service departments are based on site including (JAG accredited) Endoscopy, Radiology with Plain Film, Ultrasound, Nuclear Medicine, CT and MRI, Medical Physics provides Neurophysiology, DEXA, Respiratory Physiology, Urodynamics and Medical Illustration. The hospital also hosts the Path Links hub laboratory for Blood Sciences.

Community and Therapy services provide a wide range of support for in-patients, out-patients and throughout the community covering physiotherapy, occupational therapy, speech & language therapy, nutrition and dietetics, wheelchair services, orthotics, podiatry, psychology and community dental. Included is the Assisted Living Centre which operates on site and provides a fully refurbished centre for the assessment and provision of aids and adaptations. A satellite outpatient service in Rehabilitation Medicine is provided from premises in the nearby town of Brigg.

Pharmacy services are delivered from an out-patient dispensary (delivered by Lloyds Pharmacy), an in-patient dispensary and a centralised Aseptic Services Unit (serving both DPOWH and SGH). Medicines stocks are received from the centralised pharmacy store on the Scunthorpe site. The Trust medicines information services are also located on the Grimsby site.

From January 2021, the Trust took on the role of vaccinating both Trust and non-Trust staff, in line with Government guidance, for Covid-19.

From the 1st October 2021 the outpatient Neurology service transferred over to HUTH, all the outpatients transferred onto the HUTH patient admin system and the service is managed by HUTH and delivered at two NLAG hospital sites (DPoWH & SGH). Neurology input to NLAG medical inpatients is provided by HUTH telephone advisory service and Neurology admissions are admitted to NLAG or if there are specialist Neurology needs they are transferred to HUTH (as was the pathway before) . NLAG still employ Neurology Medical and Clinical Nurse Specialist staff within the HUTH Neurology service that provide outpatient services at NLAG hospital sites. The Neurology Service was fully implemented with HUTH from April 2022.

From March 2022 NLAG commenced a Covid Medicine Delivery Unit (CMDU) in line with national guidance.

The clinical haematology service from Northern Lincolnshire and Goole NHS FT (NLaG) is expected to transfer over to Hull University Teaching Hospitals NHS Trust (HUTH), date not yet determined, when all haematology patients will be transferred onto the HUTH patient admin system and the service will be managed by HUTH. The transition of the existing NLaG follow-up only outpatient service over to HUTH will be undertaken in a phased approach with cohorts of patients transferred according to diagnosis. A trial cohort of patients with myeloproliferative disorders was transferred successfully on 1/3/2022.

Clinical haematology advice and support for NLAG medical inpatients will not change and will be provided remotely by the HUTH haematology team. NLAG will continue to employ a haematology Specialty Doctor and Clinical Nurse Specialists who will continue to support services at both NLAG and HUTH hospital sites under the service management of HUTH. There will be no change to the NLaG laboratory haematology service which will continue to be entirely run and supported clinically by Pathlinks.

The clinical dermatology service from Northern Lincolnshire and Goole NHS FT (NLaG) transferred to Hull University Teaching Hospitals NHS Trust (HUTH) on 1st November 2022 and all dermatology patients have been transferred onto the HUTH patient admin system and the service is now managed by HUTH.

The Oncology service from Northern Lincolnshire and Goole NHS FT (NLaG) is expected to transfer over to Hull University Teaching Hospitals NHS Trust (HUTH) in 2023-24 [DATE OF FULL TRANSFER NOT YET DETERMINED]. When this occurs, all Oncology patients will be transferred onto the HUTH patient tracking list (PTL) and the service will be managed by HUTH.

The transition of the NLaG Oncology service over to HUTH will be undertaken in a phased approach starting with non-elective inpatient care (**target date 3/4/2023**) followed by outpatient care and day case treatment. If required on clinical grounds, the transfer of specific cohorts of patients will be expedited according to diagnosis/tumour site in a phased approach.

There will be no change to the delivery location of clinician-led outpatient appointments. Outpatient reviews for patients in the five main cancer tumour site groups (breast, lung, colorectal, upper gastrointestinal and urology) will remain in Diana Princess of Wales Hospital (DPoW) , Grimsby and the Queen's Centre at Castle Hill Hospital, however the care and management will be under HUTH.

There will be no change to chemotherapy delivery, with continuation in both DPoW, Scunthorpe General Hospital and also the Queen's Centre at Castle Hill Hospital.

All acute inpatient care relating to, or resulting from a patients Oncology treatment or Oncological care will occur in the Queen's Centre. No provision for this will be at either DPoW or SGH

The consultant body will remain the same (as HUTH currently provide the consultants for the NLaG activity) and NLaG will continue to employ Clinical Nurse Specialists who will continue to support services at both NLAG and HUTH hospital sites under the service management of HUTH. Care closer to home is key to the service model of care, and as such required imaging, pathology and pharmacy will continue using NLaG services.

No of approved places / overnight beds (not NHS)	

CQC service user bands The people that will use this location ('The whole population' means everyone).						
Adults aged 18-65	☐	Adults aged 65+			☐	
Mental health	☐	Sensory impairment			☐	
Physical disability	☐	People detained under the Mental Health Act			☐	
Dementia	☐	People who misuse drugs or alcohol			☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder			☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐	
The whole population	☒	Other (please specify below)			☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☒
Long-term conditions services (LTC)	☒
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☐
Community-based services for people with a learning disability (LDC)	☐
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☒
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☒

Mobile doctor service (MBS)	☒
Dental service (DEN)	☒
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☒	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity:		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Registered Manager(s) for this regulated activity:		
Surgical procedures	☒	
Registered Manager(s) for this regulated activity:		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity:		
Management of supply of blood and blood derived products etc	☐	

Registered Manager(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☒	
Registered Manager(s) for this regulated activity:		
Termination of pregnancies	☒	
Registered Manager(s) for this regulated activity:		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☒	
Registered Manager(s) for this regulated activity:		
Family planning service	☐	
Registered Manager(s) for this regulated activity:		

Statement of purpose

Health and Social Care Act 2008

Part 3

Location(s),
and

- the people who use the service there
- their service type(s)
- their regulated activity(ies)

Fill in a separate part 3 for each location

The information below is for location no.:	2	of a total of:	3	locations

Name of location	Scunthorpe General Hospital
Address	Cliff Gardens Scunthorpe North Lincolnshire
Postcode	DN15 7BH
Telephone	(01724) 282282
Email	kate.wood5@nhs.net

Description of the location
(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

Scunthorpe General Hospital (SGH) was first built in the 1920's and occupies a site surrounded by residential properties. The site has expanded over time with modernised structures attached to original buildings. Recent developments completed include a new (JAG accredited) Endoscopy Unit and Lower Gastro-intestinal Unit, a new GP/UTC facility and CT. Schemes currently under construction or in development include incorporating a CT scanner into the new ED, redevelopment of the Emergency Care Centre and to add a geothermal ground source heating system.

Scunthorpe General Hospital provides the full range of district general hospital services, including Emergency Care Centre, medicine, surgery and critical care, paediatrics, obstetrics and gynaecology, outpatients, diagnostics and therapy services. The hospital has 386 overnight beds of which 95 are for surgery and critical care patients, 211 are for medical patients with access to escalation beds when required and 80 are for Family Services patients.

Medical specialties on site include the emergency department, Same Day Emergency Care (SDEC), frail elderly assessment services, acute assessment unit, diabetes and endocrinology, cardiology (with facilities for Angiography, cardiac catheterisation and pacing), respiratory medicine, elderly care, haematology and gastroenterology, stroke services including Hyperacute, palliative medicine, rheumatology and neurology. Oncology, outpatient, Cardiothoracic Surgery, Plastic Surgery and Renal Medicine are provided by visiting consultants from Hull University Teaching Hospitals NHS Trust.

Surgical specialities on site include trauma and orthopaedics, anaesthetics, critical care, general surgery, urology, ophthalmology, ENT and maxillo-facial. The hospital is equipped with six main theatres, including one theatre dedicated to trauma and orthopaedic use (with ultra clean air facilities). One theatre is dedicated to emergency work, staffed at all times. A separate session for acute trauma cases is reserved each day, including weekends.

Family Services in Scunthorpe General Hospital provide the maternity pathway using a

traditional service model comprising antenatal/postnatal clinics, dedicated Central Delivery Suite, maternity theatre and a dedicated Antenatal / postnatal ward. Gynaecology is provided through a range of outpatient clinics and an in-patient ward facility. During the Covid-19 pandemic, some outpatient clinics were run virtually and this continues. Acute/emergency paediatrics is provided by specialist nurses in the ECC in conjunction with doctors. The children's ward works closely with ECC assessing and receiving medical and surgical patients ensuring the pathway is seamless. An inpatient paediatrics service is provided caring for children aged 0-16 years, supported by a community service. A neonatal intensive care unit is based close to Central Delivery Suite allowing easy access for mum to baby. There are four transitional care beds managed by the neonatal team.

All the diagnostic and service departments are based on site including Endoscopy, Radiology with Plain Film, Ultrasound, CT and MRI. The hospital hosts the Path Links hub laboratory for Blood Sciences. Community and Therapy services provide a wide range of support for inpatients, outpatients and throughout the community covering community nursing (operating across three networks), physiotherapy, occupational therapy, speech & language therapy, nutrition & dietetics, wheelchair services, orthotics, podiatry, psychology and community dental. A satellite outpatient service in Rehabilitation Medicine is provided from premises in the nearby town of Brigg.

Pharmacy services are delivered from an out-patient dispensary (delivered by Lloyds Pharmacy), an in-patient dispensary and a centralised pharmacy store (receiving the majority of medicines deliveries for the Trust then storing and distributing medicines stocks to all 3 sites). There is a degree of automation with an on-site pharmacy robot.

From March 2022 NLAG commenced a Covid Medicine Delivery Unit (CMDU) in line with national guidance.

The clinical dermatology service from Northern Lincolnshire and Goole NHS FT (NLaG) transferred to Hull University Teaching Hospitals NHS Trust (HUTH) on 1st November 2022 and all dermatology patients have been transferred onto the HUTH patient admin system and the service is now managed by HUTH.

New service, commencing 17th October 2022, from this location only, of Domiciliary Homecare service to enhance our intermediate care offer, supporting timely discharge and avoiding acute admission to hospital for people who need support with activities of living as they rehabilitate.

The Oncology service from Northern Lincolnshire and Goole NHS FT (NLaG) is expected to transfer over to Hull University Teaching Hospitals NHS Trust (HUTH) in 2023-24 [DATE OF FULL TRANSFER NOT YET DETERMINED]. When this occurs, all Oncology patients will be transferred onto the HUTH patient tracking list (PTL) and the service will be managed by HUTH.

The transition of the NLaG Oncology service over to HUTH will be undertaken in a phased approach starting with non-elective inpatient care (**target date 3/4/2023**) followed by outpatient care and day case treatment. If required on clinical grounds, the transfer of specific cohorts of patients will be expedited according to diagnosis/tumour site in a phased approach.

There will be no change to the delivery location of clinician-led outpatient appointments. Outpatient reviews for patients in the five main cancer tumour site groups (breast, lung, colorectal, upper gastrointestinal and urology) will remain in Diana Princess of Wales Hospital

(DPoW) , Grimsby and the Queen's Centre at Castle Hill Hospital, however the care and management will be under HUTH.

There will be no change to chemotherapy delivery, with continuation in both DPoW, Scunthorpe General Hospital and also the Queen's Centre at Castle Hill Hospital.

All acute inpatient care relating to, or resulting from a patients Oncology treatment or Oncological care will occur in the Queen's Centre. No provision for this will be at either DPoW or SGH

The consultant body will remain the same (as HUTH currently provide the consultants for the NLaG activity) and NLaG will continue to employ Clinical Nurse Specialists who will continue to support services at both NLAG and HUTH hospital sites under the service management of HUTH. Care closer to home is key to the service model of care, and as such required imaging, pathology and pharmacy will continue using NLaG services.

No of approved places / overnight beds (not NHS)	

CQC service user bands

The people that will use this location ('The whole population' means everyone).

Adults aged 18-65	☐	Adults aged 65+			☐	
Mental health	☐	Sensory impairment			☐	
Physical disability	☐	People detained under the Mental Health Act			☐	
Dementia	☐	People who misuse drugs or alcohol			☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder			☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐	
The whole population	☒	Other (please specify below)			☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐

Hospice services (HPS)	☐
Rehabilitation services (RHS)	☒
Long-term conditions services (LTC)	☒
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☐
Community-based services for people with a learning disability (LDC)	☐
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☒
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☒
Mobile doctor service (MBS)	☒
Dental service (DEN)	☒
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☒
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☒	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	

Registered Manager(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity:		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Registered Manager(s) for this regulated activity:		
Surgical procedures	☒	
Registered Manager(s) for this regulated activity:		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity:		
Management of supply of blood and blood derived products etc	☐	
Registered Manager(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☒	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☒	
Registered Manager(s) for this regulated activity:		
Termination of pregnancies	☒	
Registered Manager(s) for this regulated activity:		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☒	
Registered Manager(s) for this regulated activity:		
Family planning service	☐	
Registered Manager(s) for this regulated activity:		

Statement of purpose

Health and Social Care Act 2008

Part 3

Location(s),
and

- the people who use the service there
- their service type(s)
- their regulated activity(ies)

Fill in a separate part 3 for each location

The information below is for location no.:	3	of a total of:	3	locations

Name of location	Goole and District Hospital
Address	Woodland Avenue Goole East Riding of Yorkshire
Postcode	DN14 6RX
Telephone	(01405) 720720
Email	kate.wood5@nhs.net

Description of the location

(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

This is a purpose built community-plus hospital opened in 1988 and brought together services from a number of scattered sites around the town of Goole.

Medical Services include general medicine, elderly, cardiology, rheumatology, gastroenterology, a light treatment service, diabetes and endocrinology, haematology. Surgical services provided include general surgery, orthopaedics, ophthalmology, ENT, gynaecology and urology.

There is also a surgical day case unit, also used to perform urology endoscopic procedures. Two further main theatres are equipped for major orthopaedic work and other types of surgery. In addition, the site has a well-equipped ophthalmic suite and theatre and an outpatient department. During the Covid-19 pandemic, some outpatient clinics were run virtually and this continues. Audiology services are provided by the Surgery division.

Family Services provide outpatient consultant led gynaecology clinics, colposcopy services, hysteroscopy services and a midwifery-led 'Home from Home' unit for low risk deliveries. A Consultant Led Clinic for Obstetrics is also provided with sonographer input. Consultant led paediatric outpatient activity is also delivered from Goole, to try and provide care closer to home.

Therapy services are provided for both inpatients and outpatients with physiotherapy, occupational therapy, nutrition and dietetics and psychology services. There are two x-ray rooms together with mobile units, and an ultrasound room. The diagnostics department also provides a regular mobile MRI/CT service. The hospital also accommodates a neurological rehabilitation centre - the Goole Neuro Rehab Centre, which is now managed by the Community and Therapies Division.

Goole hospital also receives an out-patient dispensing service from a community pharmacy contractor based within the hospital grounds.

From January 2021, the Trust took on the role of vaccinating both Trust and non-Trust staff, in line with Government guidance, for Covid-19. The clinical dermatology service from Northern Lincolnshire and Goole NHS FT (NLaG) transferred to Hull University Teaching Hospitals NHS Trust (HUTH) on 1st November 2022 and all dermatology patients have been transferred onto the HUTH patient admin system and the service is now managed by HUTH.

No of approved places / overnight beds (not NHS)	

CQC service user bands The people that will use this location ('The whole population' means everyone).						
Adults aged 18-65	☐	Adults aged 65+			☐	
Mental health	☐	Sensory impairment			☐	
Physical disability	☐	People detained under the Mental Health Act			☐	
Dementia	☐	People who misuse drugs or alcohol			☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder			☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐	
The whole population	☒	Other (please specify below)			☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☒
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐

Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☐
Community-based services for people with a learning disability (LDC)	☐
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☐
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☒
Mobile doctor service (MBS)	☒
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☒	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	

Registered Manager(s) for this regulated activity:		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Registered Manager(s) for this regulated activity:		
Surgical procedures	☒	
Registered Manager(s) for this regulated activity:		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity:		
Management of supply of blood and blood derived products etc	☐	
Registered Manager(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☒	
Registered Manager(s) for this regulated activity:		
Termination of pregnancies	☐	
Registered Manager(s) for this regulated activity:		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☒	
Registered Manager(s) for this regulated activity:		
Family planning service	☐	
Registered Manager(s) for this regulated activity:		

Statement of purpose

Health and Social Care Act 2008

Part 4

Registered manager details

Including address for service of notices and other documents

Please first read the guidance document *Statement of purpose: Guidance for providers*

The information below is for manager number:	1	of a total of:	1	Managers working for the provider shown in part 1

1. Manager's full name	Dr Kate Wood, Medical Director

2. Manager's contact details	
Business address	Northern Lincolnshire and Goole NHS Foundation Trust Diana Princess of Wales Hospital Scartho Road
Town/city	Grimsby
County	North East Lincolnshire
Post code	DN33 2BA
Business telephone	03033 303616
Manager's email address[1]	
kate.wood5@nhs.net	

[1] Where the manager has agreed to service of notices and other documents by email they will be sent to this email address. This includes draft and final inspection reports on all locations where they manage regulated activities.

Where the manager does not agree to service of notices and other documents by email they will be sent by post to the provider postal business address shown in Part 1 of the statement of purpose. This includes draft and final inspection reports on all locations.

Please note: CQC can deem notices sent to manager(s) at the relevant email or postal address for service in this statement of purpose as having been served, as described in Sections 93 and 94 of the Health and Social Care Act 2008. The address supplied must therefore be accurate, up to date, and able to ensure prompt delivery of these important documents to registered managers.

3. Locations managed by the registered manager at 1 above (Please see part 3 of this statement of purpose for full details of the location(s))	
Name(s) of location(s) (list)	Percentage of time spent at this location

All locations listed in the RPIR document and including community services.	100

4. Regulated activity(ies) managed by this manager		
Personal care	☒	
Accommodation for persons who require nursing or personal care	☐	
Accommodation for persons who require treatment for substance abuse	☐	
Accommodation and nursing or personal care in the further education sector	☐	
Treatment of disease, disorder or injury	☒	
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Surgical procedures	☒	
Diagnostic and screening procedures	☒	
Management of supply of blood and blood derived products etc	☐	
Transport services, triage and medical advice provided remotely	☒	
Maternity and midwifery services	☒	
Termination of pregnancies	☒	
Services in slimming clinics	☐	
Nursing care	☒	
Family planning service	☐	

5. Locations, regulated activities and job shares

Where this manager does not manage all of the regulated activities ticked / checked at 4 above at all of the locations listed at 3 above, please describe which regulated activities they manage at which locations below.

Please also describe below any job share arrangements that include or affect this manager.