Northern Lincolnshire and Goole NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 1 August 2023
Main Boardroom, Diana, Princess of Wales Hospital
Time – 9.00 am – 12.00 pm
For the purpose of transacting the business set out below

		Note / Approve / Receive & Confirm	Time	Ref
1.	**Introduction**			
1.1	**Chair's Opening Remarks** Sean Lyons, Chair	Note	09:00 Hrs	Verbal
1.2	**Apologies for Absence** Sean Lyons, Chair	Note		Verbal
1.3	**Patients' Story** Jo Loughborough, Senior Nurse – Patient Experience	Note		Verbal
2.	**Business Items**			
2.1	**Declarations of Interest** Sean Lyons, Chair	Note	09:20 hrs	Verbal
2.2	**To approve the minutes of the Public meeting held on Tuesday, 6 June 2023** Sean Lyons, Chair	Approve		NLG(23)131 Attached
2.3	**Urgent Matters Arising** Sean Lyons, Chair	Note		Verbal
2.4	**Trust Board Action Log – Public** Sean Lyons, Chair	Note		NLG(23)132 Attached
2.5	**Chief Executive's Briefing** Shaun Stacey, Interim Chief Executive	Note	09:30 hrs	NLG(23)133 Attached
2.6	**Integrated Performance Report (IPR)**	Note		NLG(23)134 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	09:35 hrs	NLG(23)134 Attached

3.2	**Maternity Oversight Report** Ellie Monkhouse, Chief Nurse & Nicky Foster, Associate Chief Nurse – Midwifery, Gynaecology and Breast Services	Note	09:50 hrs	NLG(23)135 Attached
3.3	**Quality & Safety Committee Highlight Report and Board Challenge** Kate Truscott, Associate Non-Executive Director & Deputy Chair of the Quality & Safety Committee	Note	10:00 hrs	NLG(23)136 Attached
3.4	**Performance Report – Key Issues** Ashy Shanker, Interim Chief Operating Officer	Note	10:05 hrs	NLG(23)134 Attached
3.5	**Finance & Performance Committee Highlight Report and Board Challenge – Performance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	10:15 hrs	NLG(23)137 Attached
4.	**Strategic Objective 2 – To Be a Good Employer and Strategic Objective 5 – To Provide Good Leadership**			
4.1	**Workforce Report – Key Issues** Lee Bond, Chief Financial Officer	Note	10:20 hrs	NLG(23)134 Attached
4.2	**Workforce Committee Highlight Report and Board Challenge** Sue Liburd, Chair of the Workforce Committee and Non-Executive Director	Note	10:30 hrs	NLG(23)138 Attached
4.3	**Medical Appraisal & Revalidation Annual Report (AOA)** Dr Kate Wood, Chief Medical Officer	Approve	10:35 hrs	NLG(23)157 Attached
	BREAK – 10:40 hrs – 10:50 hrs			
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Finance – Month 03 – Key Issues** Lee Bond, Chief Financial Officer	Note	10:50 Hrs	NLG(23)139 Attached
5.2	**Finance & Performance Committee Highlight Report & Board Challenge – Finance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	11:00 hrs	NLG(23)140 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Strategic & Transformation Report – Key Issues** Ivan McConnell, Director of Strategic Development	Note	11:05 hrs	NLG(23)141 Attached
6.2	**Executive Report – Digital** Shauna McMahon, Chief Information Officer	Note	11.15 hrs	NLG(23)142 Attached
6.3	**Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge** Gill Ponder, Non-Executive Director	Note	11:25 hrs	NLG(23)143 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)145 Attached
7.2	**Board Assurance Framework (BAF) – Quarter One** Helen Harris, Director of Corporate Governance	Note & Approve	11:35 hrs	NLG(23)146 Attached

8.	**Approval (Other)**			
8.1	**Fire Annual Report** Jug Johal, Director of Estates & Facilities	Approve	11:40 hrs	NLG(23)147 Attached
8.2	**LSMS Annual Report & Workplan and Security Annual Report** Jug Johal, Director of Estates & Facilities	Approve	11:45 hrs	NLG(23)148 Attached
8.3	**Health Tree Foundation Trustees' Commmittee Terms of Reference** Gill Ponder, Non-Executive Director	Approve	11:50	NLG(23)149 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, 5 September 2023, 9.00 am **Public & Private Meeting** Tuesday, 3 October 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**	
	Committee Supporting Papers:	
	Finance & Performance Committee	
9.1	**Finance & Performance Committee Minutes – April & May 2023** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(23)150 Attached
9.2	**Health Tree Foundation Trustees' Committee Minutes – May 2023** Neil Gammon, Chair of the Health Tree Foundation Trustees' Committee	NLG(23)151 Attached
	Quality & Safety Committee	
9.3	**Quality & Safety Committee Minutes – May & June 2023** Fiona Osborne, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(23)152 Attached
9.4	**Nursing & Midwifery Assurance Report** Ellie Monkhouse, Chief Nurse	NLG(23)153 Attached
	Workforce Committee	
9.5	**Workforce Committee Minutes – May 2023** Sue Liburd, Non-Executive Director & Chair of the Workforce Committee	NLG(23)154 Attached
9.6	**Freedom to Speak Up Guardian Report – Quarter One** Liz Houchin, FTSUG	NLG(23)155 Attached
9.7	**Guardian of Safe Working Hours Report – Quarter One** Dr Liz Evans, Guardian of Safe Working Hours	NLG(23)156 Attached
	Audit, Risk & Governance Committee	
9.8	**Audit, Risk & Governance Committee Minutes – April 2023** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(23)158 Attached
9.9	**Audit, Risk & Governance Committee Annual Report to the Board 2022-23** Simon Parkes, Non-Executive Director & Chair of the Audit, Risk & Governance Committee	NLG(23)169 Attached
	Other	
9.10	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(23)159 Attached
9.11	**Documents Signed Under Seal** Shaun Stacey, Interim Chief Executive	NLG(23)160 Attached
9.12	**Trust Board Reporting Framework** Helen Harris, Director of Corporate Governance	NLG(23)161 Attached
9.13	**Covid Inquiry** Helen Harris, Director of Corporate Governance	NLG(23)162 Attached

NLG(23)131

Northern Lincolnshire and Goole NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (MEETING IN PUBLIC)

Minutes of the Public Meeting held on Tuesday, 6 June 2023 at 9.00 am
In the Main Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Chair
Lee Bond	Chief Financial Officer
Ellie Monkhouse	Chief Nurse
Shaun Stacey	Chief Operating Officer
Dr Kate Wood	Chief Medical Officer
Fiona Osborne	Non-Executive Director
Sue Liburd	Non-Executive Director
Gillian Ponder	Non-Executive Director (attended via MS Teams)
Simon Parkes	Non-Executive Director

In Attendance:

Adrian Beddow	Associate Director of Communications
Rachel Farmer	NHS Liaison
Nicky Foster	Associate Chief Nurse – Midwifery, Gynaecology & Breast Services (for item 3.2)
Helen Harris	Director of Corporate Governance
Liz Houchin	Freedom to Speak Up Guardian (for item 4.2)
Jug Johal	Director of Estates & Facilities
Mr Gordon McAdam	Medical Examiner (for item 1.3)
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Simon Nearney	Interim Director of People
Carolyn Phillips	Lead Medical Examiner Officer (for item 1.3)
Karl Portz	Equality & Diversity Lead (for item 4.3)
Ian Reekie	Lead Governor
Kate Truscott	Associate Non-Executive Director
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Director of Corporate Governance (note taker)

1. Introduction

1.1 Chair's Opening Remarks

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

Sean Lyons wanted to note appreciation and well wishes to Dr Peter Reading in the new role of Chief Executive Officer (CEO) at the Yorkshire Ambulance Service (YAS). It was agreed a letter would be sent from the Board to Dr Peter Reading to note this. Sean Lyons was grateful to Executive colleagues for acting up arrangements until the Interim CEO was appointed, a paper regarding this was due to be presented at the meeting that day. It was advised Jonathan Lofthouse the newly appointed CEO would start with both Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospital NHS Trust (HUTH) on Monday, 14 August 2023. Progress was being made in respect of the Group Model arrangements particularly in terms of governance processes.

1.2 Apologies for Absence

Apologies for absence were received by Linda Jackson and Stuart Hall. It was noted Gill Ponder was in attendance by MS teams.

1.3 Patients' Story

Jo Loughborough introduced the story of the impact of the Medical Examiner Office.

Carolyn Phillips and Mr Gordon McAdam introduced the story and referred to the presentation.

Kate Truscott queried what body held the Medical Examiners to account. Mr Gordon McAdam advised this was the National Medical Examiner. This would change from a legal perspective once Statutory Legislation was in place, it was expected this would be April 2024 due to a delay. Sue Liburd queried whether death certificate accuracy was challenged more during the pandemic. Mr Gordon McAdam explained death certificates were legally signed to the best of the clinician knowledge and believe and this remained the same. On occasions a test result may not be received until after the death certificate was issued, if this was the case and it impacted on the cause of death the wording may be altered. Dr Kate Wood explained the origin of the Medical Examiner's Office related mainly to system errors not individual clinical errors.

Sean Lyons thanked Mr Gordon McAdam and Carolyn Phillips for sharing the story, it was recognised it was important the public were aware the role existed at the Trust.

2. Business Items

2.1 Declarations of Interest

No declarations of interests were received.

2.2 To approve the minutes of the Public Meeting held on Tuesday, 4 April 2023 – NLG(23)090

The minutes of the meeting held on the 4 April 2023 were accepted as a true and accurate record and would be duly signed by the Chair. It was noted a point had been raised with Sean Lyons regarding item 3.3 of the previous minutes.

Post Meeting Note:

This was discussed in the break of the meeting held on Tuesday, 6 June 2023

Ivan McConnell referred to item 6.1. It was noted the Business Case referred to in the minutes would not be available until the end of Quarter Two not Quarter One.

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)091

Sean Lyons referred to the action log, it was noted there were no actions to be reviewed for the meeting.

2.5 Chief Executive's Briefing – NLG(23)092

Dr Kate Wood as Acting CEO the previous week shared the report with the Board. The report formally expressed thanks and support to Dr Peter Reading. The Board's attention was drawn to the exiting of the NHS Oversight Framework (NOF4) Recovery Support Programme (RSP) point within the report. Congratulations were noted to Jug Johal on being appointed as Interim Director of Estates & Facilities at HUTH. Dr Kate Wood noted other key highlights within the report.

Dr Kate Wood thanked Executive colleagues for support in preparing the report. Sean Lyons endorsed the momentous position of moving out of the NOF4 RSP, this was a great effort for the Trust.

2.5.1 Trust Priorities End of Year Report – NLG(23)093

Shaun Stacey shared the report with board members.

Kate Truscott wanted to thank everyone for the work completed and what had been achieved over the previous year. Sean Lyons agreed the paper provided a detailed account of what had been achieved.

2.6 Integrated Performance Report (IPR) – NLG(23)094

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)094

Dr Kate Wood highlighted key areas with the report. Thanks were noted to the Performance team for the work undertaken to correct the parameters for Venous Thromboembolism (VTE), these were now within range, and showed the correct information. In respect of sepsis recording, this had now improved dramatically, and would now progress with the organisation gaining an understanding whilst addressing any issues around the management of sepsis. It was noted the weighing of patients had improved. There was a low light around two duty of candour breaches to be noted by the Board.

Sean Lyons queried whether the issues around weighing patients had been resolved. Dr Kate Wood explained patients were now weighed as they arrived in the Emergency Department (ED) by ambulance. This information now linked through and the benefits of this were already being shown. There was clear evidence weight was important and should not be ignored. Dr Kate Wood thanked everyone for the support with this issue.

Ellie Monkhouse confirmed the organisation had slightly missed the target for Clostridium Difficile (C.Dif), however, the Trust had nationally performed well over that period and been the best performing Trust in the region. Unfortunately, after a 26-month period NLAG had had an Meticillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia case. A deep dive had been undertaken and learning had been identified, it was advised this case could not have been avoided.

Sean Lyons highlighted how well NLAG performed in respect of infection control. In respect of the duty of candour breach it was queried whether this would cause any ongoing issues. Dr Kate Wood advised this would be resolved, the issue had occurred due to timing as a response was required within ten days. A procedure had been put in place to ensure this did not happen again.

3.2 Maternity Oversight Report – NLG(23)095

Ellie Monkhouse thanked Nicky Foster for attending to share the report. Nicky Foster referred to the report and highlighted key points advising of good progress made against the action plan. Sue Liburd referred to the report as it detailed the organisation may not achieve the Clinical Negligence Scheme for Trusts (CNST) next year, this was surprising in light of the established recording the Trust had in place. Nicky Foster explained this was in respect of the Maternity Voices Partnership (MVP) Chair role not being appointed to. The recruitment for this role was currently being undertaken due to the previous person leaving. Ellie Monkhouse explained there had been some discussion in respect of the role due to the time it took and whether it should be remunerated. Sean Lyons offered to speak to anyone relevant at regional level to support the role being appointed to. Shaun Stacey explained the failure to appoint to this role would impact on all Trusts within the region.

Dr Kate Wood had found the report helpful and informative, a query was raised as to what the issues were around triage blockages and whether this was anything the Board could support. Nicky Foster explained work was ongoing with Simon Nearney around the issues, there had also been some engagement with Unions. It was hoped this had brought the Trust to a stage where staff may be happy with engagement rather than a consultation.

Lee Bond referred to page seven as it referenced changes to the physical footprint, it was queried what progress had been made. Nicky Foster explained this related to a room being converted from a clinical area to an office facility. It was agreed further discussion on this issue would be undertaken outside of the meeting. Helen Harris queried how confident the team were in achieving the planned targets within the Sustainability Plan. Nicky Foster confirmed the actions were almost complete so there was confidence this would be achieved.

Sean Lyons queried the table on page five that detailed Patient Advice & Liaison Service (PALS) concerns and complaints as the information within the tables contradicted other information provided. Dr Kate Wood felt the detail within the reports were for the whole division. Nicky Foster agreed to clarify the information provided.

Action: Nicky Foster

Ivan McConnell explained there would be a need to align the Maternity Strategy when the consultation for Humber Acute commenced. There may also be an opportunity to optimise the MVP relationship within this programme too.

Sue Liburd questioned whether there was anything within the plan that may cause delays in coming out of the support programme. Nicky Foster felt there was nothing that would affect this. Ellie Monkhouse advised the focus had been the Sustainability Plan, some of the actions were shown as amber but this was due to the collection of evidence. A meeting was due to take place later that week where targets dates would be agreed or updated as necessary.

Sean Lyons noted the excellent work completed within the report and thanked Nicky Foster for attending.

3.3 Annual Quality Account – NLG(23)096

Dr Kate Wood referred to the report and noted this was for approval and required sign off by the CEO and Chair. The report articulated what the Trust had been working on over the last year and included an overview of performance and progress against quality priorities. One amendment was noted within the document subsequent to the Board meeting in respect of Commissioning for Quality & Innovation (CQUIN). The report had received scrutiny through the Quality & Safety Committee (Q&SC).

Sean Lyons felt the report was well written and transparent. A query was raised as to whether there were any concerns in relation to the stakeholder comments. Dr Kate Wood advised there was nothing to be concerned about. Dr Kate Wood

wanted to thank Fiona Moore for providing the report and the work undertaken on this.

The Trust Board approved the report subject to the updated data required.

3.4 Quality & Safety Committee Highlight Report and Board Challenge including Self-Assessment – NLG(23)097

Fiona Osborne referred to the report and drew the Board's attention to the two recommendations. Shauna McMahon referred to the point raised regarding Digital and wanted the Board to be aware of the difficulties in collating data when this was not undertaken digitally as this ensured quality data. Discussion took place around various issues and the work this involved. It was noted the Q&SC would have oversight of particular pieces of work around this. Lee Bond queried whether the issue was recorded on the risk register, it was agreed this would be checked by Dr Kate Wood.

Action: Dr Kate Wood

Fiona Osborne advised Quality Priority Deep Dives would be undertaken by the committee over the next year.

Sean Lyons advised of discussions with Simon Nearney regarding recruitment and retention. Simon Nearney explained data for the current establishment could be provided and be broken down by vacancies including which area this related to. The expectations could also be included of what was expected by the end of the financial year. Sue Liburd advised Workforce Committee had started to review agency spend to show areas of concern. It was felt a more in-depth discussion was required at Board level. Ellie Monkhouse explained the issues were already understood, however, this needed triangulating. Shaun Stacey felt this needed to be reviewed from an acuity and volume perspective as what happened on a daily basis was the main challenge. Gill Ponder supported a Board level discussion as this crossed over into most committees. Lee Bond explained there were four main areas that needed to be concentrated on in respect of agency spend. In terms of Registered Nurses there was a good understanding of the next 12 months, however, the Health Care Assistant (HCA) projection required more understanding. Simon Parkes queried whether more assurance was required around issues with workforce challenges, recruitment and retention as it was not clear everything was being addressed. Ellie Monkhouse highlighted the Trust did struggle to recruit due to geographical challenges.

Sean Lyons agreed a three-hour Board deep dive on how to address those issues raised should be arranged by Simon Nearney as soon as possible.

Action: Simon Nearney

Simon Parkes offered support through the local Universities to review what could be put in place collectively. Ellie Monkhouse advised any support would be welcome, however, this had not been supported in the past.

3.5 Performance - Key Issues – NLG(23)094

Shaun Stacey referred to the report and went through key highlights. Unplanned care continued to be a challenge due to the number of patients waiting in the ED for more than 12 hours. There was a continuation of good performance around Same Day Emergency Care (SDEC) and the Urgent Treatment Centre (UTC). The challenge around managing well patients continued due to discharge issues, at some points over the last week the number of patients had reached 54. Work around patients being cared for at home was still being supported to prevent admissions for care at the Trust. Planned care continued to perform well despite interruptions with strike action. Cancer performance remained a challenge although there had been some improvements, it was not at the required level.

3.6 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(23)098

Gill Ponder referred to the report and noted key highlights.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Workforce - Key Issues - NLG(23)094

Simon Nearney referred to the report and advised recruitment on key roles had progressed well. The Leadership Programme was now available to more roles in the Trust. Core mandatory training compliance was currently 89%, Appraisal compliance was 82% which was not far from the project target of 85%. One area of concern was sickness absence as this was the highest in the Humber and Northern Region. Sean Lyons queried why role specific mandatory training was behind target, it was advised some of this related to room access as the majority were not large enough. There was a plan to alleviate this issue over coming months.

4.2 Freedom to Speak Up Guardian (FTSUG) Annual Report 2022 / 23 – NLG(23)099

Liz Houchin referred to the report and drew the Board's attention to key highlights. It was noted Liz Houchin had attended the Culture Transformation Board to share behaviours that were being reported. Discussions were taking place on how this would be addressed.

Fiona Osborne queried whether staff felt more confident that when issues were raised, they would be addressed. Liz Houchin agreed this appeared to be the case, it was noted no staff would suffer detriment after speaking up. A further query was raised as to whether Liz Houchin had noticed a difference in how staff were interacting with one another from when the FTSUG role was introduced. Liz Houchin agreed this had been noticed in some areas, however, some staff still needed to recognise the impact of personal actions with one another.

Sean Lyons felt there needed to be more awareness of how staff treated one another due to the impact this caused. Kate Truscott queried whether there had been a reduction in formal grievances due to the speaking out culture. Simon

Nearney reported there was 90% less cases but was unsure whether this was directly linked to that. Simon Nearney advised there were still issues around staff experience that managers needed to be more aware of when engaging with staff. This had been highlighted through the staff survey. Lee Bond queried whether those issues were more within the teams and not necessarily with individual managers. Simon Nearney agreed but explained it was the managers responsibility to deal with this appropriately.

The FTSUG Report was approved by the Board.

4.3 Equality, Diversity & Inclusion Report & Strategy 2023 – 2027 – NLG(23)100

Karl Portz referred to the report and drew the Board's attention to key highlights.

Kate Truscott queried whether patient experience was to be addressed as this had been raised at the Workforce Committee in terms of the Board seeking assurance. Karl Portz explained a well engaged workforce would enhance patient experience.

Simon Nearney felt the report was well presented and highlighted the foundations that had been put in place, plans would address any challenges that arose. The Quality Objectives put forward for the next four years were supported and endorsed to the Board. Simon Parkes queried that it was difficult to identify progress made to date and whether the Workforce Committee was monitoring those actions from the detail provided. Karl Portz explained the staff survey was reviewed to make improvements within the Strategy amongst other ways, reporting on improvements was provided through various groups which included the progress being made. Staff Equality Networks had also been developed. Simon Parkes queried whether the report could include headlines of progress within the year to make it easier to identify.

Dr Kate Wood queried whether the Strategy dovetailed what was being progressed at HUTH. Karl Portz advised meetings were held with the Equality & Diversity (E&D) Lead at HUTH. A further query was raised as to whether HUTHs Strategy aligned to the same period. Karl Portz advised it did not but would do going forward. Dr Kate Wood referred to section 9.5 which related to overseas colleagues, it was great to see this included within the Report, a query was raised as to how this was being put in place operationally. Karl Portz explained this information would start to be integrated into the report along with the work undertaken regionally. Work continued to be progressed with overseas colleagues.

Fiona Osborne queried how many of those items would show progress to highlight where success was being measured. Karl Portz advised this was measured through the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data and the staff survey, within the new Equality Delivery System measures. Simon Nearney advised progress was monitored at various committees through reporting, a proposal was made to use two key objectives from each report and baseline it to add to the Strategy to show measures being taken and where the organisation would be going forward. It was agreed this would also include the patient experience measurement.

Jug Johal queried whether it could be shown to highlight, Where We Were, Where We Are Now and Where We Want To Be. It was pleasing to see the Design for Manufacturability (DFM) Project had been included within the report, however, it was requested that the geographical areas could be included in terms of East Riding of Yorkshire (ERY) and North Lincolnshire (NL). Ellie Monkhouse referred to the resource that would be required to put this in place and felt this would need to be discussed further. It was agreed there was a need to educate staff on what minority groups there were. Sue Liburd commended Karl Portz on the report shared. There was a need to look at behavioural changes further rather than it just being highlighted in reports. Ivan McConnell felt there was a need to discuss with Place-based colleagues on how to progress this. It was agreed Simon Nearney and Sue Liburd would work with Karl Portz on options to take this forward. Karl Portz advised work had commenced with HUTH on how to join up staff networks between the two Trusts. Ivan McConnell agreed to discuss options with Place Boards and would report back to Karl Portz.

The Equality, Diversity & Inclusion Report & Strategy 2023 – 2027 was approved by the Board.

4.4 Workforce Committee Highlight Report & Board Challenge – NLG(23)101

Sue Liburd referred to the highlight report and noted key points. It was noted the report referred to the 22 May 2023 meeting and not the 21 March 2023.

5. Strategic Objective 3 – To Live Within our Means

5.1 Operational & Financial Plan – NLG(23)102

Lee Bond referred to the report and advised the income expenditure numbers were incorrect and changes had been made. The plan looked to deliver what was required, however, the workforce section may change due to recruitment and agency spend. In terms of finances, the deficit previously shown had been £20 million, this was now £13.3 million, which was due to additional inflation funding from the ICS. It was advised the plan would be shortly signed. Deficit plans would be in place and would include caveats. There had been agreed oversight arrangements due to being removed from SOF4 to NOF3. Modelling work was being undertaken on whether the organisation would need cash support. The Plan had been shared with Board for approval, however, it was noted there was risks within the plan.

Shaun Stacey went through the operational detail within the plan. Further work was required based on the income that needed to be generated. In terms of Getting It Right First Time (GIRFT) and productivity work had been completed around anaesthetic and pre-assessment which would show some changes to planning components for those patients planned for surgery. NLAG was aiming to be in the upper quartile for all GIRFT parameters.

Dr Kate Wood referred to previous procedures being put in place in terms of some roles not being appointed to when there were financial issues, the Trust needed to be mindful when putting this in place. Sean Lyons agreed quality needed to be preserved when putting those procedures in place.

5.2 Key Issues - Finance – Month 01 - NLG(23)103

Lee Bond referred to the report and drew the Board's attention to key highlights.

Dr Kate Wood referred to the reported cost of the strike action within Family Services as it appeared to be unusually high. Lee Bond agreed to review whether this was correct. Dr Kate Wood queried where the Cost Improvement (CIP) Schemes were being monitored. Lee Bond confirmed that the CIP program is reviewed through the monthly Finance & Performance Committee (F&PC) meetings and at Trust Management Board (TMB). It was noted that detailed agency monitoring would be reintroduced to show what was being spent. Shaun Stacey advised this was also reviewed at the Performance Review Improvement Meeting (PRIMS) on a monthly basis.

5.3 Finance & Performance Committee Highlight Report and Board Challenge – Finance - NLG(23)104

Gill Ponder referred to the report and drew the Board's attention to the issue with ventilation units and costs incurred. The Board were asked to approve the Premises Assurance Model (PAM) for submission. A query was raised regarding the issues with the ventilation units. Jug Johal advised the issue was similar to other infrastructure at the Trust, the organisation had to over-maintain equipment due to the age of so many items of equipment. This impacted on revenue due to the hiring of failed equipment.

The Trust Board approved the PAM for submission.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Key Issues – Strategic & Transformation – NLG(23)105

Ivan McConnell referred to the report and drew the Board's attention to key highlights.

6.2 Health Tree Foundation Trustees' Committee Highlight Report & Board Challenge – NLG(23)106

Gill Ponder referred to the paper and reported on key highlights.

7. Governance

7.1 Audit, Risk & Governance Committee Highlight Report & Board Challenge – NLG(23)107

Simon Parkes referred to the report and drew the Board's attention to key highlights. It was noted the Draft Annual Accounts could not be signed off at the moment due to no external auditors being appointed. Lee Bond advised external auditors had now been appointed and a contract would be offered on an initial three-year term with a possibility of five years in the future. Work would commence in September 2023 with the auditors being on site from the end of

October. Accounts would then be submitted the first week in December 2023. Special approval had been given from the Centre to allow this.

7.2 Board Assurance Framework (BAF) – Quarter Four

Helen Harris referred to the report and sought Board approval of the requirements as detailed within the report.

Dr Kate Wood referred to the point regarding the deferring of the BAF until the Group Model was in progress, it was felt this this should be addressed sooner. A further query was raised as to whether NLAG could review what HUTH had in place. Sean Lyons asked Helen Harris if this could be reviewed further as part of the Governance Workstream Group.

Action: Helen Harris

Ellie Monkhouse queried why there would be a Group BAF in place when there would still be sovereign for each Trust. Simon Parkes explained the two Trusts had agreed to work together to streamline processes, individual arrangements would be in place for some areas to ensure consistency for executives managing the BAF.

The recommendations detailed within the report were approved by the Board.

7.3 Strategic Development Committee – Disbanding of Committee – NLG(23)109

Helen Harris referred to the report and sought Board approval to disband the Strategic Development Committee (SCD). It was noted there would be four risks from SDC that would report directly to the Trust Board. Sean Lyons felt the Group Development Committee In Common (GDCIC) could have oversight going forward. This was agreed by the Board.

Action: GDCIC to have oversight of four risks

The proposal to disband the SDC was approved by the Board.

8. Approval (Other)

8.1 Health & Safety Policy Statement – NLG(23)111

Jug Johal referred to the Health & Safety Policy Statement and noted amendments were highlighted within the paper. The statement would be amended to be signed by the interim CEO.

The Health & Safety Policy Statement was approved by the Board.

9. Items for Information

The following items were shared at the June 2023 meeting:

- F&PC Minutes – February & March 2023
- HTFTC Minutes – March 2023
- Q&SC Minutes – March & April 2023
- Nursing & Midwifery Assurance Report
- Workforce Committee Minutes – March 2023
- Guardian of Safe Working Hours Report – Quarter Four
- AR&GC Minutes – February 2023
- Communications Round-Up
- Documents Signed Under Seal
- Trust Board Reporting Framework

10. Any Other Urgent Business

10.1 Interim Chief Executive Cover Arrangements – NLG(23)110

Sean Lyons referred to the report and asked for the Board to note the arrangements.

10.2 Audiology

Dr Kate Wood referred to the previous issue around audiology and provided a brief outline on the history of the issue. Subsequent to the review on the 19 May 2023 a decision had been made to suspend paediatric audiology clinics. The families had been contacted and were being managed through the correct process. It was noted all relevant stakeholders had been notified of the issue. The review had been publicised wider in the public domain that week, however, the apology for this had unfortunately not been communicated within the press release. This would be reiterated. There had been a number of Serious Incidents (SIs) arisen due to this. The Board would continue to be updated through the Q&SC. Fiona Osborne confirmed the Committee continued to be kept updated as required and had been assured that appropriate actions had been put in place.

Sean Lyons was disappointed the apology was not referred to in the article. Dr Kate Wood this reflected on the organisation badly, however, patients had been let down by this and that needed to be focussed on.

11. Questions from the Public

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

12. Date and Time of the next meeting

Board Development

Date: Tuesday, 28 June 2023
Time: 9.00 am
Venue: To be confirmed

Formal Trust Board Meeting

Date: Tuesday, 1 August 2023
Time: 9.00 am
Venue: Main Boardroom, DPOWH

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

Sean Lyons closed the meeting at 12:56 hours.

Cumulative Record of Board Director's Attendance (2023/24)

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	2	2	Shauna McMahon	2	2
Dr Peter Reading	1	0	Ellie Monkhouse	2	2
Lee Bond	2	2	Simon Nearney	2	2
Stuart Hall	2	1	Fiona Osborne	2	2
Helen Harris	2	2	Simon Parkes	2	2
Linda Jackson	2	1	Gillian Ponder	2	2
Jug Johal	2	2	Shaun Stacey	2	2
Sue Liburd	2	2	Kate Truscott	2	2
Ivan McConnell	2	2	Dr Kate Wood	2	2

NLG(23)132

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2023/2024

Kindness · Courage · Respect

ACTION LOG & TRACKER

NHS
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?
3.2	06.06.2023	Maternity Oversight Report		Information referring to the Patient Advice & Liaison Service data to be reviewed.	Nicky Foster	Aug-23	Update to be provided at the August 2023 meeting.			
3.4	06.06.2023	Quality & Safety Committee Highlight Report - Record on the risk register		Dr Kate Wood to review whether this issue was on the Risk Register.	Dr Kate Wood	Aug-23	Update to be provided at the August 2023 meeting.			
3.4	06.06.2023	Quality & Safety Committee Highlight Report - Issues around recruitment		Simon Nearney to arrange a Workforce Deep Dive for the Trust Board.	Simon Nearney	Aug-23	A Deep Dive was arranged for the 1 August 2023 following the board meeting.			
7.2	06.06.2023	Board Assurance Framework (BAF)		A request was made to consider an earlier review of the BAF and for this to be considered as part of the Group Governance Workstream.	Helen Harris	Aug-23	The Group Corporate Governance Workstream considered the review of the BAF for NLAG and HUTH and agreed that this would be undertaken at a later stage.			

Key:

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

ACTION LOG & TRACKER

NHS
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?
3.4	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.		Update shared at the April 2023 meeting as part of the CEO Briefing.	
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

Kindness · Courage · Respect

Page 3 of 3

NLG(23)133

Name of the Meeting	**Trust Board**	
Date of the Meeting	1st August 2023	
Director Lead	Shaun Stacey, Interim Chief Executive	
Contact	Richard Peasgood, Executive Assistant	
Title of the Report	**Chief Executive's Update**	
Purpose of the Report and Executive Summary	To provide a high level overview of work ongoing both across the Trust and wider health economy	
Background Information and/or Supporting	Other Board documents provide more detailed information	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working Agenda	✓ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ✓ Digital ☐ The NHS Green
Which Trust Risk(s)* in the Board Assurance (BAF) does this link (*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** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more** ✓ 4 **To provide good** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to

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

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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
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
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
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 Executive's Briefing

1. Delays with Mental Health Patients within our Emergency Departments

There has recently been an increase in patients attending our Emergency Department (ED) who require the support of our psychiatric providers where long delays have been identified to their assessment and treatment planning. We are working with place and our mental health partners to review and improve these challenges.

2. Cancer Backlog

Since January 2023 the Trust has held a 62 day backlog of 17.6% (213 patients), some of whom (40) had been waiting longer than 104 days. As at 30th June the backlog is 7.6% (153 patients) Reducing the volume of patients waiting longer than 62 days by 30%.

The transformation work program and improvements the divisions are making towards the 'Best Practice Timed Pathways' (BPTP) will deliver further benefits, but there remain risks related to diagnostic/pathology demands. As you can see in the Integrated Performance Report (IPR) which will be detailed later in the meeting overall there are real small signs of improvement in our cancer management.

3. Planning Letter from Amanda Bloor

The trust recently received a letter sent to all organisation Chief Executives within the Humber and North Yorkshire Integrated Care Board (ICB) to thank us for the hard work that had been put into the 2023/24 planning process. The letter went on to outline the proposed approach that is being taken within the ICB to ensure oversight of the delivery and monitoring of the plans. This approach links to the system support letter from Richard Barker. With some enhanced monitoring through the ICB oversight and assurance group, financial controls and system leadership.

4. Paediatric Audiology Service Review

The review into the paediatric audiology service continues, and the final report from the British Association of Audiology (commissioned by the Trust) has now been received with 38 recommendations, the 14 most urgent addressing the safety of the paediatric audiology service. Monitoring of the incident continues on a fortnightly basis through the well-established NHS England incident cell. The Trust is unable to provide the Auditory Brainstem Response service (ABR testing is done for newborns who have failed the newborn screening hearing test) or a community paediatric audiology service until the findings of the BAA review have been addressed. This has resulted in no internal resilience to manage the demands and is reliant on a small and unsustainable external resource to provide specialist audiology advice, scientific expertise and testing until the audiology service is reinstated.

Working with the Divisions of Surgery and Critical care, and Family and Community Services Dr Kate Wood, Chief Medical Officer and interim Chief Operating Officer Ashy Shanker are progressing a programme of work over the next 12- 18 months to minimise and manage clinical harm and risk in the immediate term, and to rebuild Paediatric audiology services to national quality standards in the medium to longer term. All affected patients' progress will be tracked on NLAG's COBRA system and be tracked on a Patient Tracker List in the next few weeks. They will also be managed in line with national best practice clinical pathways for paediatric audiology, with assurance gained to though oversight from external independent experts. Options to provide a joint Audiology service across HUTH and NLAG are also being considered for the future.

5. Discharge Ready Date

NHS England (NHSE) have released new updated guidance around a new data item that trusts were asked to start collecting earlier this year. The Discharge Ready Date will measure the time between a patient no longer meeting the Criteria to Reside (their "Discharge Ready Date") and their actual date of discharge.

Collecting this data is important to allow the central team to understand the number of simple discharges vs complex discharges, the length of delay for each patient, and do more detailed analysis to understand trends in those data which can then be used to create better outcomes for patients.

6. Impact from Industrial Action

The recent Industrial Action taken by Junior Doctors – from Thursday 13th July to Monday 17th July, followed by a 48-hour period of strike action by Consultants (20-21 July) - had an impact on our services with outpatient appointments, day case procedures and inpatient stays postponed.

Due to careful planning, we were able to keep disruption to patients at a minimum during the Junior Doctor's Industrial Action with no inpatient procedures cancelled at all. Unfortunately, some routine outpatient appointments had to be postponed, but this was a very small percentage, around 5% of the total outpatient appointments held during this period. We expect to see most of these patients rebooked by September.

The impact of the Consultants Strike action was more significant with inpatient and day case procedures affected in addition to outpatient appointments. This is because Consultants provide supervision to Junior Doctors as well as seeing patients themselves. They provided a Christmas Day cover ensuring emergency services could continue.

ED attendances have been comparable and, on some days, lower than the average for this financial year so far (462).

	Junior Doctors Strike Action					Consultant Strike Action	
	Thurs 13 July	*Fri 14 July*	*Sat 15 July*	*Sun 16 July*	*Mon 17 July*	*Thurs 20 July*	*Fri 21 July*
ED Attendances	486	449	411	465	536	481	491
ED 4hr Performance	59.50%	59.51%	56.16%	67.81%	64.37%	66.94%	69.65%
ED 12 hr trolley waits (unvalidated)	26	23	14	11	32	7	0
Number of strikers	94	72	35	24	102	44	44
Number of Outpatient cancellations	129	56	0	0	6	293	201
Number of Inpatient cancellations	0	0	0	0	0	14	16
Day Case cancellations	0	0	0	0	0	31	19

Thank you to all our staff for their efforts in preparing for this period of Industrial action helping us to go ahead with as much planned activity as possible whilst ensuring we continued to prioritise patients using our emergency departments and those being cared for on our wards.

7. NHSE Quality Board

The trust is continuing to develop an exit strategy from the Maternity Safety Support Programme (MSSP) which still does not have a timeline confirmed. The regional team are onsite in Northern Lincolnshire and Goole (NLaG) reviewing the evidence on the 24th of August 2023 with the intention that the Local Maternity and Neonatal System (LMNS) will then be able to provide recommendations to the regional team within 3 months.

Tracey Grainger is working with the trust on a series of case studies to share with other trusts on exiting from special measures.

A plan is in development to transition to segment 3 of the National Oversight Framework (NOF) which is likely to take 6 months with enhanced surveillance before then moving to routine surveillance led by the ICB. We recognise the importance of developing a strong quality, finance, performance and workforce plan to ensure the success as many providers in NOF 3 have slipped back during the transition period. This predisposes the move and de-escalation of surveillance back into segment 2 within 18 months.

8. Pastoral Care Award

The Trust has been awarded the Pastoral Care Charter Mark from NHS England which recognises the support we provide to our Internationally Educated Nurses and Midwives. The Charter Mark is awarded to trusts who can demonstrate and evidence competencies against a set of standards and is reassessed every 3 years.

9. HUTH & NLAG Electronic Patient Record

NLaG have received an email from the ICB raising concerns about delays to the process of procuring a system and the potential impact this would have on NLaG and Hull University Teaching Hospitals (HUTH). We have responded jointly to the ICB stating that several program, strategic and clinical consultation alongside the group program have led to the delay. NHSE have confirmed our delayed timeline (i.e. Board approval in Oct) would present them with no problems. We are waiting a response from the ICB which we hope will be positive.

10. Humber Acute Services (HAS)

On Wednesday 12 July the Humber and North Yorkshire ICB discussed the HAS proposals for how NLaG hospital services might look in the future. The Board praised the work undertaken to date and approved moving forward to public consultation on the proposals, subject to ratification by NHSE. The consultation is expected to commence in September and run for around 12 weeks. It will be seeking views from anyone living or working in the Humber area or who uses local hospital services to help inform the ICB's decision about the proposed changes. Decisions about the future shape of services will be made after the responses to the public consultation have been considered in full.

The proposals recommend retaining and improving the services available at local EDs in Grimsby, Scunthorpe and Hull and joining up better with services outside of hospital. Proposed improvements include increased availability of urgent care services for people with minor injuries and illnesses, enabling more people to be treated more quickly and helping to tackle long waiting times and ambulance handover delays.

Under the proposals, both Grimsby and Scunthorpe would continue to provide 24/7 Emergency Departments with comprehensive assessment, short-stay and same day emergency care services for adults and children.

To improve the sustainability of services and ensure all patients get the best outcomes, the proposals also recommend concentrating some specialist services, including trauma and overnight emergency surgery, in one hospital on the south bank of the Humber – Diana Princess of Wales Hospital, Grimsby. Bringing these more specialist services together at one hospital would improve the quality of care and help to make services more sustainable in the long run. Proposed changes would enable services to meet key national standards such as providing 7-day consultant-led care.

11. Grimsby Community Diagnostic Centre

The Secretary of State for Health and Social Care has approved funding of £10 million for the Community Diagnostics Centre at Grimsby. The centre is a 'spoke' centre and will go live offering tests for local people in December 2023, with the plan being to fully open in March 2024. Work is ongoing to finalise what tests will be offered from the centre in Freshney Place in Grimsby town centre.

12. Death whilst in service

It is with regret that I announce that Dr Kevin Speed, the clinical lead for Haematology and the lead for the clinical Haematology network has passed away. Dr Speed worked for the trust for 40 years as consultant in Haematology and single handedly for many years developed the Chemotherapy Service for Children and Adults for leukemia and other Haematological disorders. He was prominent in the training of medical students. Dr Speed was also a key person in the trusts hospital cricket team. Our condolences have been sent

to his family, his funeral took place on Monday 24th July

I also regret to announce the death of Dr Ritesh Singh who died on 24th July in HUTH. Dr Singh was a specialty doctor in Orthopedics and has worked in the trust since 2008. Our condolences have been sent to his family.

13. Partnership with Local Colleges

I met last week with the executive team from North Lindsey College in Scunthorpe which was very productive. There are clearly opportunities for us which also may be a value for money opportunity as well going forward across the group in these discussions. I have a planned next session with the Chief Executive Officer (CEO) John Rees in the next couple of weeks after his holiday to take this further. This alongside the introductory work by Kate Truscott linking with Lincoln University on opportunities for partnership and degree education, is a real opportunity for the trust to become an employment partner with these organisations and benefit our recruitment and retention of staff.

14. Pathlinks

I wish to announce formally the retirement of Mick Chomyn, the associate director of Pathlinks, and I am pleased to say that we have successfully recruited James McClean, currently the Pathology Manager at Kettering General Hospital.

15. Incident Response

On Sunday 9th July a workstation on wheels between ward C5 and C6 caught fire. This small fire was well managed by the ward sister and staff on duty. The fire brigade attended and whilst some staff and a visitor attended ED there were no injuries and no escalation of this incident. The estates and facilities team returned the ward to full operation quickly that day and subsequently the safety of workstations across the trust have been reviewed.

On Tuesday 18th July the ceiling of ward 27 suffered a collapse due to a broken water pipe, whilst this was disruptive it was managed extremely well, and no harm was brought to patients, staff or visitors.

My thanks go out to all the staff involved in these incidents, showing camaraderie and team working, with great responsive leadership. There was no impact on Urgent Care or patient flow from these incidents which is a great credit to everyone.

16. Cricket

We are pleased to report that the hospital cricket team won for the first time the hospital doctors versus GP cricket match, not at Lords, but at Heslam Park Scunthorpe on Sunday 25th June.

Shaun Stacey
Interim Chief Executive

Agenda item: NLG(23)134

Name of the Meeting	**Trust Board**	
Date of the Meeting	Tuesday 1st of August 2023	
Director Lead	Shauna McMahon, Chief Information Officer	
Contact Officer/Author	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Chief Medical Officer Simon Nearney, Director of People	
Title of the Report	**Integrated Performance Report (IPR)**	
Purpose of the Report and Executive Summary (to include recommendations)	The IPR aims to provide the Trust 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.	
Background Information and/or Supporting Document(s) (if applicable)	Access and Flow – IPR Quality and Safety – IPR Workforce – IPR	
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.

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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

IPR EXECUTIVE SUMMARY	Date: July 2023

1. ACCESS & FLOW – Aswathi Shanker

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

- Cancer – Two Week Wait
- % UCS Waiting Times (4 Hour Performance)
- % Discharge Letters Completed Within 24 Hours of Discharge

Lowlights: (share 3 areas of challenge/struggle)

- % Inpatient Discharges Before 12:00 (Golden Discharges)
- Number of patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission
- Cancer Waiting Times – 104+ Days GP Referrals

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
% Inpatient Discharges Before 12:00 (Golden Discharges)	Increase of capacity within OPAT	Increasing the size of the OPAT Virtual Ward will allow more patients to be discharged into the service. As the service is run by NLaG then this should allow for earlier in the day discharges.
Number of patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Work being carried out in relation to system issues that are leading to invalid 12 hour breaches	Closer system working will help to alleviate breaches caused by delays with system partners.
Cancer Waiting Times – 104+ Days GP Referrals	Timely removal of patients from cancer tracking once non-malignancy confirmed	Removal of patients from the Cancer pathways in a timely manner should help reduce the number of breaches

2. QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

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

- There has been a decrease in the number of reported falls
- New formal complaint numbers were 26 and for a third month over 80% of those closed were in timescale.
- The CHPPD benchmarks well, with no wards with CHHPD below 6.0. The overall combined fill rate remains good with May being 97.6%
- SHMI data for deaths associated with infection linked diagnosis groups are lower than the expected rate
- The rate of adult clinical observations recorded on time is improving
- VTE risk assessment compliance rate is sustained at the national target

Lowlights: (share 6 areas of challenge/struggle)

- There was an increase in the number of Mix sex breeches
- For C.difficile 2 hospital acquired have been declared for the month against a total target of 21
- The number of pressure ulcer incidents reported has increased slightly.
- Continued period of no mortality benchmarking systems, except for national SHMI data
- SJR plus system reliability issues, no longer has dedicated support from NHSE, impacting on clinical reviewer engagement.
- Paediatric sepsis audit data gap

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
• For C.difficile 2 hospital acquired have been declared for the month against a total target of 21	Each case has been reviewed by the IPC team.	The IPC closely monitor and review all C.Difficile cases on a case by case and will identify any themes
• The number of pressure ulcer incidents reported has increased slightly.	Currently there are no concerning trends. From 1st May 2023, the acute sites introduced a rapid review of all Category 3, 4 and unstageable pressure ulcers.	The rapid review process is resulting in the Pressure Ulcer incidents being reviewed and closed within 10 working days with rapid actions undertaken.
• Paediatric Sepsis audit data gap	ACN and ADQG scheduled time to review methodology and develop with new postholder in August.	Revision of the audit methodology and address any practice variances. This will demonstrate sepsis screening undertaken for all relevant children, which appears to be done, but not documented reliably.
• SJR platform not reliable	Exploring other SJR capture options, including alternative software solutions.	Improve engagement and confidence in the system for SJR

3. WORKFORCE – Simon Nearney

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

- The Sickness position has now decreased for 6 consecutive months, this is now at 4.85% and the lowest it has been since recording via the IPR
- Turnover position has now decreased for 11 consecutive months, this is now at 10.75% against a target of 10%. The turnover rate is gradually reducing, and the position is the lowest it's been since October 21.
- The Unregistered Nursing vacancy rate has reduced consecutively for the last year and still currently in the expected range but remains above target by 1.5% This is on a reducing trend seeing a decrease of vacancy position of 11% from March 22

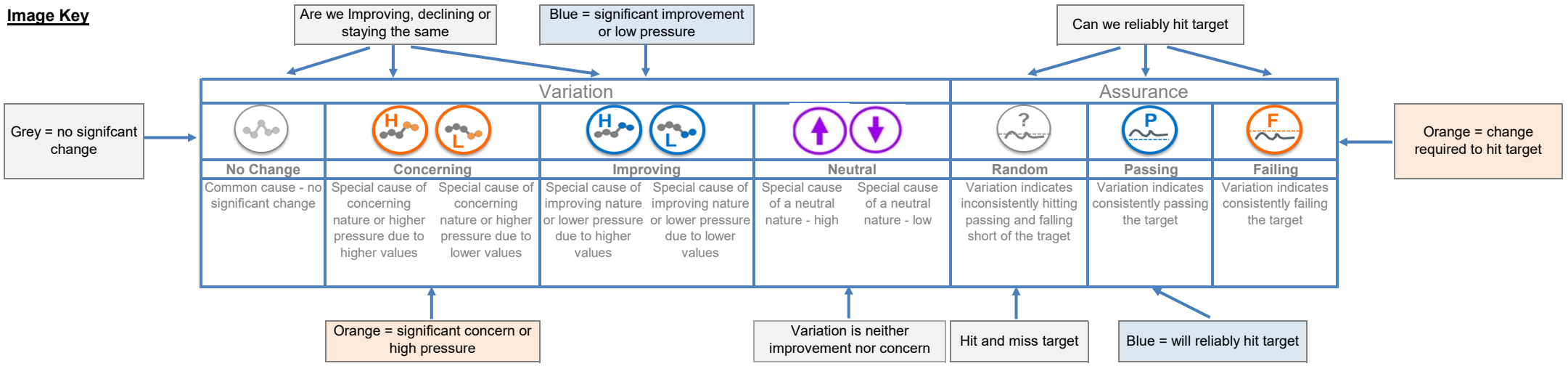
Lowlights: (share 3 areas of challenge/struggle)

- PADR compliance remains below target at 84% against a target of 85% The PADR position is gradually increasing, and the current position is the highest it's been since December 21
- Role Specific Mandatory Training remains below target, however, there has been an increase over the last six months at 79.3% as a direct result of a Resus training and Moving & Handling initiative in, improving compliance.
- Registered Nursing vacancy positions continues to be high at 11.8% against a target of 8%. However, this recent increase is a result of expected establishment increase not because of under delivery of vacancy and turnover activity

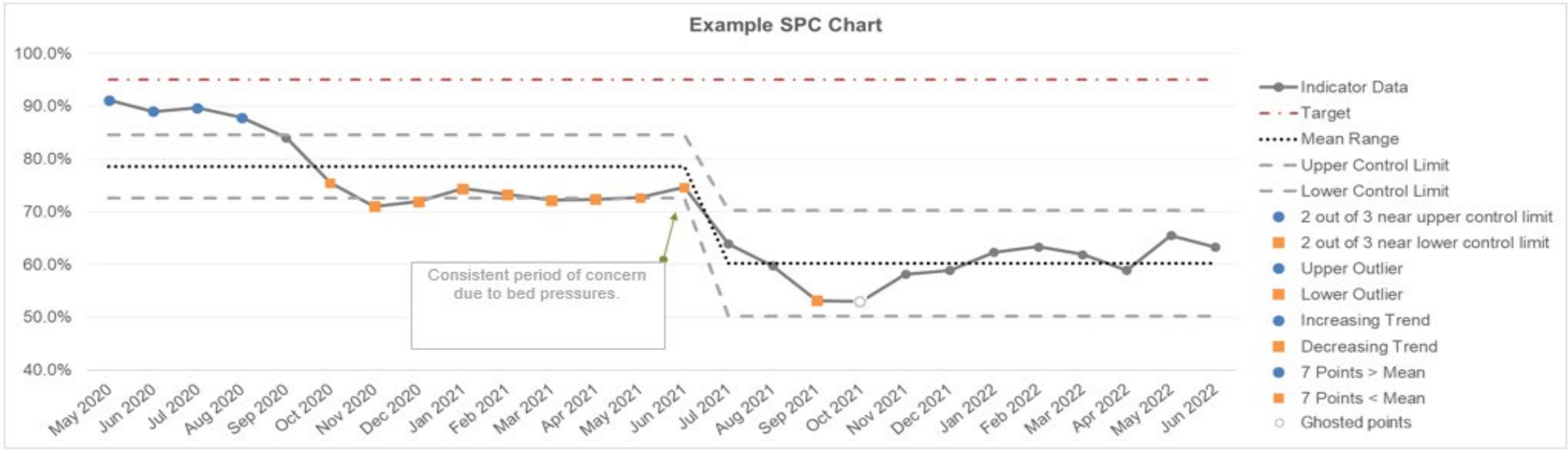
Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
PADR The Trust PADR compliance rate has remained below target for the last 18 months. **Role Specific Mandatory Training** Role specific mandatory training compliance remains below target, however, has increased by a further 0.81% in June, continuing the upward trajectory since the beginning of 2023**.** **Registered Nursing vacancy** An establishment increase of 43 WTE between April and June has negatively impacted upon the vacancy rate.	**PADR** This month we can see improvement, though it remains 1% below target. From May 23 the support and monitoring of PADR compliance has now moved to the ESR team who continue with targeted communication to managers for out of compliance PADRs. education. **Role Specific Mandatory Training** Throughout June, additional Level 2 Resus - Adult Basic Life Support and Moving and Handling - Module 11 provision was delivered by an external training provider, supporting the teams to reduce high numbers out of compliance in these areas. **Registered Nursing vacancy** Ongoing engagement with 119 international nurses sourced in Kerala is underway, although no international nurses started in June a cohort of 23 are due to arrive in July. Engagement with Newly Qualified Nurses is underway, with numbers currently exceeding target, and conversations taking place to allow for over establishments in areas to reduce withdrawal rates	**PADR** The ESR Team continue to support managers around PADR compliance with myth busting and education, feedback has been greatly received from managers. **Role Specific Mandatory Training** This resulted in a 9% and above increase in compliance across the targeted provision. The teams will now continue to build on these improvements through effective planning which is consistently reviewed and adapted to address numbers coming out of compliance. **Registered Nursing vacancy** Planning is now underway for a further recruitment project in Kerala in November 2023 to recruit further international nurses. Forecasts are currently expecting the Registered Nursing staff group to reach 33 WTE vacancies by the end of 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.

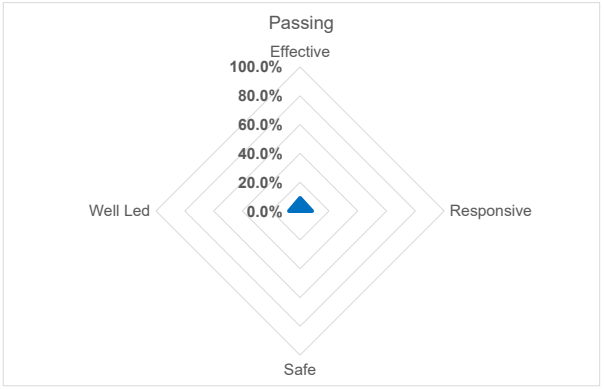
Radar

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

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Consistently Passing

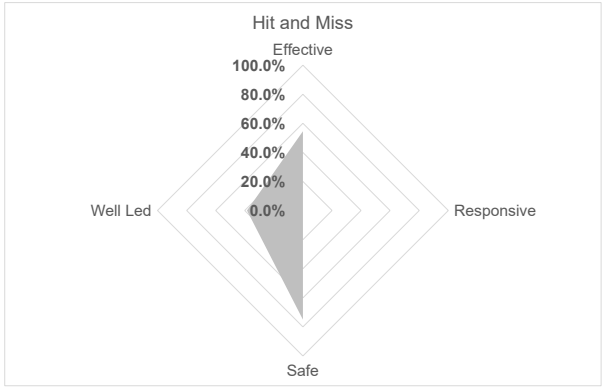
Total: 3



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

Hit and Miss

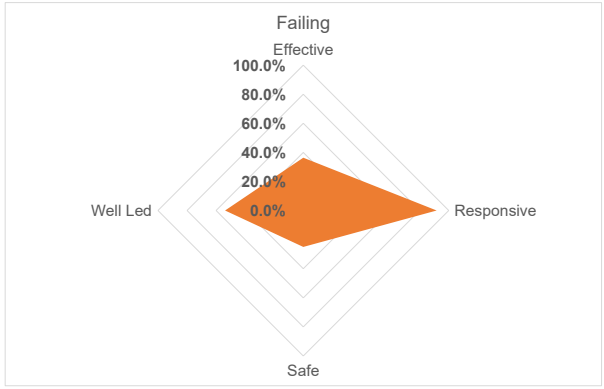
Total: 14



% Patients Discharged On The Same Day As Admission (excluding daycase)
Bed Occupancy Rate (G&A)
Duty of Candour Rate
Medical Staff PADR Rate
Mixed Sex Accommodation Breaches
Venous Thromboembolism (VTE) Risk Assessment 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
Sickness Rate
Registered Nurse Vacancy Rate *
Medical Vacancy Rate *
Medical Vacancy Rate - Other *

Consistently Failing

Total: 23



% Discharge Letters Completed Within 24 Hours of Discharge
% Inpatient Discharges Before 12:00 (Golden Discharges)
Ambulance Handover Delays - Number 60+ Minutes
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*
Role Specific Mandatory Training Compliance Rate
Turnover Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
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
Cancer Request To Test In 7 Days*
Community Acquired Pressure Ulcers (Number)
Unregistered Nurse Vacancy Rate *
Trustwide Vacancy Rate *
Medical Vacancy Rate - Consultants *

			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement	H		% Patients Discharged On The Same Day As Admission (excluding daycase) Inpatient Non Elective Average Length Of Stay	% Discharge Letters Completed Within 24 Hours of Discharge Outpatient Did Not Attend (DNA) Rate
		L		Complaints Responded to on time Venous Thromboembolism (VTE) Risk Assessment Rate Medical Staff PADR Rate Sickness Rate Medical Vacancy Rate *	Ambulance Handover Delays - Number 60+ Minutes Turnover Rate Combined AfC and Medical Staff PADR Rate Role Specific Mandatory Training Compliance Rate Unregistered Nurse Vacancy Rate *
	Common Cause		Core Mandatory Training Compliance Rate	Bed Occupancy Rate (G&A) % of Extended Stay Patients 21+ days Inpatient Elective Average Length Of Stay Duty of Candour Rate Mixed Sex Accommodation Breaches Registered Nurse Vacancy Rate * Medical Vacancy Rate - Other *	% Inpatient Discharges Before 12:00 (Golden Discharges) Cancer Waiting Times - 104+ Days Backlog* Cancer Waiting Times - 62 Day GP Referral* Emergency Department Waiting Times (% 4 Hour Performance) 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* Cancer Request To Test In 7 Days* Community Acquired Pressure Ulcers (Number) PADR Rate Trustwide Vacancy Rate * Medical Vacancy Rate - Consultants *
	Special Cause Concern	H	% Outpatient Non Face To Face Attendances Total Inpatient Waiting List Size		Number of Overdue Follow Up Appointments (Non RTT) Number of Incomplete RTT pathways 52 weeks*
		L			Percentage Under 18 Weeks Incomplete RTT Pathways* Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)* Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge

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*	Jun 2023	63.2%	92.0%	Alert		
	Number of Incomplete RTT pathways 52 weeks*	Jun 2023	830	0	Alert		
	Total Inpatient Waiting List Size	Jun 2023	11,959	11,563	Alert		
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Jun 2023	35.3%	1.0%	Alert		
	Number of Incomplete RTT pathways 65 weeks	Jun 2023	86	No Target	Highlight		n/a
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Jun 2023	34,644	9,000	Alert		
	Outpatient Did Not Attend (DNA) Rate	Jun 2023	6.8%	5.00%	Alert		
	% Outpatient Non Face To Face Attendances	Jun 2023	21.7%	25.00%	Alert		
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Jun 2023	55.1%	85.0%	Alert		
	Cancer Waiting Times - 104+ Days Backlog*	Jun 2023	31	0	Alert		
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Jun 2023	10.0%	75.0%	Alert		
	Cancer - Request To Test In 7 Days*	Jun 2023	58.5%	100.0%	Alert		
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Jun 2023	65.3%	95.0%	Alert		
	Number Of Emergency Department Attendances	Jun 2023	14,294	No Target			n/a
	Ambulance Handover Delays - Number 60+ Minutes	Jun 2023	205	0	Highlight		
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Jun 2023	673	0	Alert		
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Jun 2023	349	0	Alert		
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Jun 2023	43.7%	40.0%			
	% of Extended Stay Patients 21+ days	Jun 2023	11.8%	12.0%			
	Inpatient Elective Average Length Of Stay	Jun 2023	2.1	2.5			
	Inpatient Non Elective Average Length Of Stay	Jun 2023	3.4	3.9			
	% Discharge Letters Completed Within 24 Hours of Discharge	Jun 2023	91.6%	90.0%	Alert		
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Jun 2023	16.9%	30.0%	Alert		
	Bed Occupancy Rate (G&A)	Jun 2023	91.8%	92.0%			

Scorecard - Quality and Safety

NHS Northern Lincolnshire and Goole NHS Foundation Trust

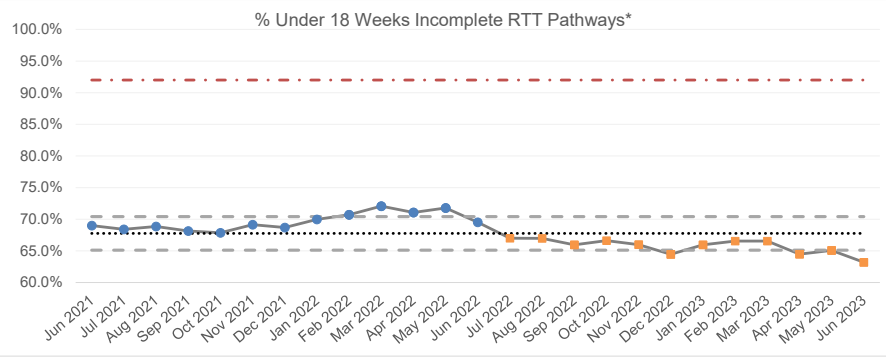
Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
n/a is stated when 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)*	May 2023	0.00	see analysis			n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	May 2023	0.40	see analysis			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	May 2023	0.10	see analysis			n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	May 2023	0.10	see analysis			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	May 2023	0.54	see analysis			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dec 2022	98.7	As expected			As expected
	Summary Hospital level Mortality Indicator (SHMI)	Jan 2023	102.5	As expected		L	As expected
	SHMI diagnosis groups outcome risk percentage (infections)	Jan 2023	97.0%	No target			n/a
End of Life	Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes	Apr 2023	20.0%	No target		n/a	n/a
Safe Care	Patient Safety Alerts actioned by specified deadlines	May 2023	100%	100%		H	n/a
	Number of Serious Incidents raised in month	Jun 2023	10	No target			n/a
	Occurrence of 'Never Events' *(Number)*	Jun 2023	0	0		n/a	n/a
	Duty of Candour Rate	Jun 2023	100%	100%			?
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	May 2023	5.3	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	May 2023	3.7	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Jun 2023	95.0%	95.0%		H	?
	Care Hours Per Patient Day (CHPPD)	May 2023	8.8	No target			n/a
	Mixed Sex Accommodation Breaches	May 2023	9	0			?
	Community Acquired Pressure Ulcers (Number)	Mar 2023	40	0	Alert		F
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	May 2023	4.8	No target			n/a
	Complaints Responded to on time	May 2023	92.0%	85.0%		H	?
	Friends & Family Test: Inpatient Score Percentage Positive	May 2023	92.9%	0%			n/a
	Friends & Family Test: A&E Score Percentage Positive	May 2023	76.9%	No target			n/a
Observations	Number of incidents with harm caused due to failure to recognise or respond to deterioration	May 2023	6.0	No target			n/a
Mental Capacity	Number of contacts with the MCA/DoLS team	Apr 2023	No Data	No target		n/a	n/a
	Percentage of MCA assessments that meet the legal requirements	Apr 2023	41.0%	No target		n/a	n/a
	Percentage of best interest recording for adults who lack capacity and meet the legal requirements	Apr 2023	0.0%	No target		n/a	n/a
Prescribing	Harm impact for weight related medication prescribing incidents	Jun 2023	6	No target			n/a
Maternity	Robson Scores - Group 1	Jun 2023	18.6%	No target			n/a
	Robson Scores - Group 2	Jun 2023	37.3%	No target			n/a
	Number of Deliveries With Post Partum Haemorrhage > 1500 ml	Jun 2023	13	No target			n/a
	Still Birth Rate per 1000	Jun 2023	0.0	No target			n/a
	Spontaneous 3rd or 4th Degree Tear	Jun 2023	1.3%	No target			n/a
	Instrumental 3rd or 4th Degree Tear	Jun 2023	8.3%	No target			n/a

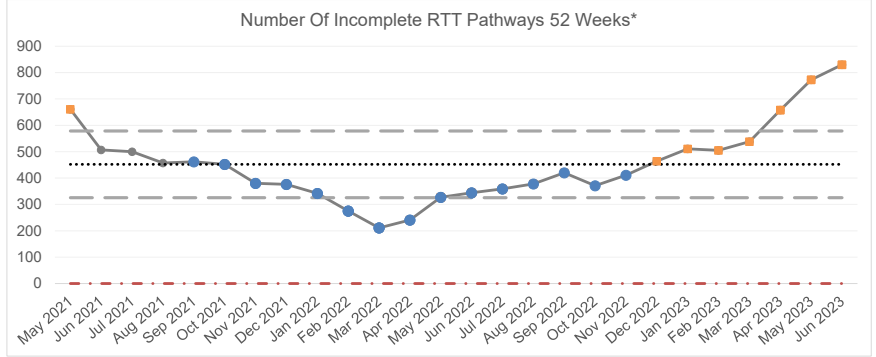
Scorecard - Workforce

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.

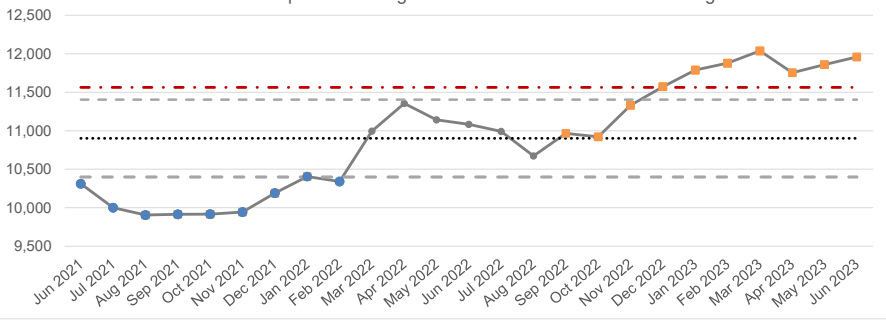
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate	Jun 2023	9.5%	8.0%	Alert		
	Registered Nurse Vacancy Rate	Jun 2023	11.8%	8.0%			
	Medical Vacancy Rate	Jun 2023	14.2%	15.0%			
	Trustwide Vacancy Rate	Jun 2023	10.4%	8.0%	Alert		
	Medical Vacancy Rate - Consultants	Jun 2023	18.7%	15.0%	Alert		
	Medical Vacancy Rate - Other	Jun 2023	11.5%	15.0%			
Staffing Levels	Turnover Rate	Jun 2023	10.7%	10.0%	Alert		
	Sickness Rate	May 2023	4.9%	4.1%			
Staff Development	PADR Rate	Jun 2023	84.0%	85.0%	Alert		
	Medical Staff PADR Rate	Jun 2023	95.0%	85.0%			
	Combined AfC and Medical Staff PADR Rate	Jun 2023	85.0%	85.0%	Alert		
	Core Mandatory Training Compliance Rate	Jun 2023	89.9%	85.0%			
	Role Specific Mandatory Training Compliance Rate	Jun 2023	79.3%	85.0%	Alert		



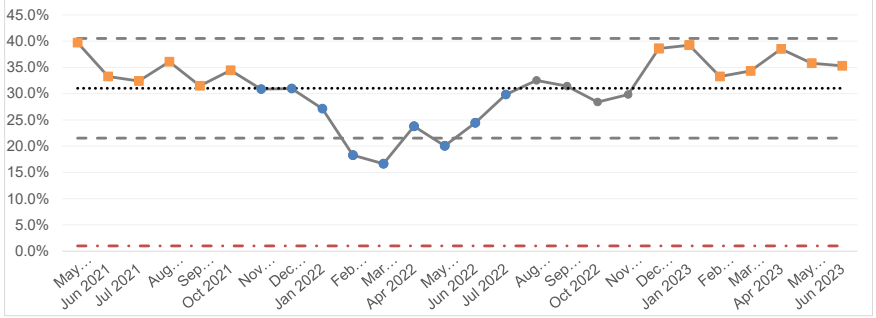
Jun 2023
63.2%
Target
92.0%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Consistently falling short of the target



Jun 2023
830
Target
0
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently falling short of the target



Jun 2023
11,959
Target
11,563
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently passing the target



Jun 2023
35.3%
Target
1.0%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently falling short of the target

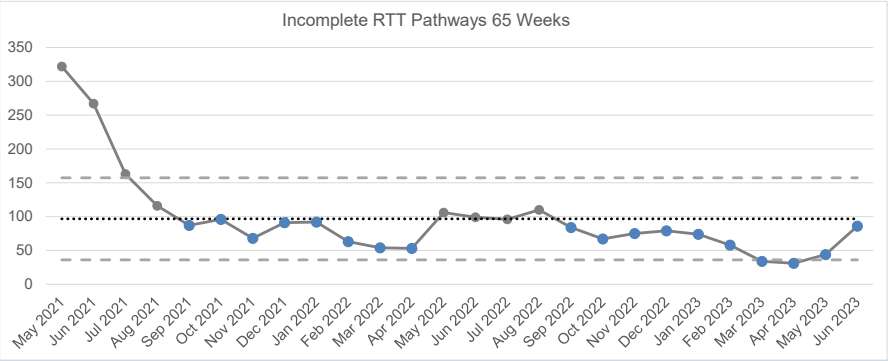
Data Analysis:
Under 18 weeks incomplete*: The indicator has been showing special cause concern 12 months. Current data indicates that the target will not be met without action, planned actions outlined below.
Incomplete 52 weeks*: The number of 52 week waits has gradually increased since spring last year and is showing special cause concern. 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 has been increasing over the past few months and is showing special cause concern. The process limits suggest that the target will be met.
Diagnostics 6 Week Wait (DM01)*: Performance remains within the expected range. However, performance has recorded values higher than the mean for the past 7 months. Data indicates that the target will not be met without action, planned actions outlined below.

Challenges:
- Workforce vacancies resulting in reduced capacity for OP, subsequent increase in 52 week waits
- The balance of the risk of patient flow versus elective activity amid ongoing Opel status escalation
- Ongoing performance management of the Independent Sector (IS) Provider contracts
- Acceptance of Mutual Aid
- Diagnostic Demand is greater than capacity for Echo and MRI
- Managing the impact of lost capacity within the Trust due to the Industrial Action
- 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
- Delivery of additional £13m - activity needs to increase to support delivery.
- Aging Diagnostic Equipment
- Diagnostic Reporting Capacity

Key Risks:
- Impact of ability to fill consultant vacancies in hard to fill specialties
- Site flow and bed capacity
- Unable to mitigate the activity gaps of tenders not being realised
- The Community Paediatric Audiology service clinics have been put on hold due to issues raised by an external reviweing team, this will see an impact on the Audiology waiting times
- Recruitment and retention of Radiographers and Radiologists

Actions:
- Establish additional sessions to support delivery of Divisional activity plans (ongoing)
- Risk stratify all potential elective cancellations due to proposed Industrial action (Ongoing)
- Contract negotiations underway to secure on-going use of the Independent Sector with sign off expected (July 23)
- Continue to push for funding for WLIs to uplift theatre activity to support performance and waiting list position (ongoing)
- Continue to utilise St Hugh's for new patients for Ophthalmology and General Surgery when waiting lists allow (ongoing)
- Robust recruitment plan for theatres with external company (ongoing)
- HIT Theatres completed but further actions required to embed changes in some specialties. Agreement that GIRFT numbers continue if not a cancer list (ongoing)
- Procurement of 2 mobile vans to support capacity for MRI (July 23)
- Workforce planning for recruitment of Radiologists (Aug 23)
- Procurement of additional reporting capacity via Independent Sector (Aug 23)

Mitigations:
- Locum staff in place where able, to maintain services
- Activity plans reviewed weekly, continue to see a reduction in longer waiters and movement towards constitutional standards
- Clinical risk stratification to ensure allocation of all appointments is led by clinical priority of patients
- Additional sessions still being undertaken by NLaG clinicians. Working with various external providers to provide additional clinic capacity and reduce the time patients wait to receive treatment
- Diagnostic equipment maintainence contracts in place



Jun 2023
86.0

Target
No Target

Variance

Special cause of improving nature or lower pressure due to lower values

Assurance

There is no target, therefore target assurance is not relevant

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Data Analysis:
Number of Incomplete RTT pathways 65 weeks: This metric is new to the A&F IPR as part of the 23/24 annual review. This month has seen a slight increase but is still within expected range and is recording as improvement.

Challenges:
- Workforce vacancies resulting in reduced capacity for OP, subsequent increase in 52 week waits
- The balance of the risk of patient flow versus elective activity amid ongoing Opel status escalation
- Ongoing performance management of the Independent Sector (IS) Provider contracts
- Acceptance of Mutual Aid
- Diagnostic Demand is greater than capacity for Echo and MRI
- Managing the impact of lost capacity within the Trust due to the Industrial Action
- 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
- Delivery of additional £13m - activity needs to increase to support delivery.
- Aging Diagnostic Equipment
- Diagnostic Reporting Capacity

Key Risks:
- Impact of ability to fill consultant vacancies in hard to fill specialties
- Site flow and bed capacity
- Unable to mitigate the activity gaps of tenders not being realised
- The Community Paediatric Audiology service clinics have been put on hold due to issues raised by an external reviweing team, this will see an impact on the Audiology waiting times
- Recruitment and retention of Radiographers and Radiologists

Actions:
- Establish additional sessions to support delivery of Divisional activity plans (ongoing)
- Risk stratify all potential elective cancellations due to proposed Industrial action (Ongoing)
- Contract negotiations underway to secure on-going use of the Independent Sector with sign off expected (July 23)
- Continue to push for funding for WLIs to uplift theatre activity to support performance and waiting list position (ongoing)
- Continue to utilise St Hugh's for new patients for Ophthalmology and General Surgery when waiting lists allow (ongoing)
- Robust recruitment plan for theatres with external company (ongoing)
- HIT Theatres completed but further actions required to embed changes in some specialties. Agreement that GIRFT numbers continue if not a cancer list (ongoing)
- Procurement of 2 mobile vans to support capacity for MRI (July 23)
- Workforce planning for recruitment of Radiologists (Aug 23)
- Procurement of additional reporting capacity via Independent Sector (Aug 23)

Mitigations:
- Locum staff in place where able, to maintain services
- Activity plans reviewed weekly, continue to see a reduction in longer waiters and movement towards constitutional standards
- Clinical risk stratification to ensure allocation of all appointments is led by clinical priority of patients
- Additional sessions still being undertaken by NLaG clinicians. Working with various external providers to provide additional clinic capacity and reduce the time patients wait to receive treatment
- Diagnostic equipment maintainence contracts in place

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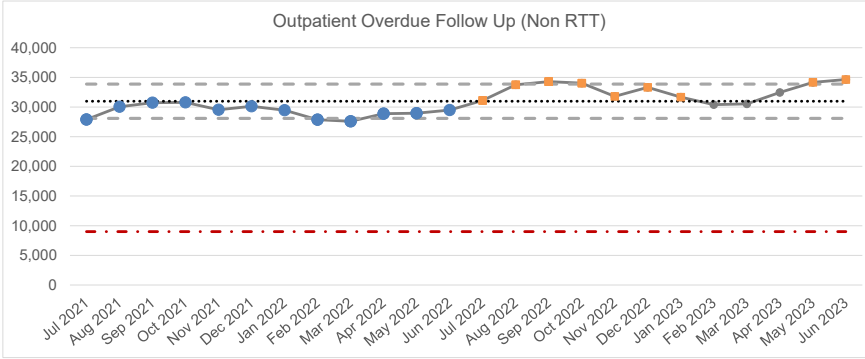
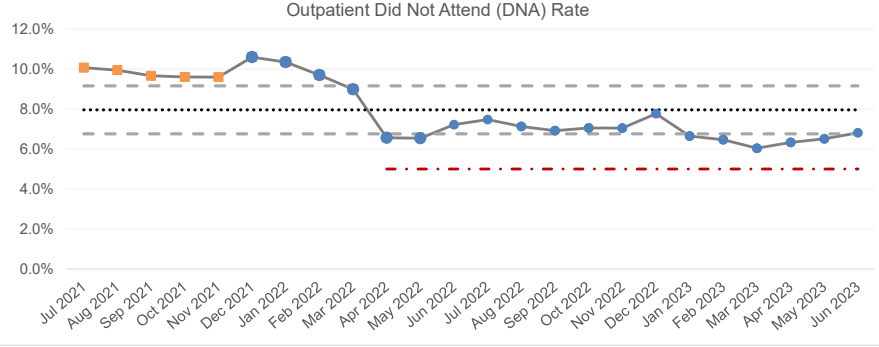
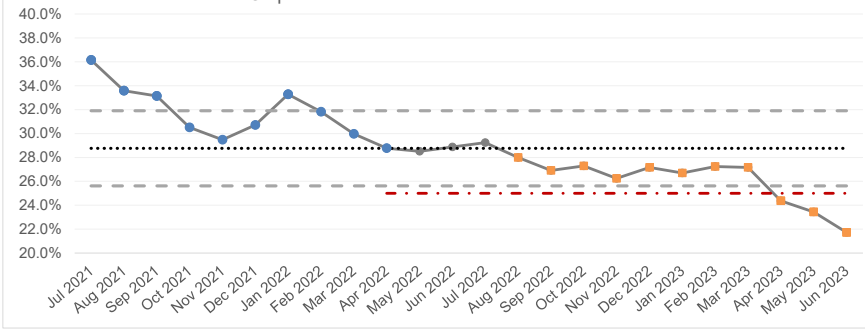


Jun 2023
34,644
Target
9,000
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently falling short of the target



Jun 2023
6.8%
Target
5.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently falling short of the target



Jun 2023
21.7%
Target
25.0%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Consistently passing the target

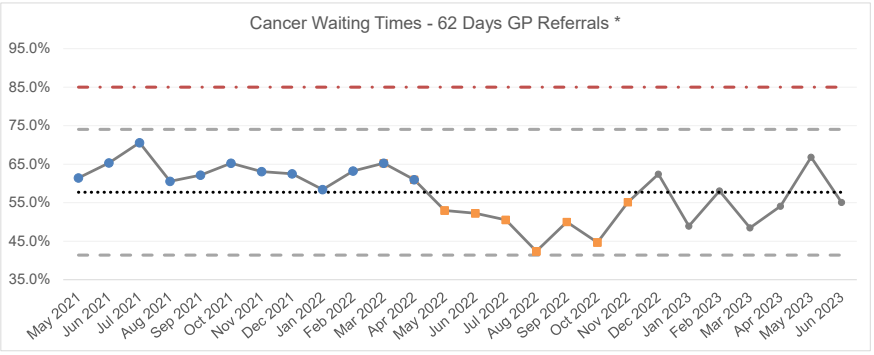
Data Analysis:
Outpatient Overdue follow up: For the past year performance has been at or above the two year average suggesting a gradual increase. The indicator is failing the target by some margin. Current data indicates that the target will not be met without action, planned actions outlined below.
Outpatient DNA rate: 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: The indicator has recorded below the mean for over 12 months, registering special cause concern. The process limits suggest that the ICS target of 25% will be met.

Challenges:
- To deliver the 25% reduction in follow-ups within the next 9 months is a significant challenge without radical change across all specialties that has an immediate impact
- Delivery of 5% PIFU
- Funding arrangements for the Connected Health Network Model (CHN) model post 2022-23 fiscal year is a challenge with no designated funding identified
- To manage the impact on follow-up activity whilst the focus remain on performance of the RTT waiters.

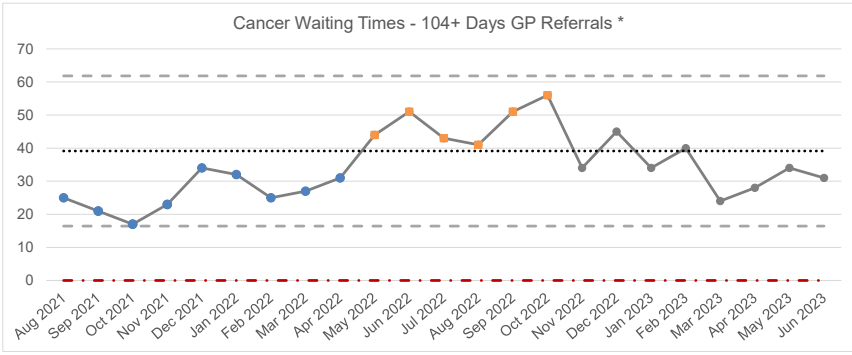
Key Risks:
- Clinical buy-in across some specialities to embed PIFU as standard clinical practice
- There is significant risk to delivering a reduction in the follow up backlog unless there is significant focus on changing traditional models.
- Impact on operational delivery due to ongoing industrial action
- Inability to secure a long-term finance model for CHN as pump prime funding expired in March 2023.
- The outstanding decision on the business case for the Phase 2 and 3 Digital Letters continues to delay progress significantly at 3 months behind plan

Actions:
- Further collaborative work with Primary Care Networks (ongoing)
- Heart Failure at home being trialled as part of Patient Knows Best in Cardiology (ongoing)
- Working with Clinical Leads and speciality leads to consider PIFU in pathways where clinically appropriate (Sep 2023)
- Minimise the operational impact of industrial action to reduce inconvenience to patients (July 2023)
- Getting It Right First Time (GIRFT) Clinically led Outpatient Guidance is being evaluated against recommended specialities (Sep 2023)
- Working with Divisional Medical Directors to explore options for delivering the 25% reduction in follow-ups (July 23)
- Deep dive into Do Not Attend (DNA) - Analysis of patients underway who persistently DNA/Cancel their appointment (July 23)
- Getting It Right First Time (GIRFT) Clinically led Outpatient Guidance has completed evaluation for 14 specialities and action plan is now being developed (July 2023)
- Discussions on CHN future finance model in progress wiht NLAG and ICB finance leads (July 2023)

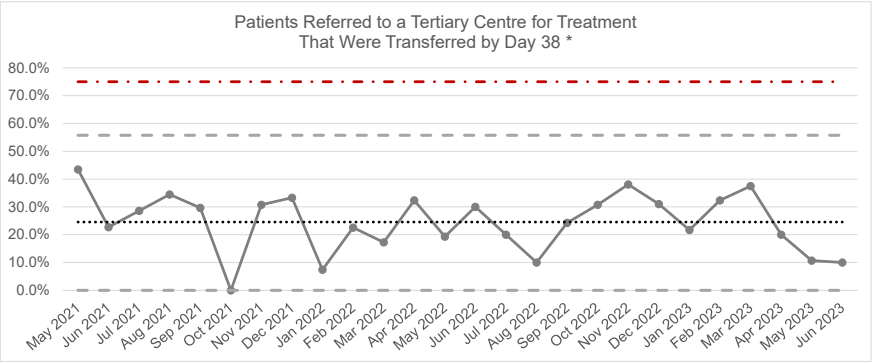
Mitigations:
- Clinicians engaged in following the access policy appropriately managing patients who DNA
- Specialty level trajectories in place within the activity plans for 2023-24
- The plans will deliver a reduction in the backlog of overdue follow ups, increased PIFUs and improved response times to Advice and Guidance
- Director of PLACE at North Lincolnshire is co-ordinating a group to try and secure funding to support the CHN Model from March 2023 onwards



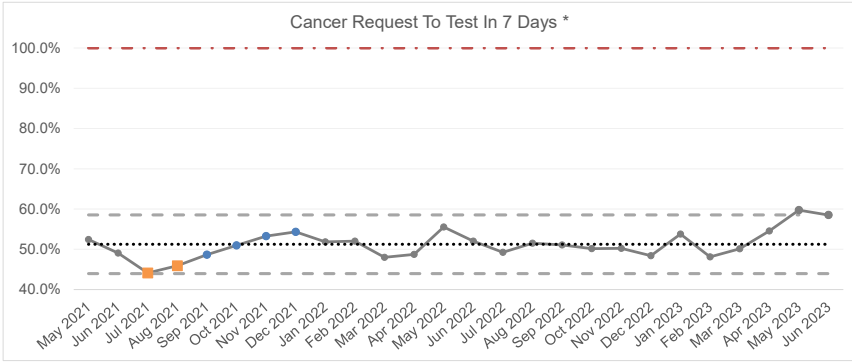
Jun 2023	Target	Variance	Assurance
55.1%	85.0%	Common cause - no significant change	Consistently falling short of the target



Jun 2023	Target	Variance	Assurance
31	0	Common cause - no significant change	Consistently falling short of the target



Jun 2023	Target	Variance	Assurance
10.0%	75.0%	Common cause - no significant change	Consistently falling short of the target



Jun 2023	Target	Variance	Assurance
58.5%	100.0%	Common cause - no significant change	Consistently falling short of the target

Data Analysis:

62 days GP referral*: Performance is stable and as expected. This target has not been achieved for more than 2 years. Current data indicates that the target will not be met without action, planned actions outlined below.

104+ days GP referrals*: Performance is as expected. The indicator is consistently failing the target and current data indicates that the target will not be met without action, planned actions outlined below.

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

Request to test 7 days*: Performance is stable and as expected. More data is needed to determine whether the improvement will continue. 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 pathway)
- 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 pathology turnaround times, patient choice.
- Colorectal is a challenge but the teams are working to improve referrals in to ensure the right patients receive the diagnostics required
- Notable increase in Urological Cancer referrals over last 3 months and increase in 62 day breaches due to TURBT no longer being classed nationally as a first treatment.
- Increase in Urology patients awaiting surgery at HUTH due to Urology Renal consultant vacancy.

Key Risks:

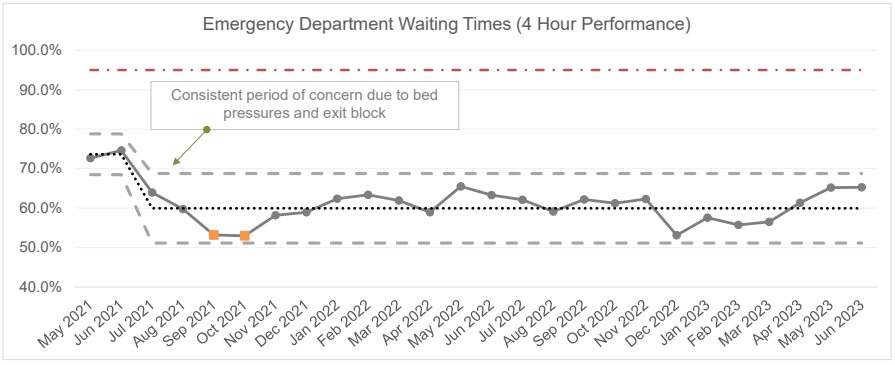
- Request to Test (14 days) requires reduction to 7 calendar days to meet 28-day Faster Diagnosis Standard
- Upper Gastrointestinal pathway includes HUTH, currently significant delay due to demand on services
- There are issues related to visiting consultant services for Oncology referrals for tertiary based staging scans (EUS, PET CT) and associated wait for results, affect the ability to transfer for treatment by Day 38 - when patients are transferring to Hull.
- 1 x wte Consultant vacancy in Respiratory (Lung Cancer). Appointed, but remains a risk until candidate accepts the post formally.
- For Upper Gastrointestinal and Head & Neck surgery is carried out in Hull which is currently causing significant delay - small numbers
- Lack of Oncology Capacity for 1st appointments - now booking 6 weeks from point of referral
- One Clinician at SGH running Striaght To Test Upper Gastrointestinal 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
- Urology cancer consultant now on phased return following extended sick leave
- HUTH Urology no longer providing visiting consultant clinics due to cons vacancies.

Actions:

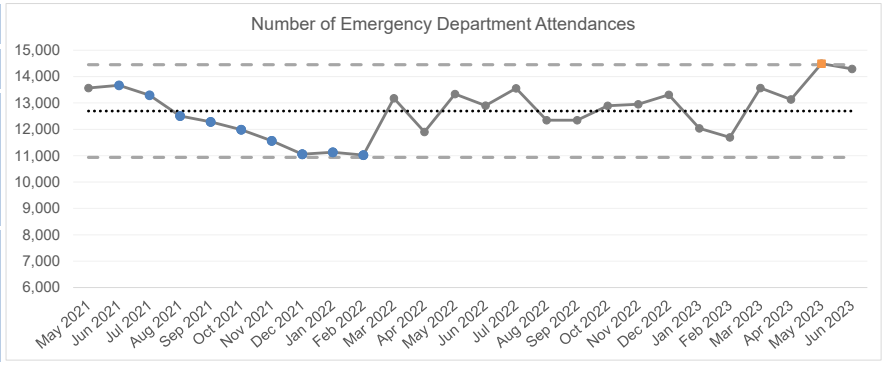
- Timely removal of patients from cancer tracking once non-malignancy confirmed - targeted daily actions by Cancer Teams (ongoing action)
- Regular review with HUTH of demand and capacity for Oncology (ongoing action)

Mitigations:

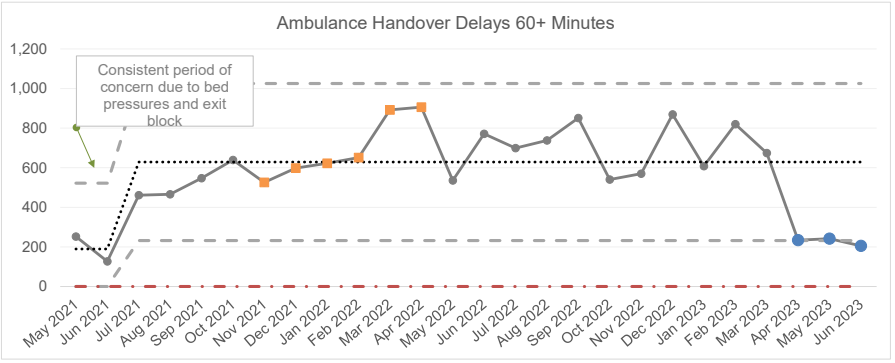
- 62-day performance is being reviewed and managed weekly.
- Joint weekly PTL review between Medicine and Surgery Upper Gastrointestinal - resulting in improved position
- Cancer Improvement Plans developed for each cancer tumour site
- Micro-management of the completion of cancer packs with any incomplete after 5 working days is now being overseen at senior divisional level
- Funding now approved to recruit to administrative support roles
- The joint transformation pathway work with HUTH will help with the transfer of patients between NLaG/ HUTH to identify areas where the pathway can be accelerated
- Increase RDC capacity to work alongside Straight To Test to streamline service in Colorectal- managing numbers albeit increased
- Funding approved to recruit to Band 3 and Band 2 admin support
- RDC to be opened up to non site specific pathway from 1st May 2022 with minimal uptake - this remains minimal
- 62 day performance is being reviewed and managed weekly - along with the 28 day performance
- Urology agency consultant currently in post to support the cancer work until cancer consultant fully returned.



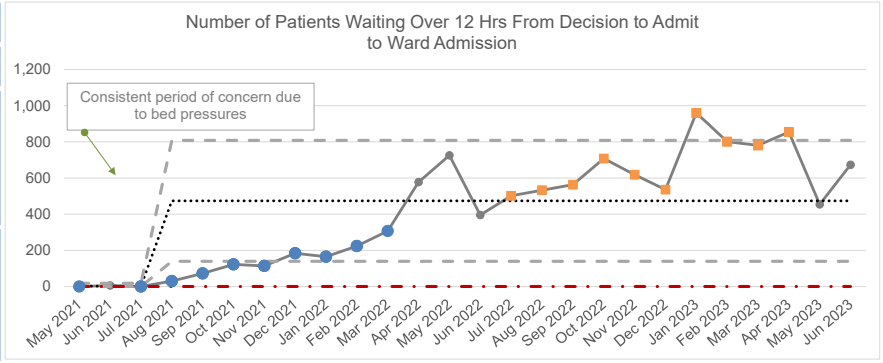
Jun 2023	65.3%
Target	95.0%
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target



Jun 2023	14,294
Target	No Target
Variance	Common cause - no significant change
Assurance	There is no target therefore target assurance is not relevant



Jun 2023	205
Target	0
Variance	Special cause of improving nature or lower pressure due to lower values
Assurance	Consistently falling short of the target



Jun 2023	673
Target	0
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target

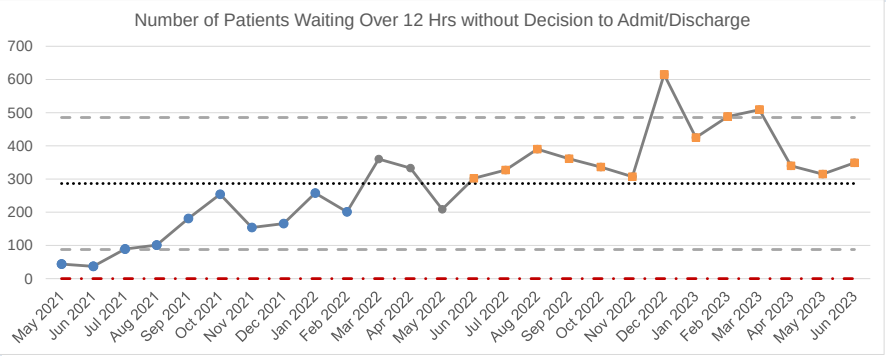
Data Analysis:
ED 4 hour waiting: Following the significant deterioration in 2021, performance has been stable and within the expected range.
ED Attendances: Performance has been stable and as expected. More data is needed to determine whether the concerning performance will continue.
Ambulance handover 60+ minutes: Performance has been showing improvement for the past three months. However, more data is needed to determine whether this will continue.
DTA 12 hours: Performance is still recording very high numbers and will unlikely return to the 2021 figures in the near future. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:
- Pressure created within the community due to demand for ambulances which may be held up in hospital handover process
- Elevated level of acuity resulting in pressures within Resus and delays for walk in patients
- Same Day Emergency Care (SDEC) regularly running at full capacity
- Plan to increase the Urgent Care Service to 24-hours a day
- Demand on services impacts on hospital flow and delays in admission resulting in regular escalation of OPEL status

Key Risks:
- Gaps in both medical and nurse staffing resulting in high levels of agency and locum staff
- Challenge to achieve Ambulance Handover targets due to lack of flow within the hospital - however progress being made against current targets set
- Inability to meet waiting times in Emergency department due to demand
- Staff burnout and maintaining morale through ongoing pressures - impacting on recruiting and retention

Actions:
- Review of all Urgent Care Services across Northern Lincolnshire, new model to be implemented (Oct 2023)
- Expansion of the Virtual ward services (ongoing)
- QI project is in place to improve the flow within the department (October 23)
- Work carried out on the SAS 2021 doctors rota and the 30 day consultation has began to improve capacity versus demand with the aim to reduce locum spending and improve 4 hour performance (Aug 23)
- Process improvement has been carried out in relation to Ambulance Handover to ensure achievement of 30 minute mean time (ongoing)
- Work being carried out in relation to system issues that are leading to invalid 12 hour breaches (ongoing)

Mitigations:
- Senior clinician reviews taking place in ambulances when delays to off loading occur
- New structure in place within ED with senior decision makers identified daily 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 place within ED
- 2-hourly board rounds with EPIC and Clinical Coordinator with nursing care needs, monitored through care round document
- SDEC nurse-in-charge attends 08:00am ED board round to support identification of patients suitable for SDEC
- Direct electronic referrals to SDEC for GP/EMAS via SPA now in place to support alternative pathways and direct SDEC access.
- Virtual ward, Outpatient Parenteral Antimicrobial Therapy (OPAT) and Home first now implemented



Jun 2023	**349**
Target	**0**
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Consistently falling short of the target

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Data Analysis:

Patients waiting 12h+ without decision: Performance has been deteriorating for over a year and as such is recording concern. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

- Pressure created within the community due to demand for ambulances which may be held up in hospital handover process
- Elevated level of acuity resulting in pressures within Resus and delays for walk in patients
- Same Day Emergency Care (SDEC) regularly running at full capacity
- Plan to increase the Urgent Care Service to 24-hours a day if funded
- Demand on services impacts on hospital flow and delays in admission resulting in regular escalation of OPEL status

Key Risks:

- Gaps in both medical and nurse staffing resulting in high levels of agency and locum staff
- Challenge to achieve Ambulance Handover targets due to lack of flow within the hospital - however progress being made against current targets set
- Inability to meet waiting times in Emergency department due to demand
- Staff burnout and maintaining morale through ongoing pressures - impacting on recruiting and retention

Actions:

- Review of all Urgent Care Services across Northern Lincolnshire, new model to be implemented (Oct 2023)
- Expansion of the Virtual ward services (ongoing)
- QI project is in place to improve the flow within the department (October 23)
- Work carried out on the SAS 2021 doctors rota and the 30 day consultation has began to improve capacity versus demand with the aim to reduce locum spending and improve 4 hour performance. This has been completed, implementation (Aug 23)
- Process improvement has been carried out in relation to Ambulance Handover to ensure achievement of 30 minute Mean time (ongoing)
- Work being carried out in relation to system issues that are leading to invalid 12 hour breaches (ongoing)

Mitigations:

- Senior clinician reviews taking place in ambulances when delays to off loading occur
- New structure in place within ED with senior decision makers identified daily for EPIC, Resus/Majors, Initial Assessment and Ambulance Triage
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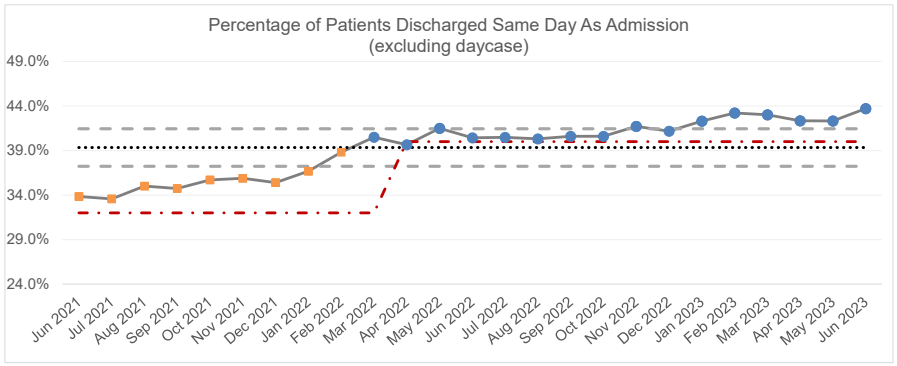
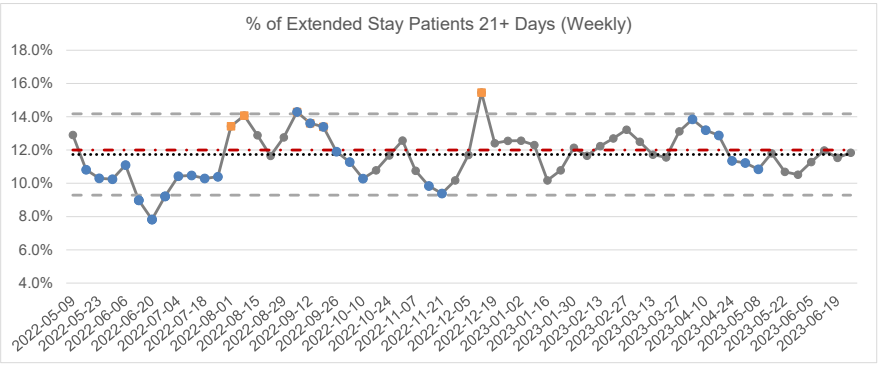
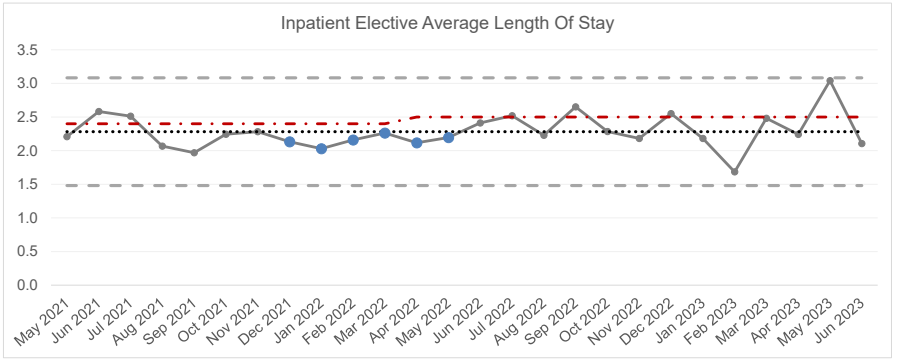


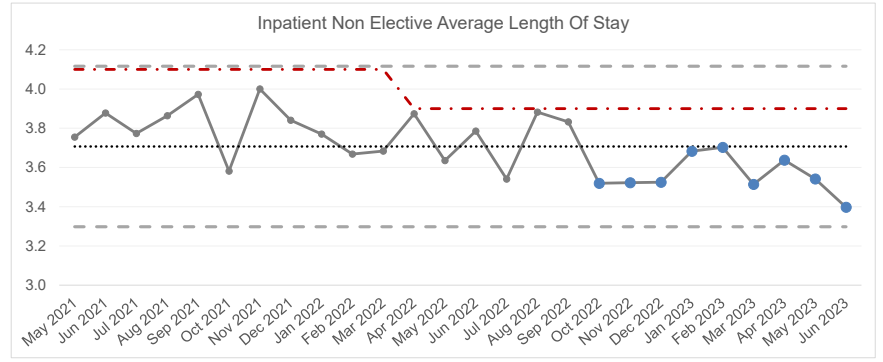
Jun 2023	Target	Variance	Assurance
43.7%	40.0%	Special cause of improving nature or lower pressure due to higher values	Inconsistently hitting passing and falling short of the target



Jun 2023	Target	Variance	Assurance
11.8%	12.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Jun 2023	Target	Variance	Assurance
2.1	2.5	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Jun 2023	Target	Variance	Assurance
3.4	3.9	Special cause of improving nature or lower pressure due to lower values	Inconsistently hitting passing and falling short of the target

Data Analysis:
Discharged same day as admission: Performance has recorded higher values for some time and as such is registering improvement.
% 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: Performance is as expected and within the expected range. The target can be expected to achieve and fail at random.
Non elective length of stay: 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 vacancies impact on service delivery
- Increased medical staff sickness
- Covid and infection prevention constraints remain
- Exit block due to Social Care constraints (staffing, interim bed availability, lack of packages of care availability)
- The hospital environment and staff availability and layout does not lend itself to the creation of escalation beds
- Earlier more timely discharge is delayed as the discharge lounge at DPOW as it is also utilised 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
- High acuity levels and patients means more patients require further support on discharge

Actions:
- Expansion of virtual wards planned (ongoing)
- Increase of capacity within OPAT work remains ongoing
- System wide action plan in place to support patient flow (ongoing)
- Review of demand and capacity across specialties to identify any imbalances and remedial action required (July 2023)

Mitigations:
- Virtual ward, OPAT and Home First now implemented
- Single Point of Access available with 2-hour community response in place
- Acute and Community joint working group established between Medicine and Community & Therapies
- Community Response Team GP supporting Category 3 & 5 calls
- Daily meetings led by the site senior team 7 days per week, who work with system partners to have a clear delayed discharge and escalation plan
- Escalation Themes are collated and fed back into an improvement plan
- 7-Day Services for equipment provision to support discharge at both North and North East Lincolnshire
- Work taking place with system partners to understand the current constraints and agree actions to alleviate exit block from the acute Trust
- Work taking place within care homes to support falls, therapy and training provided within NL, SAFE service now operating direct referrals from
- Urgent Care Service and Single Point of Access to enable anticipatory/proactive management of frailty cases

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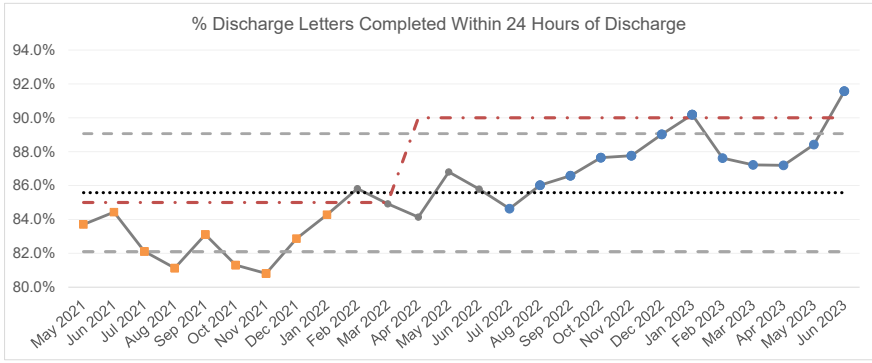
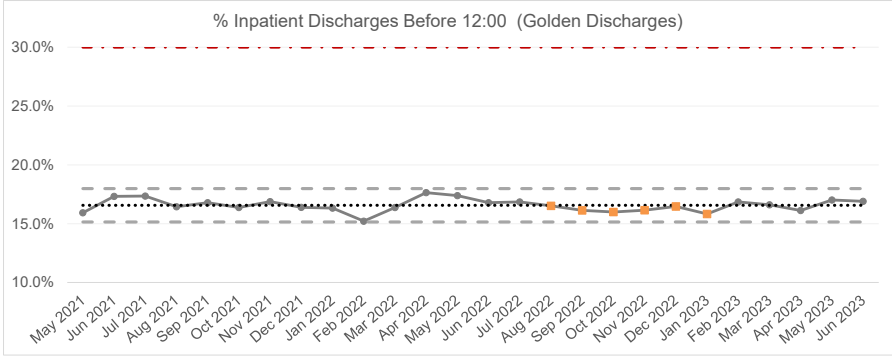
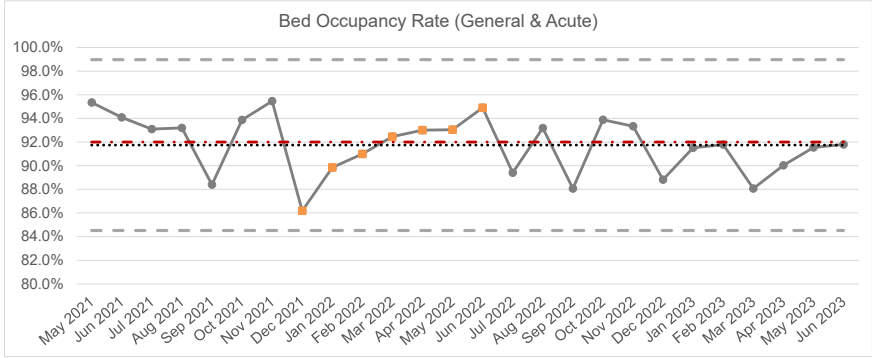


Jun 2023	Target	Variance	Assurance
91.6%	90.0%	Special cause of improving nature or lower pressure due to higher values	Consistently falling short of the target



Jun 2023	Target	Variance	Assurance
16.9%	30.0%	Common cause - no significant change	Consistently falling short of the target



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

Data Analysis:

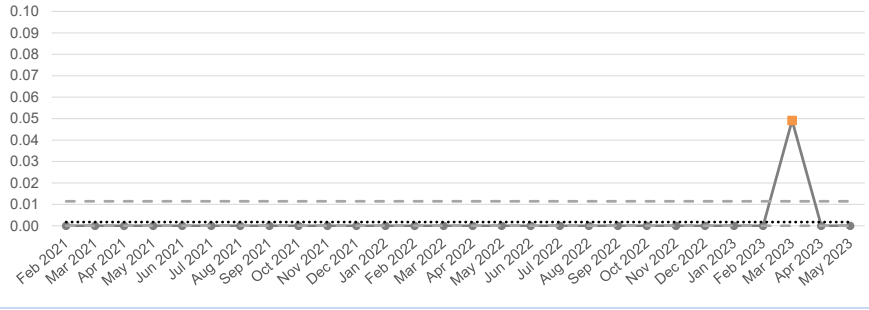
Inpatient discharge letters: Performance has triggered improvement for 12 months with June 2023 achieving the target for the second time. Current data indicates that the target will not continue to be met without action, planned actions outlined below.
Inpatient discharges before 12:00: Performance is currently stable following a six 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 vacancies impact on service delivery
- Increased medical staff sickness
- Covid and infection prevention constraints remain
- Exit block due to Social Care constraints (staffing, interim bed availability, lack of packages of care availability)
- The hospital environment and staff availability and layout does not lend itself to the creation of escalation beds
- Earlier more timely discharge is delayed as the discharge lounge at DPOW as it is also utilised 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
- High acuity levels and patients means more patients require further support on discharge

Actions:
- Expansion of virtual wards planned (ongoing)
- Increase of capacity within OPAT work remains ongoing
- System wide action plan in place to support patient flow (ongoing)
- Review of demand and capacity across specialties to identify any imbalances and remedial action required (July 2023)

Mitigations:
- Virtual ward, OPAT and Home First now implemented
- Single Point of Access available with 2-hour community response in place
- Acute and Community joint working group established between Medicine and Community & Therapies
- Community Response Team GP supporting Category 3 & 5 calls
- Daily meetings led by the site senior team 7 days per week, who work with system partners to have a clear delayed discharge and escalation plan
- Escalation Themes are collated and fed back into an improvement plan
- 7-Day Services for equipment provision to support discharge at both North and North East Lincolnshire
- Work taking place with system partners to understand the current constraints and agree actions to alleviate exit block from the acute Trust
- Work taking place within care homes to support falls, therapy and training provided within NL, SAFE service now operating direct referrals from
- Urgent Care Service and Single Point of Access to enable anticipatory/proactive management of frailty cases



May 2023
0.00

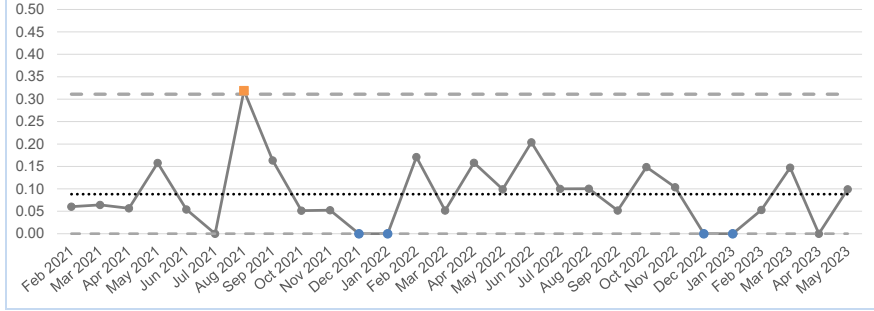
*Target
see analysis below

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant



May 2023
0.10

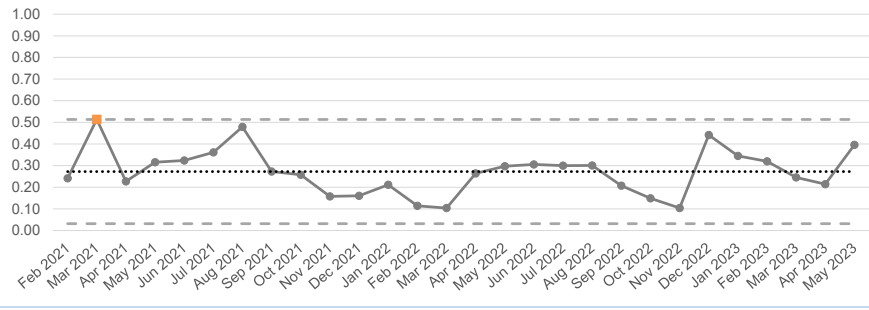
*Target
see analysis below

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant



May 2023
0.40

*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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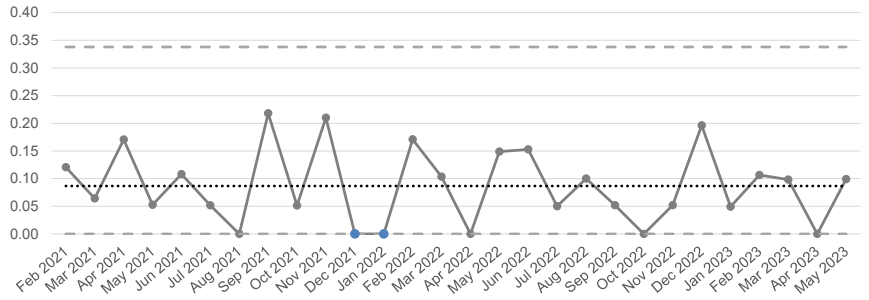
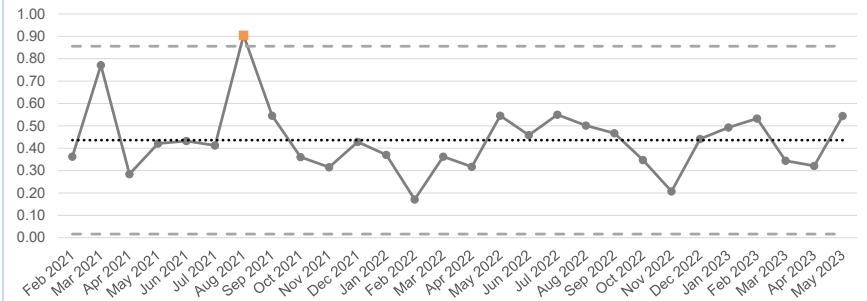
Data Analysis:
MRSA: Performance is stable and within the expected range of the data. The YTD figure is 0 against an annual target of 0.
C Diff: Performance is stable and within the expected range of the data. The YTD figure is 4 against an annual target of 21.
E Coli: Performance is stable and within the expected range of the data. The YTD figure is 12 against an annual target of 65.

Commentary:
Zero MRSA bacteraemias. There have been 2 CDI hospital cases and 2 community cases. Work is continuing around the prevention of UTIs and antimicrobial management



May 2023
0.10
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



May 2023
0.54
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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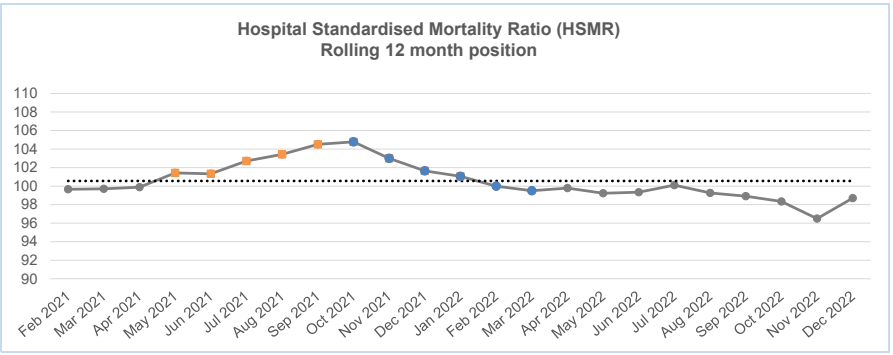
Data Analysis:
MSSA: Performance is stable and within the expected range of the data. The YTD figure is 2, there is no annual target.
Gram Neg: Performance is stable and within the expected range of the data. The YTD figure is 15 against an annual target of 97.

Commentary:
All within expected thresholds for this month no concerns.



Dec 2022
98.7

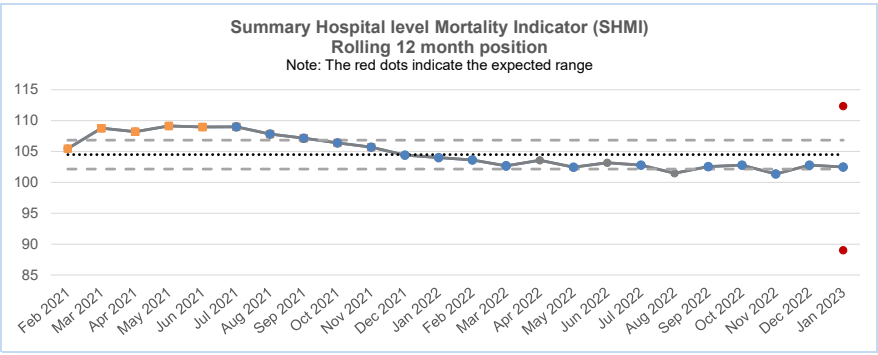
Target
As expected

Variance

Common cause - no significant change

Assurance

Within 'as expected' range



Jan 2023
102.5

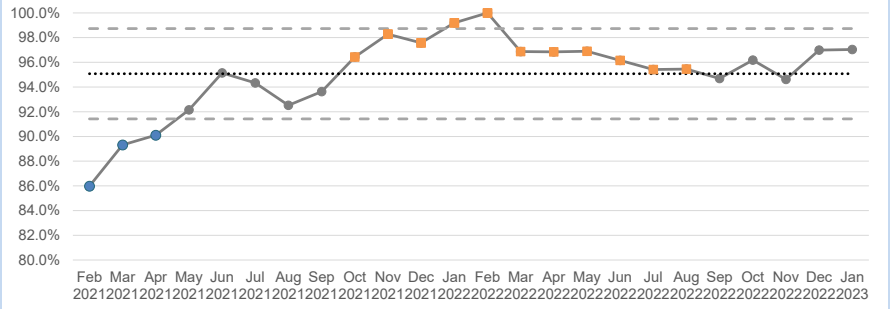
Target
As expected

Variance

Special cause of improving nature or lower pressure due to lower values

Assurance

Within 'as expected' range



Jan 2023
97.0%

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant

This space is intentionally blank

Data Analysis:
HSMR: We are not able to update this data until a new contract is in place which is currently scheduled for September 2023.
SHMI: The data continues to perform well compared with expected performance. The data represents a rolling 12 month position.
SHMI diagnosis: The data is stable and largely within the expected range.

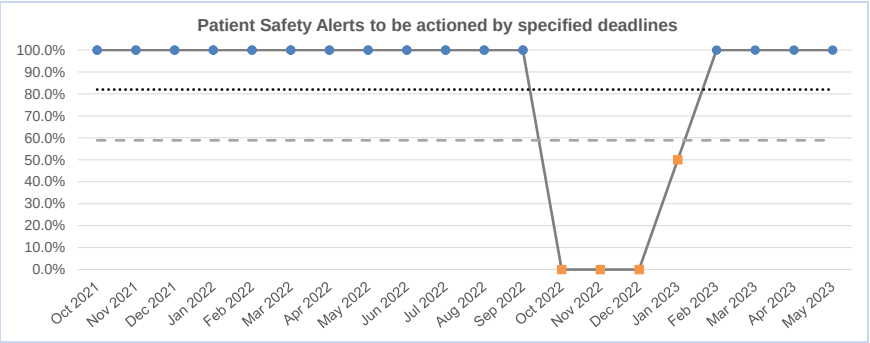
Commentary:
The Trust has a SHMI of 102.5 for the latest period of February 2022 to January 2023, which is in the 'as expected' bracket.

The gap in mortality data oversight continues due to no access to mortality systems or assurance reports. The Mortality Improvement Group are continuing to review Nationally published NHS Digital mortality data to mitigate risk until the Trust has access to a new benchmarking system which is expected imminently.

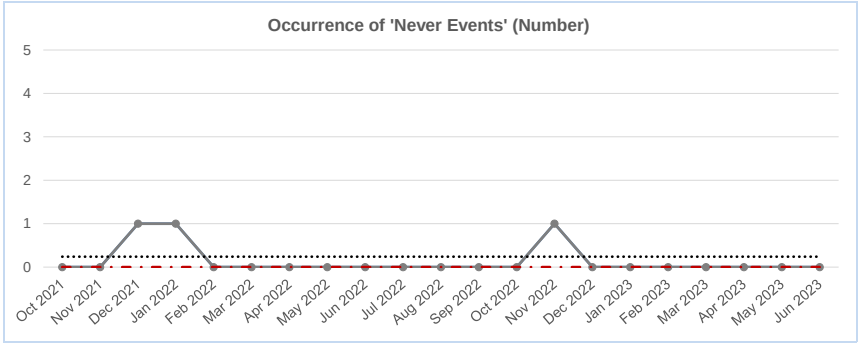
SHMI Diagnosis Groups:
The number of patients that died with an infection related cause was 97% for January 2023 and remains within the expected range.

Calculation for this SHMI ratio is based on a a numerator of observed deaths (actual number), divided by the denominator (expected deaths), multiplied by 100. Monitoring deaths due to infection related causes allows early detection of higher than expected deaths (a percentage over a 100) to direct investigation and review work.

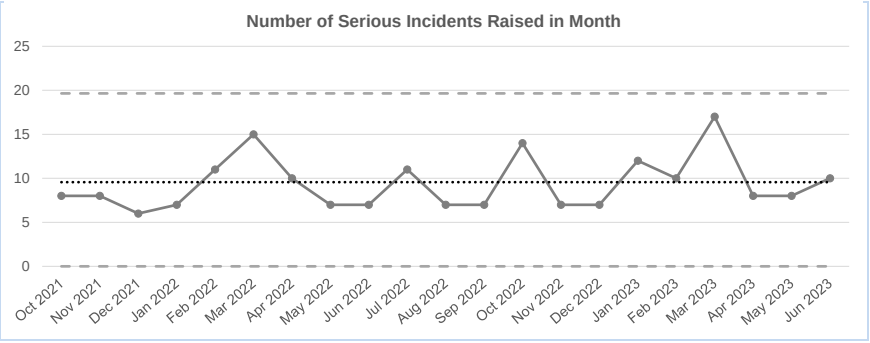
End of Life Quality Priority:
An End of Life staff survey was undertaken to help understand the challenges and areas of focus. An action plan in response to survey findings is currently being developed as part of the QI project.



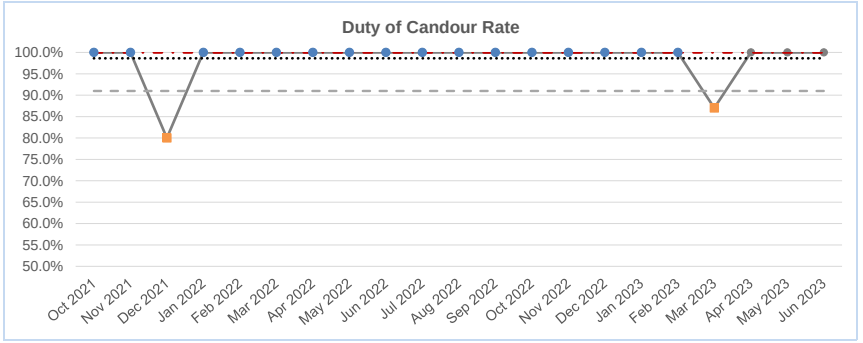
May 2023
100.0%
Target
No target
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
There is no target therefore target assurance is not relevant



Jun 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



Jun 2023
10
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

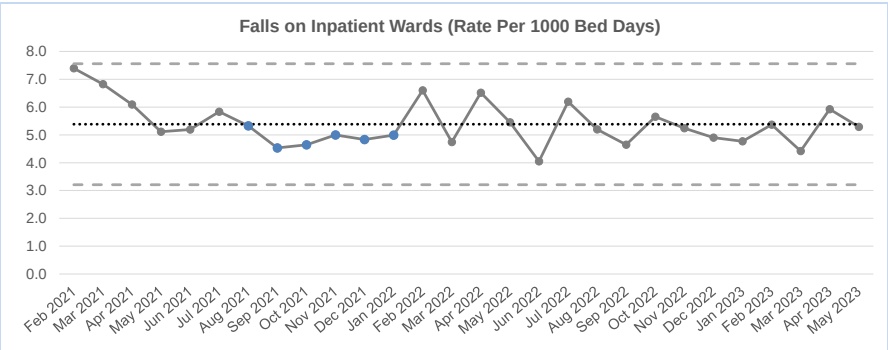


Jun 2023
100.0%
Target
100.0%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target

Data Analysis:

Patient Safety Alerts: After four months of concerning performance this indicator has recorded 100% for the past four months. However, the numbers involved are low.
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: Following a low figure in March the indicator has returned to regularly recording 100%

Commentary:
The number of serious incidents declared during June 2023 remains within normal variation rates.



May 2023
5.3

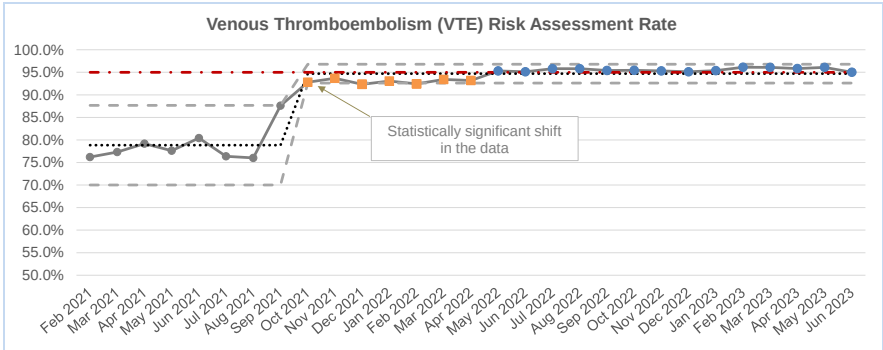
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant



Jun 2023
95.0%

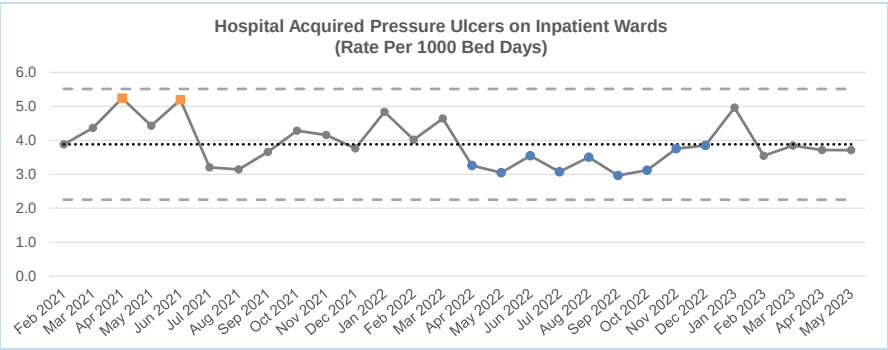
Target
95.0%

Variance

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

Assurance

Inconsistently hitting passing and failing the target



May 2023
3.7

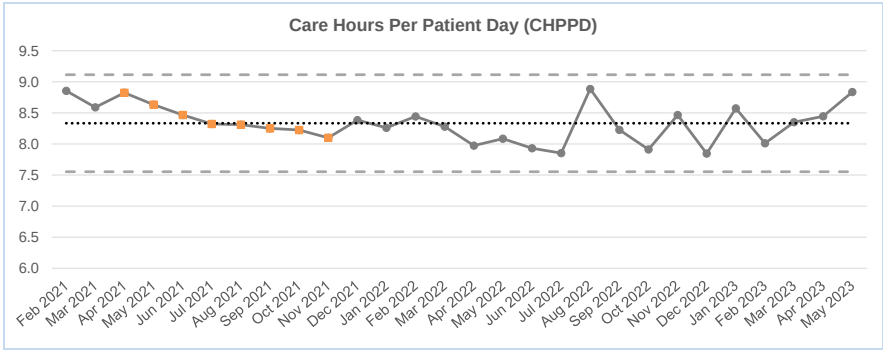
Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant



May 2023
8.8

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target therefore target assurance is not relevant

Data Analysis:
Falls on Inpatient Wards: Performance is stable and as expected.
VTE Risk Assessment: Performance has shown significant improvement and has achieved the target for over 12 months.
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.

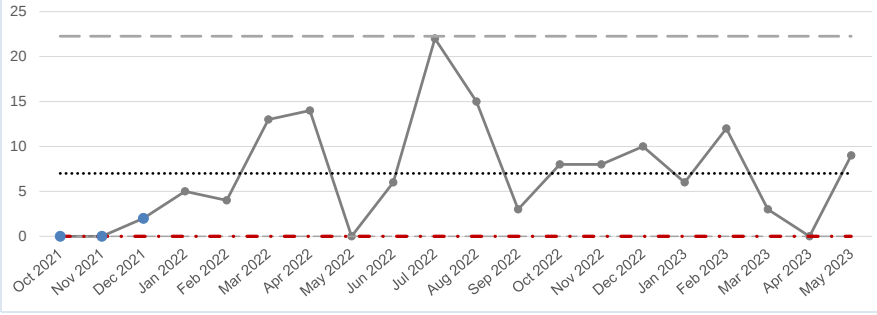
Commentary:

Sustained achievement in the completion of VTE risk assessments in line with the agreed target of 95%.

Falls: There has been a decrease in the number of reported falls per 1000 bed days. Falls huddles continue to be undertaken with themes shared at these as well as Nursing Metrics.

Pressure Ulcers: The number of reported pressure ulcer incidents per 1000 beds days has slightly increased in Category 2 pressure ulcers. The new rapid review process continues to offer timely and supportive interventions as well as release time for ward staff to support and deliver improvements.

Mixed Sex Accommodation



May 2023	Target	Variance	Assurance
9	0	Common cause - no significant change	Inconsistently hitting passing and failing the target

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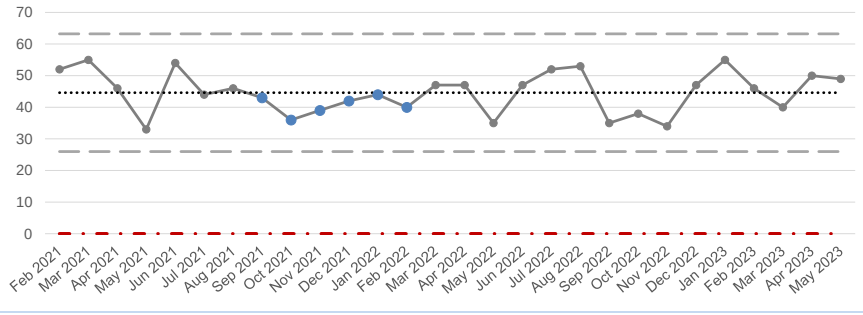
Community Acquired Pressure Ulcers (Number)



Mar 2023	Target	Variance	Assurance
40	0	Common cause - no significant change	Consistently failing the target

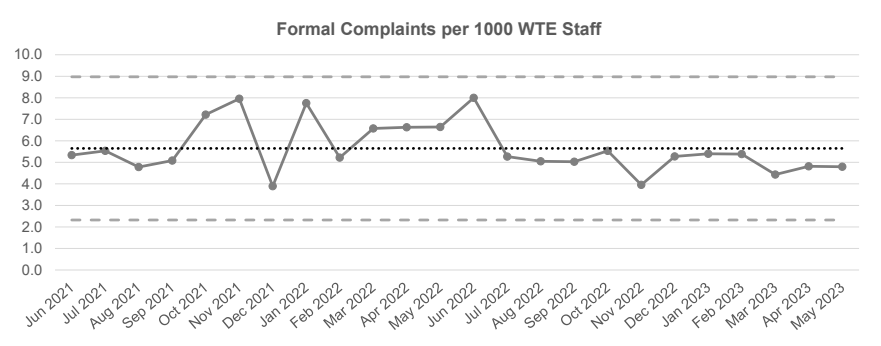
This space is intentionally blank

Data Analysis:

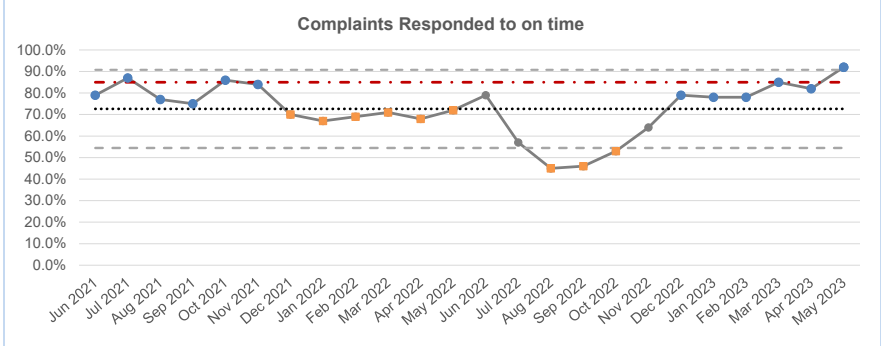
Mixed sex accommodation: Performance is within the expected range of the data. However, the target is unlikely to be met without action, planned actions outlined below.

Community Acquired Pressure Ulcers (Number): Performance is within the expected range of the data. However, the target is unlikely to be met without action, planned actions outlined below.

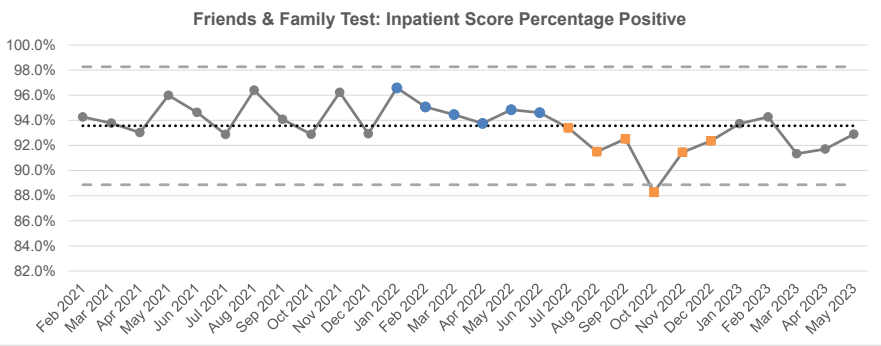
Commentary:



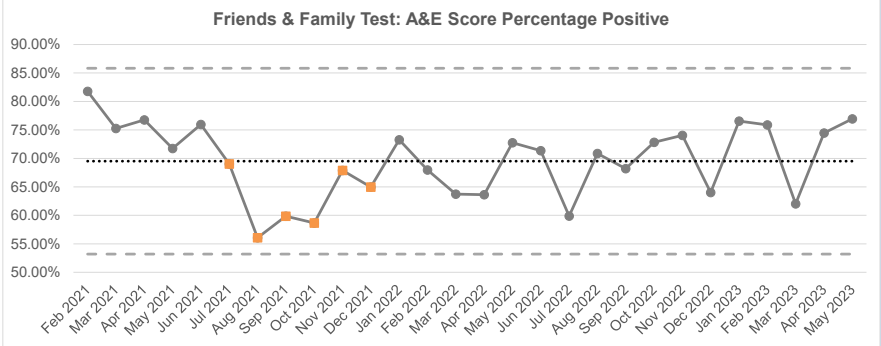
May 2023
4.8
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore assurance is not relevant



May 2023
92.0%
Target
85.00%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target



May 2023
92.9%
Target
0.0%
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

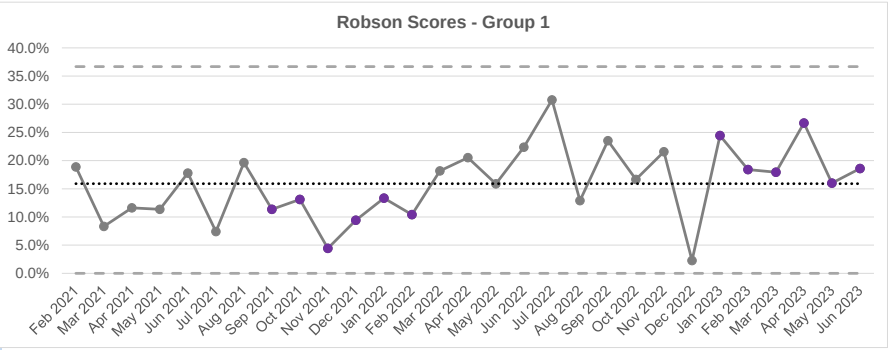


May 2023
76.9%
Target
0.0%
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

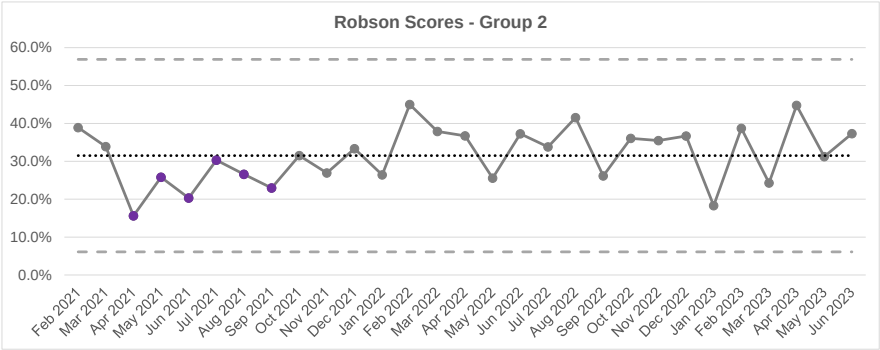
Data Analysis:
Formal Complaints: Performance is stable and continues within the expected range of the data.
Complaints Responded to on time: The general direction of performance is upwards and the target has been achieved for the first time in two years. More data is needed to provide assurance that the target will consistently be met.
FFT Inpatient: The majority of respondents continue to provide positive feedback. The data continues within the expected range.
FFT A&E: The majority of respondents continue to provide positive feedback. The data continues within the expected range.

Commentary:
Formal complaints closed in timescale
Progress
* continued good progress against KPI
* Ulysses learning log now in pilot phase ensuring divisions have monthly oversight of learning outcomes and themes from closed complaints
* annual report highlights overall improvement sustainability with process/timescale changes
* PBI data inconsistency noted against other reported data in review - data extract date to be changed to amend issue
Risks
* loss of patient experience manager post and impact to rejoining PALS/Formal complaints
* increased timescales
* potential decline in current acheivements
Mitigations
* Risk escalated
* post extended until August 31st 2023

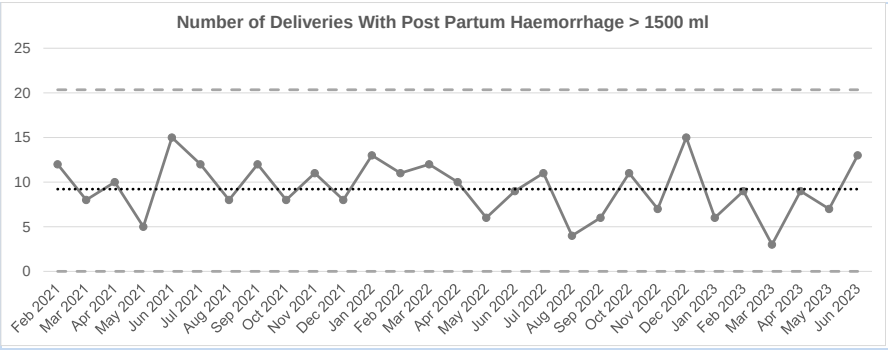
Friends and Family Test
** Please note the data only shows the percentage of recommended and does not include percentage of responses
Progress
* new FFT provider secured , Healthcare Communications
* digital solitions being offered wider in new model
* implementation plan of 4-6 weeks
* lack of potential digital support considered (Digital Solutions Board approval given but resource availiabity not allocated as yet)
* Temp paper collections being rolled out internally to some areas
* FFT reporting now occurring monthly
* PE Manager post extended until August 31st 2023
Risks
* lack of data for NHSE monthly submission due to delays
* increased implemtation period will mean reduced patient feedback - recommendation percentages will therefore have less meaning
* potential impact of loss of PE Manager role and extended implementation plan
* loss of PE Manager post in ability to effectively engage and embed and develop FFT agenda
Mitigations
* temp internal paper solution in place for key areas during implementation period
* awaiting digital sub group allocation of resource



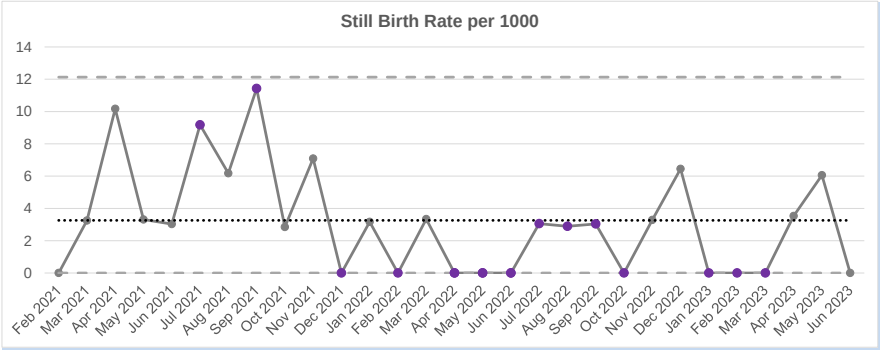
Jun 2023
18.6%
Target
No target
Variance
Special cause of a neutral nature - high
Assurance
There is no target, therefore target assurance is not relevant



Jun 2023
37.3%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Jun 2023
13
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



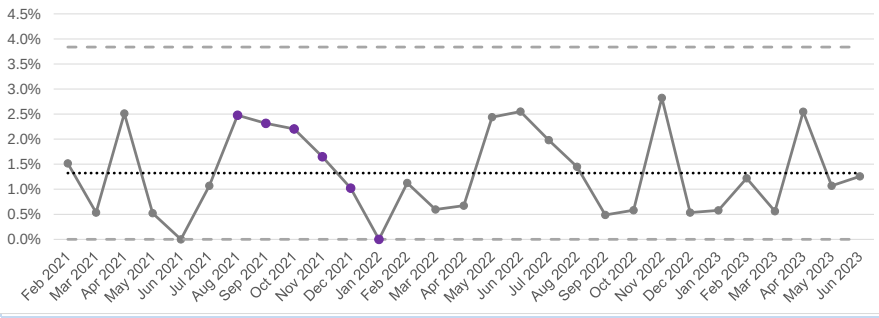
Jun 2023
0.0
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:

Robson Scores 1: Performance is within the expected range of the data with the most recent six months recording higher than the average of the data.
Robson Scores 2: Performance is within the expected range of the data
PPH > 1500 ml: Performance is within the expected range and as expected.
Still birth rate per 1000: The past 18 months have generally recorded lower figures than during 2021.

Commentary:

Spontaneous 3rd or 4th Degree Tear



Jun 2023
1.3%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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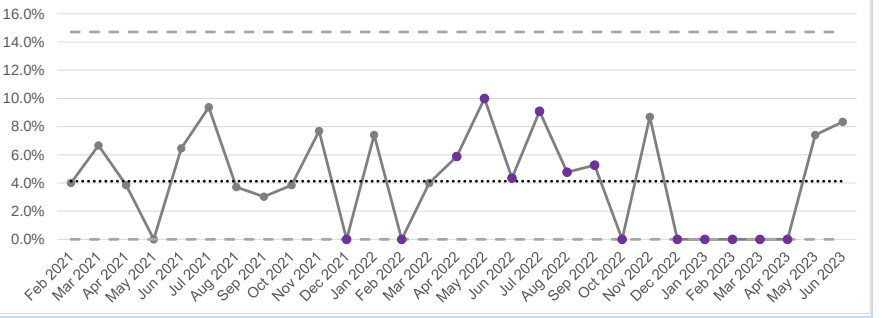
Instrumental 3rd or 4th Degree Tear

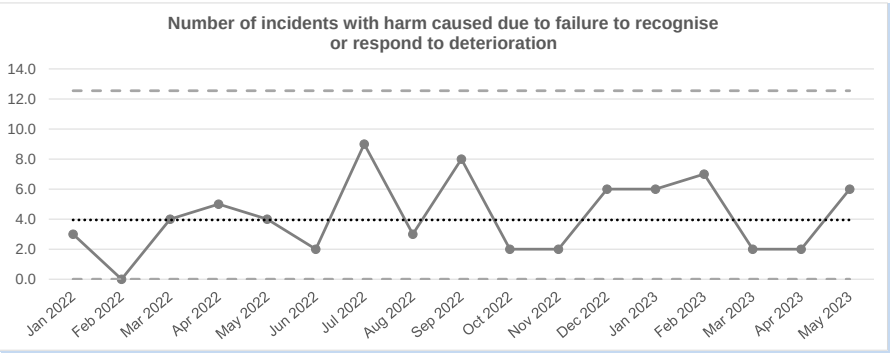


Jun 2023
8.3%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

This space is intentionally blank

Data Analysis:
Spontaneous 3rd or 4th degree tear: The data is within the expected range and as expected.
Instrumental 3rd or 4th degree tear: The data is within the expected range and as expected.

Commentary:



May 2023
6.0

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

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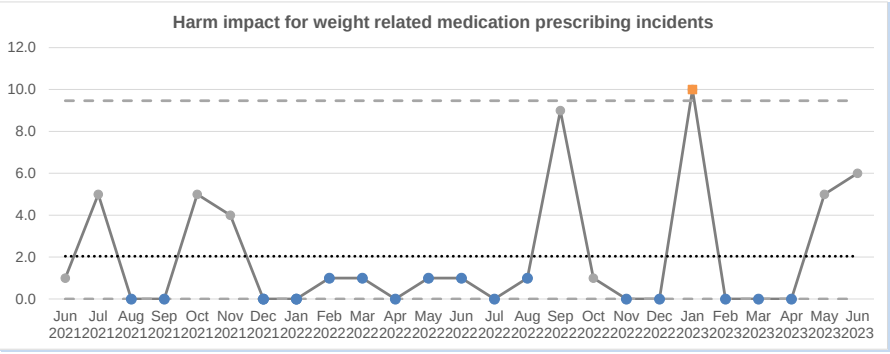
Data Analysis

Harm caused deterioration: Performance is as expected and within the expected range of the data.

Commentary

Incidents reported with harm due to delays in recognition or escalation are identified in the chart, capturing this an outcome measure.

In April 2023 one death was identified and is being investigation through the serious incident process. In May 2023 there were 6 incidents identified that resulted in low/minor harm.



Jun 2023
6

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

Harm impact: Performance is sporadic ranging for zero to 10 over the past two years. The most recent figures are at the midpoint of this range.

Commentary

A low number of incidents and infrequent incidents with harm have been identified, so applying a weighted scoring for harm being the 5-point scale of no harm to death caused by the Incident has been used.

The harm value from 1-5 has been squared to illustrate the significant impact of incidents that cause more harm than others, while monitoring the no-harm/near-miss incidents cumulatively. This means that a patient's death would score 25; severe harm 16; moderate harm 9; low harm 4; no harm 1. Whilst not reflected in the chart above, the SPC chart limits have been set in line with historical data points following the SI case in March 2018 with a score of 25.

Chart alerts:
Sept 2022 - 1 low harm, 5 no harm incidents
Jan 2023 - 1 low harm , 6 no harm incidents
May 2023 - 1 low harm, 1 no harm incidents
Jun 2023 - 1 low harm, 2 no harm incidents.

Number of contacts with the MCA/DoLS team	Apr 2023 **No Data** Target **No target** Variance There is insufficient data for variance and assurance Assurance There is no target, therefore target assurance is not relevant	**Percentage of MCA assessments that meet the legal requirements**	Apr 2023 **41.0%** Target **No target** Variance There is insufficient data for variance and assurance Assurance There is no target, therefore target assurance is not relevant
Percentage of best interest recording for adults who lack capacity and meet the legal requirements	Apr 2023 **0.0%** Target **No target** Variance There is insufficient data for variance and assurance Assurance There is no target, therefore target assurance is not relevant	This space is intentionally blank	

Data Analysis

MCA/DoLS contacts: No data as yet provided

MCA Assessments: There is currently just one figure for this indicator, 41.0% in April 2023. A chart will be added when there are three data points.

Best interests: There is currently just one figure for this indicator, 0.0% in April 2023 (zero out of six). A chart will be added when there are three data points.

Commentary

A data collection from has been created using Microsoft Forms and has been trialled on ward B6, Stroke and Neuro Rehab to identify themes and targeted support.

When a patient has been identified as not having Mental Capacity through completion of a Mental Capacity Assessment staff are not always completing a Best Interest Record. The Divisions have been asked to form a working group to help support improvement changes to tackle issues identified by the data collection as there is limited capacity within the MCA/DoLS team.

Data collection relating to the workload for the MCA/DoLS team has not yet been collected as focus has been given to planning and collecting the pilot data relating to compliance with MCA assessments and Best Interest records. MCA/DoLS team workload data will be collected from July.

Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes	Apr 2023 **20.0%** Target **No target** Variance There is insufficient data for variance and assurance Assurance There is insufficient data for variance and assurance	This space is intentionally blank	
This space is intentionally blank		This space is intentionally blank	

Data Analysis

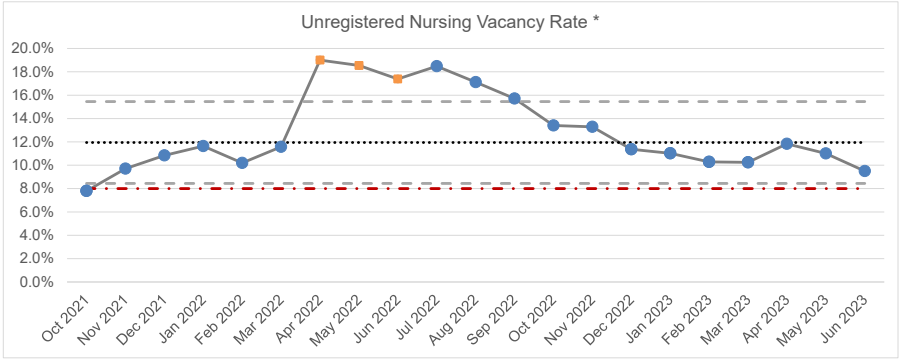
SJRs: There is currently just one figure for this indicator, 20% in April 2023. A chart will be added when there are three data points.

Commentary

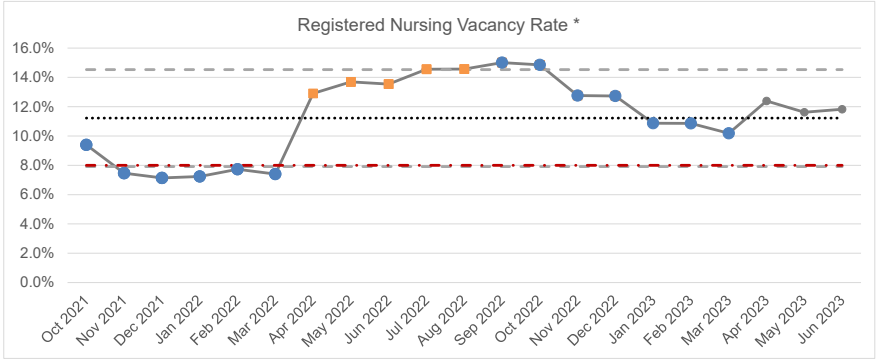
The Trust continues to experience a number of issues with the electronic national data capture system (SJR Plus) resulting in a dip in SJR completion reate and a lack of engagement from reviewers who were previously relaible reviewers within the divisons. This is a national known issue which has been escalated to NHS England but as of yet are unable to provide a solution. In the meantime, the Trust are taking measures to re-engage reviewers to the SJR process and exploring options to improve the data collection system.

SJRs and EOL Theming

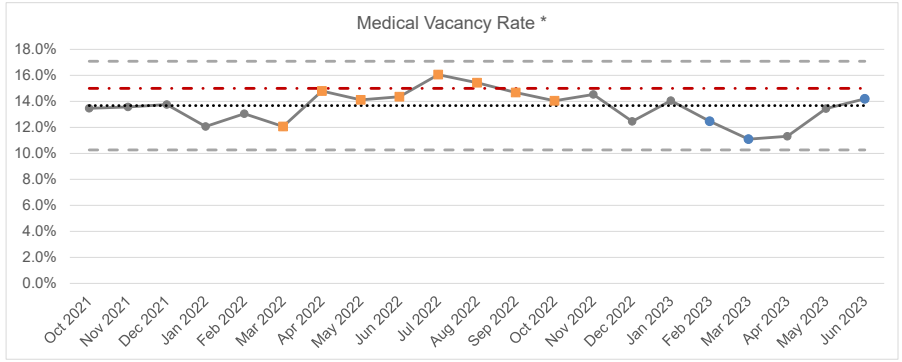
During the period of April 2022 to March 2023 the Trust completed 69 structured judgement reviews. Of those, 14 identified problems in care/negative learning themes associated with recognition of End-of-Life pathway, quality of ReSPECT or advanced care planning documentation.
Themes identified will be triangulated with the ongoing work around the of the End-of-Life quality priority for 2023/24 and the QI project.



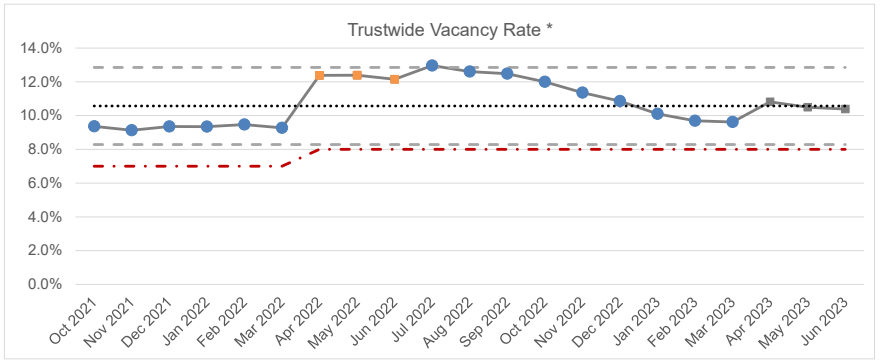
Jun 2023
9.5%
Target
8.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently failing the target



Jun 2023
11.8%
Target
8.0%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target



Jun 2023
14.2%
Target
15.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target



Jun 2023
10.4%
Target
8.0%
Variance
Common cause - no significant change
Assurance
Consistently failing the target

Data Analysis:
Unregistered Nursing Vacancies: The last twelve months present a continuous decreasing trend; with the rate still currently within the expected range.
Registered Nursing Vacancies: After a short period of deterioration, the vacancy rate has remained stable in recent months but is still currently within the expected range.
Medical Vacancy Rate: After a period of deterioration, the last six months present a a stable performance than previous months. The target can be expected to be achieved and failed at random.
Trustwide Vacancy Rate: After a period of deterioration, the vacancy rate has gradually increased in recent months but is still currently within the expected range.

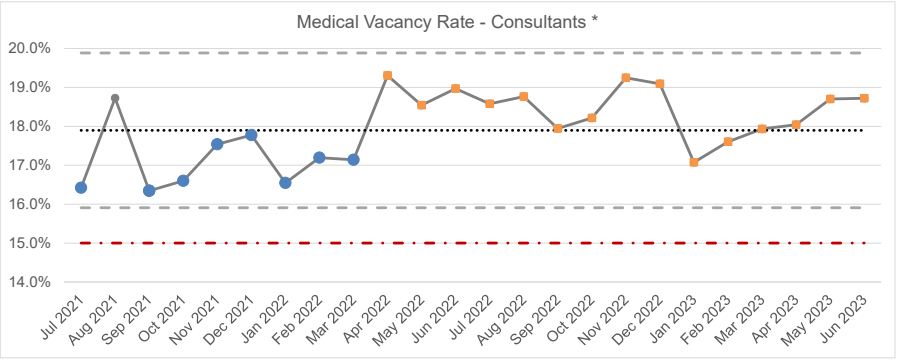
Commentary:
An establishment increase of 25 WTE in April saw the vacancy position increase, but is now on a downward trend. Successful mass recruitment events have been in implemented with a pool process in place with ongoing work to allocate appointed candidates to roles. In addition to the Pool process Medicine and Surgery have expressed an interest in running Division specfic HCA recruitment projects which the recruitment team are now exploring with a view to implementing in order to meet specific Divisional needs. The recruitment team have engaged with the DWP and have a joint recruitment event planned for July 2023 to further widen participation and target job seekers who may not have previously considered a career in the NHS. Regular meetings with the NHSI/E HCSW Programme Lead for support and accountabilty, with a visit planned to the Trust early July to discuss further widening participation and retention. Forecasts are currently expecting the Unregistered nursing staff group to reach 44 WTE vacancies by the end of the financial year.

An establishment increase of 43 WTE between April and June has negatively impacted upon the vacancy rate. Ongoing engagement with 119 international nurses sourced in Kerala is underway, although no international nurses started in June a cohort of 23 are due to arrive in July. Engagement with Newly Qualified Nurses is underway, with numbers currently exceeding target, and conversations taking place to allow for overestablishments in areas to reduce withdrawal rates. Planning is now underway for a further recruitment project in Kerala in November 2023 to recruit further international nurses. Forecasts are currently expecting the Registered Nursing staff group to reach 33 WTE vacancies by the end of the financial year.

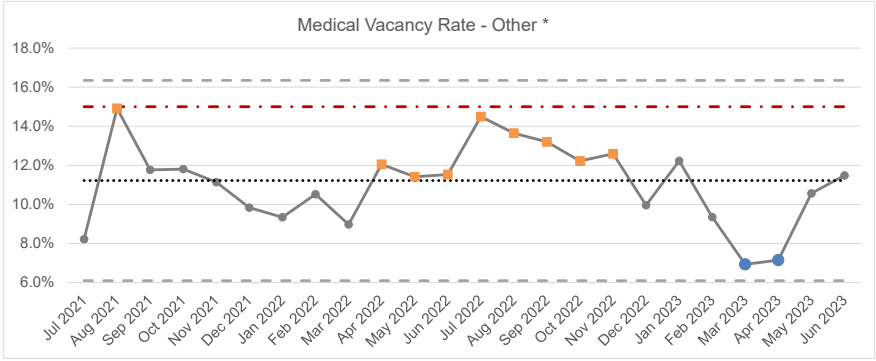
Commentary Vacancies Cont/d:

An establishment increase of 23 WTE between April and June has negatively impacted upon the vacancy rate for Medical Staff. 9 medics were started in June, with a further 12 scheduled to start in July. In addition engagement with the existing pipeline of 54 medical staff is ongoing to facilitate starts as soon as possible. Anaesthetics and Medicine SAS level doctors were sourced as part of the Kerala recruitment project in May 23, and the recruitment team have been workign closely with the GMC for the Trust to become a sponsor to support these and other candidates. Sourcing of senior medical staff via the Talent Acquisition Team will be inplemented following investment in the team for and additional Recuitment Specialist with interviews taking place early July. Further Kerala recruitment project planning underway, scheduled to take place Novemebr 2023. In addition to recruitment of substantive roles the recruitment team have been processing offers and pre-employment checks to support the junior doctors intake in August 2023. Some issues are being experienced with HEE in receiving information in a timely manner, this is due to organisational change in HEE, and the recruitment team are chasing regularly to obtain the information required to facilitate trainee doctor starts.

An establishment increase of 128 WTE between April and June has negatively impacted upon the Trustwide vacancy position. Despite this the vacancy rate is showing a downward trend. Various staff group specific projects are underway to impact Registered Nursing, Unregistered Nursing, and Medical Staff. Trustwide recruitment continues to see an increase in activity with the recruitment team supporting by making 316 offers in month and starting 165 new starters. In June there were 198 active vacancies being recruited to, and 3460 applications received and processed.



Jun 2023
18.7%
Target
15.0%
Variance
Common cause - no significant change
Assurance
Consistently failing the target

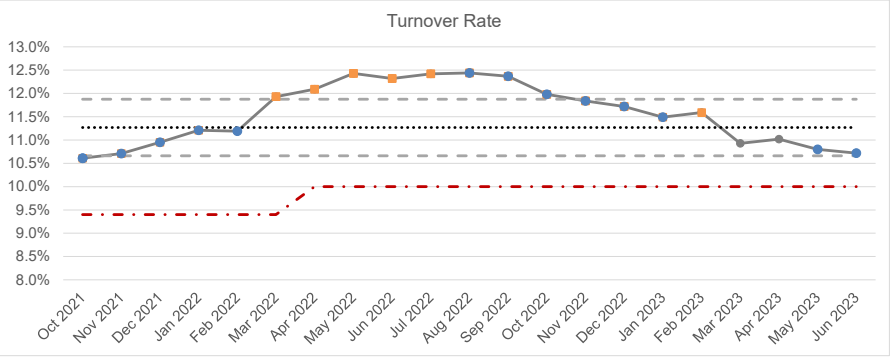


Jun 2023
11.5%
Target
15.0%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target

Data Analysis:
Medical Vacancy Rate - Consultants: The vacancy rate has gradually continued to increase in the last six months but still within the expected range. The current performance reliably fails to achieve the target.
Medical Vacancy Rate - Other: Performance has improved since Jan-23 and has since returned to normal variation in latest month.

Commentary:
An establishment increase of 6 WTE Consultant posts between April and June has impacted the vacancy position. June saw 1 Consultant start, with a further Consultant starting early July, A pipeline of a further 11 Consultants has been established awaiting start, with engagement ongoing to facilitate starts as soon as possible. Sourcing of senior medical staff via the Talent Acquisition Team will be inplemented following investment in the team for and additional Recuitment Specialist with interviews taking place early July. Work is underway to design and implement a CESR support programme to support employees towards being granted specialist GMC Registration and appointment into substantive Consultant roles.

An establishment increase of 17 WTE other medical staff between April and June has impacted the vacancy position. 8 other medical staff started in June, with 11 other grade medics scheduled to start in July. A pipeline of a further 43 non-Consultant medical staff has been established awaiting start.Medics recruitment for SAS grades in Anaesthetics and Medicine are under way as part of Kerala recruitment project from May 23, and application for the Trust to become a GMC sponsor to support this is in progress. Work is underway in issuing offer letters, undertaking pre-employment checks, and planning induction for the cohort of trainee doctors due to start in August. Some issues are being experienced with HEE in receiving information in a timely manner, this is due to organisational change in HEE, and the recruitment team are chasing regularly to obtain the information required to facilitate trainee doctor starts.



Jun 2023
10.7%
Target
10.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently failing the target

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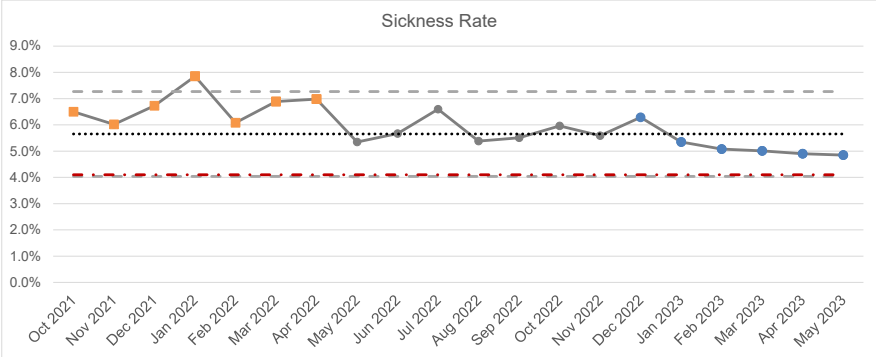

May 2023
4.85%
Target
4.1%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target

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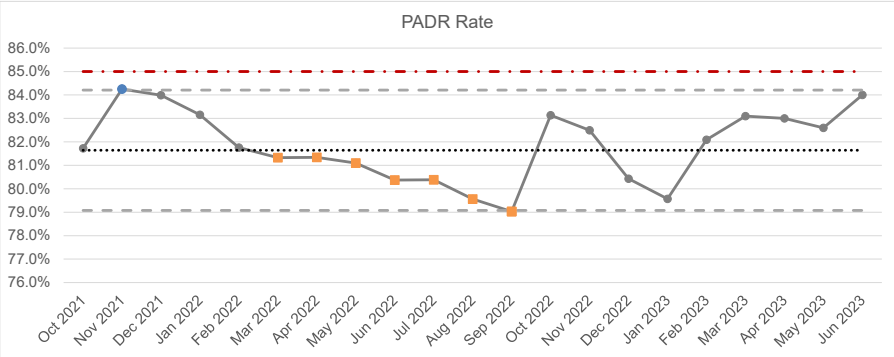
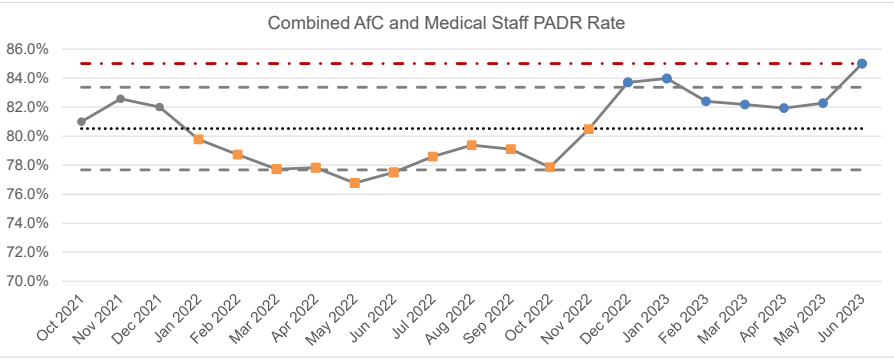
Data Analysis:
Turnover Rate: After a short period of deterioration in summer 2022, the turnover rate has gradually reduced and has currently fallen within the expected range.
Sickness Rate: Following a period of concern, the past few months of Sickness rate performance shows a significant decreasing trend and is within the expected range. Current data indicates that the target will not be met without action. Planned actions outlined below.

Commentary:
HR and OD work activities in divisions have had a positive influence on turnover, specifically with initiatives such as:
Medicine:
•More engaging and transparent positioning of roles for colleagues prior to applying which improves retention and manages expectations.
•Better support to colleagues requiring support/adjustments in their role with redeployment where needed to avoid resignations and case reviews (Potential dismissals for ill health capability)
• Compassionate and inclusive Leadership approach to increase morale ; engagement events generated positive feedback including local colleague reward and recognition schemes
Surgery and Critical Care :
•Leadership development drive to ensure the division demonstrates compassionate, supportive leadership and for managers to share knowledge, experience and learning with their teams to encourage and develop individuals
•Improved senior manager visibility who attend department and ward meetings, huddles, 'Opening Doors', to provide the staff on the shop floor with an opportunity to discuss concerns or issues, or to put forward ideas for improvement
Communities and Therapies :
• International AHP support with clear induction for all
• Local engagement and listening events to improve involvement and motivation
• Value based leadership development programme for selected leaders to roll out more widely all contribute positively to better retention and lower through more inclusive and compassionate leadership
Family services :
Celebrating successes – shared in blog, newsletters; Exit interviews to understand reasons for leaving and inform improvements
Planned Care : Health Care Assistant Day ; International Midwife / Nurse Day
Surgery & CC, Family Services and Community and Therapy all run local Recognition and reward scheme to improve morale – drive to utilise 'Thank You' on the Hub, consistent nominations month on month for Divisional Stars of the Month to recognise those who do their utmost or make a difference to others

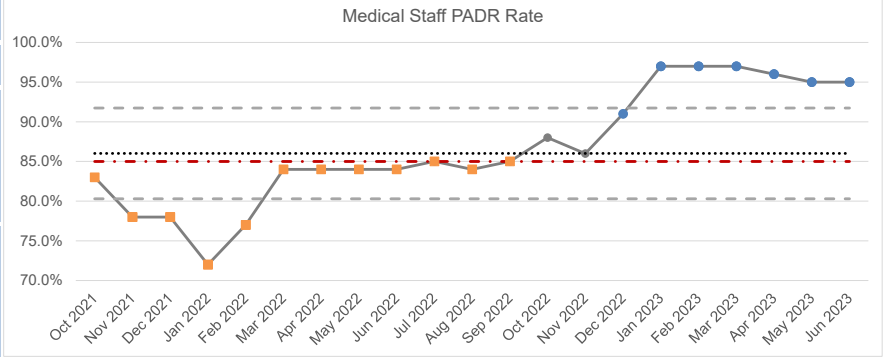
Whilst the sickness % has reduced across the course of the last year and continues to show a downward trend, it remains above the Trust target of 4.1%. The HR team have been working closely with managers to robustly manage cases and this shows in the decrease in % however we recognise that there remains work to do. Having reviewed the managing attendance managers toolkit, this will be kept under review to ensure it is fit for purpose to ensure managers have access to appropriate tools to support them in the management of their staff. In addition, further analysis of the sickness data is underway to identify longstanding cases where there may be blockages that need unpicking. There is an increased focus on ensuring absence reasons are recorded accurately, e.g. not 'unknown', so that interventions can be appropriately targeted. The HR team will drive this work further setting up a sickness audit process for all areas. A working group is currently reviewing the stress risk assessment process and policy including reviewing the training available with a view to supporting staff to remain well at work. Within the directorates and divisions there is much focus on sickness including education for managers around the process, flexible working, reasonable adjustments and the recently launched disability policy. As part of the staff survey action planning, divisions and directorates are focusing on preventative measures, one example being introducing 'wellbeing boards' for staff.



Jun 2023
84.0%
Target
85.0%
Variance
Common cause - no significant change
Assurance
Consistently failing the target



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



Jun 2023
95.0%
Target
85.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target

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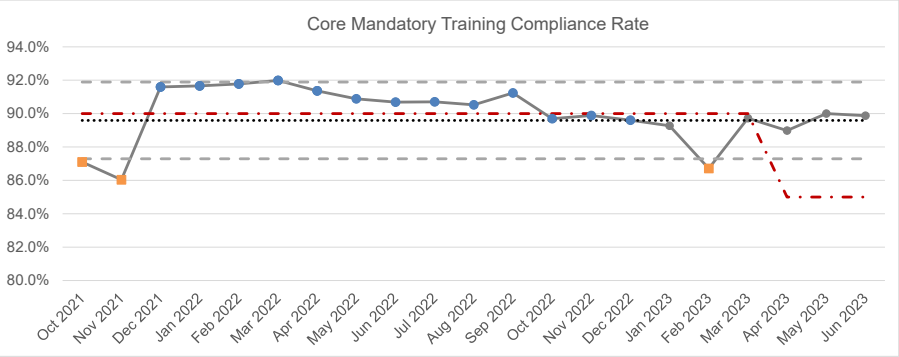
Data Analysis:
PADR Rate: After a period of deterioration, improvement has been seen in the last four months. Current data indicates that the target will not be met without action. Planned actions outlined below.
Medical Staff PADR Rate: There has been significant improvement over the last seven months. Performance is now above the expected range and is achieving the target.
Combined AfC and Medical Staff PADR Rate: Following previous months of concern, last seven months performance has been statistically improving towards the target.

Commentary:
The Trust PADR compliance rate has remained below target for the last 18 months , this month we can see improvemnet, though it still remains 1% below target. From May 23 the support and monitoring of PADR compliance has now moved to the ESR team who continue with targeted communication to managers for out of compliance PADRs. The ESR Team cotinue to support managers around PADR compliance with myth busting and education.

Commentary:
Medical and Dental PADR compliance continues to be above target and has been since the beginning of this year. The CMO, via dedicated revalidation and medical appraisal coordinator, who supports and maintains the process. The revalidation and medical appraisal coorindator supports doctor 1:1 who are delayey and continues to inform doctors when their appraisal is due (3 months notification), along with the clinical governance information/evidence required for appraisal



Jun 2023
89.9%
Target
85.0%
Variance
Common cause - no significant change
Assurance
Consistently passing the target

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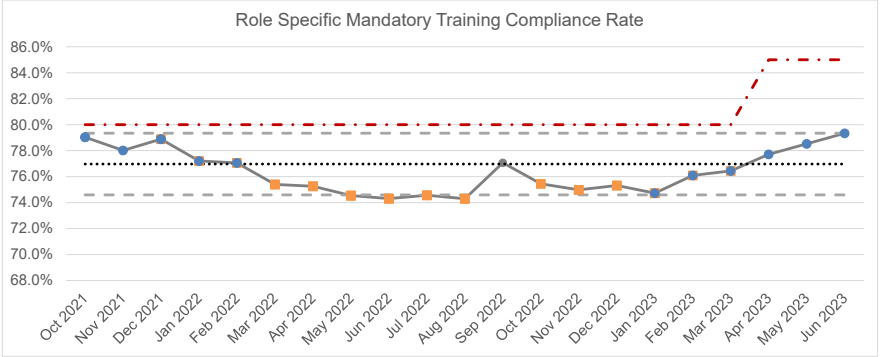

Jun 2023
79.3%
Target
85.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Consistently failing the target

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Data Analysis:
Core Mandatory Training: After a long run of stable and improving performance, the last six months months indicate a drop in performance. However, compliance rate was still achieved from Mar-23 and fall within the expected range. Note: Target has been decreased to 85% from April 23.
Role Specific Mandatory Training: After a a period of poor performance; the last six months presents a positive increasing trend. Note the target has been increased to 85% from April 23.

Commentary:
Core mandatory training has seen a slight decline (0.41%) in overall compliance since the previous report. As in the previous month, Fire Safety and Preventing Radicalisation - Advanced Prevent Awareness remain below 80% compliance. Fire safety continues to be impacted by reduced space availabile at SGH. Further, the mean average Withdrawal / DNA for Fire Safety per month from January to June 2023 was 248. The T&D Admin team are continuing to support with targeted emails to individuals and line managers and the Fire Safety Training Lead has been provided with all DNA data to support his planning. Preventing Radicalisation - Advanced Prevent Awareness compliance has increased by 7.38% over the past month to a current compliance of 72.11%. Trageted emails will continue to be sent to support attainment of the 85% compliance target. Throughout July 2023, the T&D Admin team will also provide targeted support for improving compliance of Information Governance and Data Security training which currently stands at 87.06%, with 872 out of compliance at the time of reporting.

From the above graph, it can be seen that role specific mandatory training compliance has increased by a further 0.81% in June, continuing the upward trajectory since the beginning of 2023. Throughout June, additional Level 2 Resus - Adult Basic Life Support and Moving and Handling - Module 11 provision was delivered by an external training provider, supporting the teams to reduce high numbers out of compliance in these areas. This resulted in a 9% and above increase in compliance across the targeted provision. The teams will now continue to build on these improvements through effective planning which is consistently reviewed and adapted to address numbers coming out of compliance. It must be noted that the upcoming doctors' strikes will impact delivery in these areas as specific planned modules are focussed on the Medical and Dental staff group. As identified in the previous report, Safeguarding Adults Level 3 and NG Tube Displacement are currently reporting a compliance below 60%. The T&D Admin team are now working closely with the Safeguarding Training Lead and team to support with targeted emails to all staff out of compliance for Safeguarding Adults Level 3 (currently 298). They will also be supporting with any follow up manager emails to report wasted spaces through DNAs (mean average Withdrawal / DNA per month from January to June 2023 was 38, 13 higher than the mean average completion per month in the same period). This support will be on-going with regular meetings planned for the Safeguarding Training Lead, the T&D Manager and Head of T&D. NG Tude Displacement has seen a 7.5% increase in complaince since the previous report following a targeted approach to staff out of compliance. Isses with recording completion of this competency were raised last month and this is being addressed by the T&D Manager.

IPR Appendix - National Benchmarked Centiles

Northern Lincolnshire and Goole NHS Foundation Trust

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 17/07/2023

* 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	Jun 23	63.2%	92.0%	58	72 / 171	May 23
	Planned	Number of Incomplete RTT pathways 52 weeks	Jun 23	830	0	58	72 / 170	May 23
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Jun 23	35.3%	1.0%	19	128 / 157	May 23
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Jun 23	55.1%	85.0%	66	46 / 133	May 23
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Jun 23	65.3%	95.0%	18	119 / 145	Jun 23
	Urgent Care	Number Of Emergency Department Attendances	Jun 23	14,294	No target	44	81 / 145	Jun 23
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Jun 23	673	0	7	144/154	Jun 23
	Flow	Bed Occupancy Rate (General & Acute)	Jun 23	91.8%	92.0%	64	57 / 157	Q4 22/23
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Jun 23	6.8%	5.0%	63	60 / 160	May 23

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Quality & Safety	Infection Control	Number of MRSA Infections	May 23	0.00	No target	61	54 / 137	Mar 23
	Infection Control	Number of E Coli Infections	May 23	0.40	No target	65	48 / 137	Mar 23
	Infection Control	Number of Trust Attributed C-Difficile Infections	May 23	0.10	No target	93	10 / 137	Mar 23
	Infection Control	Number of MSSA Infections	May 23	0.10	No target	65	54 / 137	Mar 23
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Jan 23	102.5	As expected	43	69 / 120	Feb 23
	Safe Care	Number of Serious Incidents Raised in Month	Jun 23	10	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	May 23	8.8	No target	33	128 / 190	Apr 23
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Jun 23	95.0%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	May 23	4.8	No target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Percentage Positive Inpatient Scores	May 23	92.9	No target	33	89 / 132	Feb 23

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	May 23	4.9%	4.1%	56	94 / 124	Feb 23

Scorecard - Access and Flow (F&P 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*	Jun 2023	63.2%	92.0%	Alert			Board
	Number of Incomplete RTT pathways 52 weeks*	Jun 2023	830	0	Alert			Board
	Total Inpatient Waiting List Size	Jun 2023	11,959	11,563	Alert			Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Jun 2023	35.3%	1.0%	Alert			Board
	Number of Incomplete RTT Pathways*	Jun 2023	40,308	No Target	Alert		n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Jun 2023	18,012	No Target			n/a	FPC
	% of Inpatient Live Waiting List Overdue Risk Strat Date	Jun 2023	48.1%	37%	Alert			FPC
	Number of Incomplete RTT pathways 65 weeks	Jun 2023	86	No Target			n/a	Board
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Jun 2023	34,644	9,000	Alert			Board
	Outpatient Did Not Attend (DNA) Rate	Jun 2023	6.8%	5.00%	Alert			Board
	% Outpatient Non Face To Face Attendances	Jun 2023	21.7%	25.00%	Alert			Board
	% Outpatient summary letters with GPs within 7 days	May 2023	56.3%	50.0%	Alert			FPC
	Advice and Guidance as a Percentage of all Referrals	Jun 2023	8.0%	No Target			n/a	FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Jun 2023	84.7%	99.0%	Alert			FPC
	% of Outpatient Waiting List Overdue Risk Strat Date (New and Review)	Jun 2023	28.8%	23.0%	Alert			FPC
	Patient Initiated Follow Up	Jun 2023	2.5%	5.0%	Highlight			FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Jun 2023	55.1%	85.0%	Alert			Board
	Cancer Waiting Times - 104+ Days Backlog*	Jun 2023	31	0	Alert			Board
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Jun 2023	10.0%	75.0%	Alert			Board
	Cancer Request To Test In 7 Days*	Jun 2023	58.5%	100.0%	Alert			Board
	Cancer Waiting Times - 2 Week Wait*	Jun 2023	96.2%	93.0%				FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Jun 2023	92.7%	93.0%				FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Jun 2023	73.3%	75.0%				FPC
	Cancer Request To Test In 14 Days*	Jun 2023	87.0%	100.0%	Alert			FPC
	Cancer Waiting Times - 31 Day First Treatment*	Jun 2023	94.5%	96.0%				FPC
	Cancer Waiting Times - Cancer 62-day backlog	Jun 2023	100.0	No Target			n/a	FPC
	Cancer Waiting Times - 62 day Screening*	Jun 2023	57.1%	90.0%				FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Jun 2023	65.3%	95.0%	Alert			Board
	Number Of Emergency Department Attendances	Jun 2023	14,294	No Target			n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Jun 2023	205.0	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Jun 2023	673.0	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Jun 2023	349.0	0	Alert			Board
	Number of UCS Attendances	Jun 2023	5,486	No target	Alert		n/a	FPC
	% UCS Waiting Times (4 Hour Performance)	Jun 2023	99.3%	92.00%				FPC
	Ambulance Handover Delays - Number 30-60 Minutes	Jun 2023	317.0	No Target			n/a	FPC
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Jun 2023	43.7%	40.0%				Board
	% of Extended Stay Patients 21+ days	Jun 2023	11.8%	12.0%				Board
	Inpatient Elective Average Length Of Stay	Jun 2023	2.1	2.5				Board
	Inpatient Non Elective Average Length Of Stay	Jun 2023	3.4	3.9				Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Jun 2023	91.6%	90.0%	Alert			Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Jun 2023	16.9%	30.0%	Alert			Board
	Bed Occupancy Rate (G&A)	Jun 2023	91.8%	92.0%				Board
	Percentage of patients re-admitted as an emergency within 30 days	Jun 2023	8.8%	No Target	Alert		n/a	FPC
	Percentage of Daycase Spells From Elective Activity	Jun 2023	94.8%	No Target			n/a	FPC
	% of Extended Stay Patients 7+ days	Jun 2023	43.9%	No Target			n/a	FPC
	% of Extended Stay Patients 14+ days	Jun 2023	21.2%	No Target			n/a	FPC
	% Inpatient Discharges Before 17:00	Jun 2023	71.5%	80.0%	Highlight			FPC
Theatre	Placeholder: Theatre Session Utilisation (Core Capacity)							
	Theatre In Session Capped Utilisation	Jun 2023	82.4%	No Target			n/a	FPC
	Theatre In Session Non-Capped Utilisation	Jun 2023	82.4%	No target			n/a	FPC

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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)*	May 2023	0.00	see analysis			n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	May 2023	0.40	see analysis			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	May 2023	0.10	see analysis			n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	May 2023	0.10	see analysis			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	May 2023	0.54	see analysis			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dec 2022	98.7	As expected			As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Jan 2023	102.5	As expected		L	As expected	Board
	SHMI diagnosis groups outcome risk percentage (infections)	Jan 2023	97.0%	No target			n/a	Board
End of Life	Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes	Apr 2023	20.0%	No target		n/a	n/a	Board
	Percentage of in hospital deaths with anticipatory medication prescribed	Mar 2023	10.7%	No target		L	n/a	Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	May 2023	100%	No target		H	n/a	Board
	Number of Serious Incidents raised in month	Jun 2023	10	No target			n/a	Board
	Occurrence of 'Never Events' *(Number)*	Jun 2023	0	0		n/a	n/a	Board
	Duty of Candour Rate	Jun 2023	100%	100.0%			?	Board
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	May 2023	5.3	No target			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	May 2023	3.7	No target			n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Jun 2023	95.0%	95.0%		H	?	Board
	Care Hours Per Patient Day (CHPPD)	May 2023	8.8	No target			n/a	Board
	Mixed Sex Accommodation Breaches	May 2023	9.0	0			?	Board
	Community Acquired Pressure Ulcers (Number)	Mar 2023	40.0	0	Alert		F	Board
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	May 2023	4.8	No target			n/a	Board
	Complaints Responded to on time	May 2023	92.0%	85.0%		H	?	Board
	Friends & Family Test: Inpatient Score Percentage Positive	May 2023	92.9%	0%			n/a	Board
	Friends & Family Test: A&E Score Percentage Positive	May 2023	76.9%	No target			n/a	Board
Observations	Number of incidents with harm caused due to failure to recognise or respond to deterioration	May 2023	6.0	No target			n/a	Board
	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Jun 2023	92.0%	90.0%			?	Q&S
	Recording of and response to NEWS2 score for unplanned critical care admissions	Apr 2023	42.9%	No target		n/a	n/a	Q&S
Mental Capacity	Number of contacts with the MCA/DoLS team	Apr 2023	No Data	No target		n/a	n/a	Board
	Percentage of MCA assessments that meet the legal requirements	Apr 2023	41.0%	No target		n/a	n/a	Board
	Percentage of best interest recording for adults who lack capacity and meet the legal requirements	Apr 2023	0.0%	No target		n/a	n/a	Board
Sepsis	Percentage of paediatric primary sepsis screenings using national risk stratification criteria	Jun 2023	No Data	No target		n/a	n/a	Q&S
	Percentage of Adult Sepsis screening completed within 15 minutes in response to elevated NEWS2 score	Jun 2023	21.8%	90.0%	Alert	H	F	Q&S
Prescribing	Harm impact for weight related medication prescribing incidents	Jun 2023	6	No target			n/a	Board
	Actual weight recorded on Web V within 24 hours of admission	Jun 2023	No Data	No target		n/a	n/a	Q&S
	Weight recorded on EPMA matches actual weight recorded in Web V	Jun 2023	No Data	No target		n/a	n/a	Q&S
Maternity	Robson Scores - Group 1	Jun 2023	18.6%	No target			n/a	Board
	Robson Scores - Group 2	Jun 2023	37.3%	No target			n/a	Board
	Number of Deliveries With Post Partum Haemorrhage > 1500 ml	Jun 2023	13	No target			n/a	Board
	Still Birth Rate per 1000	Jun 2023	0.0	No target			n/a	Board
	Spontaneous 3rd or 4th Degree Tear	Jun 2023	1.3%	No target			n/a	Board
	Instrumental 3rd or 4th Degree Tear	Jun 2023	8.3%	No target			n/a	Board

Scorecard - Workforce

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Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Vacancies	Unregistered Nurse Vacancy Rate *	Jun 2023	9.5%	8.0%	Alert			Board
	Registered Nurse Vacancy Rate *	Jun 2023	11.8%	8.0%				Board
	Medical Vacancy Rate *	Jun 2023	14.2%	15.0%				Board
	Trustwide Vacancy Rate *	Jun 2023	10.4%	8.0%	Alert			Board
	Medical Vacancy Rate - Consultants *	Jun 2023	18.7%	15.0%	Alert			Board
	Medical Vacancy Rate - Other *	Jun 2023	11.5%	15.0%				Board
Staffing Levels	Turnover Rate	Jun 2023	10.7%	10.0%	Alert			Board
	Sickness Rate	May 2023	4.9%	4.1%				Board
Staff Development	PADR Rate	Jun 2023	84.0%	85.0%	Alert			Board
	Medical Staff PADR Rate	Jun 2023	95.0%	85.0%				Board
	Combined AfC and Medical Staff PADR Rate	Jun 2023	85.0%	85.0%	Alert			Board
	Core Mandatory Training Compliance Rate	Jun 2023	89.9%	85.0%				Board
	Role Specific Mandatory Training Compliance Rate	Jun 2023	79.3%	85.0%	Alert			Board
Disciplinary	Number of Disciplinary Cases Live in Month	Jun 2023	4	No Target			n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Jun 2023	17	12	Alert			WFC
	Number of Suspensions Live in Month	Jun 2023	6	No Target	Alert		n/a	WFC
	Average Length of Suspension (Weeks)	Jun 2023	39	No Target	Alert		n/a	WFC
Culture	Staff Survey - Advocacy	Apr 2023	5.8	6.8		n/a	n/a	WFC
	Staff Survey - Involvement	Apr 2023	6.3	6.8		n/a	n/a	WFC
	Staff Survey - Motivation	Apr 2023	6.9	7.0		n/a	n/a	WFC

A&E	Accident and Emergency
A&F	Access and Flow
ACN	Associate Chief Nurse
ADQG	Associate Director Quality Governance
AfC	Agenda for Change
CDI	Clostridioides difficile infection
CESR	Certificate of Eligibility for Specialist Registration
CHPPD	Care hours per patient day
CMO	Chief Medical Officer
DM01	Diagnostic Waiting Times and Activity
DNA	Did not attend
DOLS	Deprivation Of Liberty Safeguards
DPOW	Diana Princess of Wales Hospital
DWP	Department of Work and Pension
ED	Emergency Department
EMAS	East Midlands Ambulance Service
EPIC	Emergency Physician in Charge
EPMA	Electronic Prescribing and Medicines Administration
FFT	Friends and Family Test
GMC	General Medical Council
GP	General Practitioner
HCSW	Health Care Support Worker
HEE	Health Education England
HIT	High Intensity Theatre
HR	Human Resources
HSMR	Hospital Standardised Mortality Ratio
HUTH	Hull University Teaching Hospital
IAAU	Integrated Acute Assessment Units
IAAU	Integrated Acute Assessment Unit
ICS	Integrated Care Systems
IPC	Infection Prevention and Control
KPI	Key Performance Indicators

LOS	Length of Stay
MCA	Mental Capacity Act
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-susceptible Staphylococcus aureus
NEWS	National Early Warning System
NG	National Guidance
NHSE/I	NHS England and Improvement
NL	North Lincolnshire
NLAG	Northern Lincolnshire and Goole NHS Trust
OD	Organisational Development
OOH	Out of Hospital
OP	Outpatient
OPAT	Outpatient Parenteral Antimicrobial Therapy
OPEL	Operational Pressures Escalation Levels
PADR	Performance Appraisal and Development Review
PALS	Patient Advice and Liaison Service
PBI	Power BI
PE	Patient Experience
PIFU	Patient Initiated Follow Ups
PTL	Patient Tracking List
Q&S	Quality and Safety
QI	Quality Improvement
RDC	Rapid Diagnostics Centre
RTT	Referral to Treatment
SAS	Specialist and Specialty
SGH	Scunthorpe General Hospital
SHMI	Summary Hospital Mortality Index
SJR	Structured Judgement Reviews
SPA	Single Point of Access
SPC	Statistical Process Charts
T&D	Training and Development
UCS	Urgent Care Centre
VTE	Venous Thromboembolism
WLIs	Waiting List Initiative's
WTE	Whole Time Equivalent
YTD	Year to Date

NLG(23)135

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 1 August 2023
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jenny Hinchliffe, Deputy Chief Nurse Melanie Sharp, Deputy Chief Nurse
Title of the Report	**Maternity & Neonatal Oversight Report**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this new highlight report is to provide the 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** • The midwife to birth ration in April was 1:22.37, below the acceptable level of 1:28. • Midwifery vacancy rate demonstrates a slightly improving picture in May, although remains challenging. Positively the first cohort of four international midwives have commenced in post in March and a further three in May. • Pastoral and Retention midwife role of supporting midwives (specifically early career) impacting positively on the service. • Recruited to Maternity audit and compliance manager post • Maternity Matron (Grimsby) appointed 13/6/23 • Head of Midwifery and Deputy Governance Lead posts in the recruitment process **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. CNST Year 5 published 31/5/23 – currently benchmarking requirements against Year 4. **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. 3-year single delivery plan** Maternity deliverables action plan completed. Work will now progress on achieving compliance with the plan. **5. Quality Improvement** Current ongoing Quality Improvement (QI) projects within maternity services include: • Induction of Labour • Maternity Triage • Neonatal Thermoregulation Progression of phase 2 of the Maternity Triage Service is reliant on agreeing next steps with the Union regarding concerns raised by Health Care Assistants (HCA) and to agree estates changes

	required. Both HR and Estates teams are actively working with the Division to progress this work.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Quality & Safety Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Maternity & Neonates Oversight Report – July (May 2023 data)

1. Workforce/Staffing

There has been a reduction in midwife vacancies at Grimsby in May, however an increase was seen at Scunthorpe:

Grimsby — Registered reduced from 16.5 to 16.1 Whole Time Equivalent (WTE)
Unregistered increased from 0.6 to 1.3 (WTE)

Scunthorpe — Registered increased from 18.4 to 20.3 (WTE)
Unregistered reduced from 1.1 to 0.0 (WTE)

Midwifery staffing is reviewed daily (weekdays), and a weekend plan cascaded widely. Maternity Operational Pressure Escalation Level (OPEL) levels are reported internally and regionally, ensuring swift escalation as per the Staffing Escalation policy and to request or support with regional mutual aid as required to maintain safety. If required at Grimsby maternity wards are consolidated.

Recruitment

- Pastoral and Retention midwife role of supporting midwives (specifically early career) impacting positively on the service.
- Recruited to Maternity audit and compliance manager post
- Maternity Matron (Grimsby) appointed at interview 13/6/23
- Deputy Governance Lead appointed at interview 10/7/23
- Head of Midwifery post in the recruitment process – interview planned 13/7/23

Maternity Wards Fill Rates and CHPPD May 2023

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**89.6%**	**-3.0%**	**83.5%**	**-0.5%**	**11.8**	**-4.19**
Registered Nurses and Midwives	86.5%	-2.2%	79.8%	-0.3%	7.2	-2.50
Care Staff	95.0%	-4.5%	90.1%	-0.9%	4.5	-1.69
Central Delivery Suite	**83.0%**	**-1.6%**	**47.1%**	**-5.9%**	**26.1**	**0.37**
Registered Nurses and Midwives	79.7%	-3.3%	37.6%	-9.5%	20.2	-0.15
Care Staff	96.6%	5.5%	86.3%	8.8%	5.9	0.52
Jasmine & Honeysuckle	**91.3%**	**2.5%**	**78.3%**	**-1.3%**	**11.0**	**0.62**
Registered Nurses and Midwives	90.5%	7.6%	79.2%	5.7%	7.3	0.81
Care Staff	93.2%	-8.0%	76.2%	-15.6%	3.7	-0.20
Ward 26 SGH	**90.5%**	**-1.3%**	**65.2%**	**2.0%**	**7.5**	**-1.47**
Registered Nurses and Midwives	89.5%	-1.6%	61.5%	-4.3%	5.4	-1.09
Care Staff	93.5%	-0.4%	75.4%	19.1%	2.1	-0.38
Total	**88.8%**	**-0.8%**	**69.9%**	**-1.4%**	**11.4**	**-1.48**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	61.5%	0.5%
Central Delivery Suite	77.3%	-1.7%
Jasmine & Honeysuckle	66.6%	3.9%
Ward 26 SGH	72.2%	-0.3%
Total	**68.6%**	**0.8%**

***Key – CHPPD (Care Hours Per Patient Day); RNMW (Registered Nurse/Midwife); DPOW (Diana, Princess of Wales Hospital); SGH (Scunthorpe General Hospital)**

Assurance that safety was maintained within the maternity units is supported by the Midwife to Birth ratio data. In May 2023 the midwife: birth ratio for the Trust was 1:22.37 (Grimsby was 1:23.89 and Scunthorpe was 1:20.48) which is below the acceptable ratio of 1:28. Although the vacancy factor is high, the ability to cover shifts shows positively.

Fill rate and Care Hour Per Patient Day (CHPPD) data for the two neonatal units is outlined below.

Fill Rate Dashboard May 2023

By day or night - display may exceed print limits

Site: All | Division: All | Ward name: Multiple selections

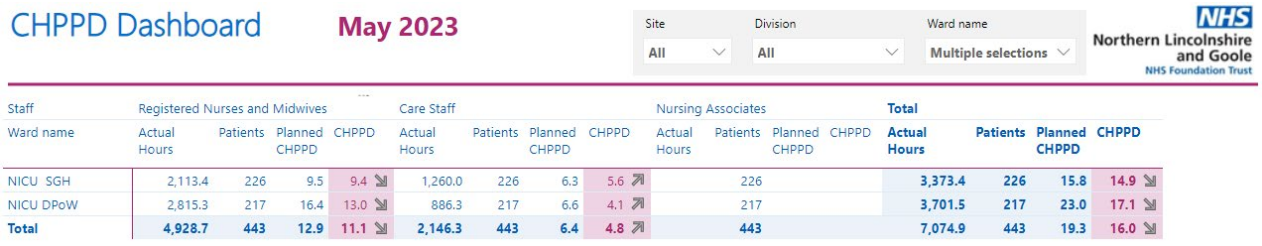
NHS Northern Lincolnshire and Goole NHS Foundation Trust

Staff	Registered Nurses and Midwives						Care Staff					
Day or Night	Day			Night			Day			Night		
Ward name	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %
NICU SGH	1,069.5	1,055.9	98.7%	1,069.5	1,057.5	98.9%	713.0	643.0	90.2%	713.0	617.0	86.5%
NICU DPoW	1,782.5	1,411.5	79.2%	1,782.5	1,403.8	78.8%	713.0	437.0	61.3%	713.0	449.3	63.0%
Total	**2,852.0**	**2,467.4**	**86.5%**	**2,852.0**	**2,461.3**	**86.3%**	**1,426.0**	**1,080.0**	**75.7%**	**1,426.0**	**1,066.3**	**74.8%**

The fill rate for Registered Nurses at Scunthorpe Newborn Intensive Care Unit (NICU) is above the target of 95% for both days and nights. At Grimsby the fill rate is less due to an increase in the establishment which is being recruited to with newly qualified nurses expected to start in the autumn. Bed occupancy is reviewed daily and shifts are only covered when necessary if there is full cot occupancy.

The fill rate for Health Care Assistants is low at both sites. This is due to the daily review and movement of staff between Children and the Newborn Intensive Care Unit to keep areas safe and some vacancy and long-term sickness gaps which are being managed appropriately.

Care Hour Per Patient Day Dashboard (CHPPD)



CHPPD Dashboard May 2023

Site: All | Division: All | Ward name: Multiple selections

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Staff	Registered Nurses and Midwives				Care Staff				Nursing Associates				Total			
Ward name	Actual Hours	Patients	Planned CHPPD	CHPPD	Actual Hours	Patients	Planned CHPPD	CHPPD	Actual Hours	Patients	Planned CHPPD	CHPPD	**Actual Hours**	**Patients**	**Planned CHPPD**	**CHPPD**
NICU SGH	2,113.4	226	9.5	9.4	1,260.0	226	6.3	5.6		226			**3,373.4**	**226**	**15.8**	**14.9**
NICU DPoW	2,815.3	217	16.4	13.0	886.3	217	6.6	4.1		217			**3,701.5**	**217**	**23.0**	**17.1**
Total	**4,928.7**	**443**	**12.9**	**11.1**	**2,146.3**	**443**	**6.4**	**4.8**		**443**			7,074.9	**443**	**19.3**	**16.0**

The CHHPD are in line with the fill rates above and do fluctuate due to the number of occupied cots and the reviewed staffing levels to ensure patient safety. The care staff CHHPD is lower to a planned higher ratio of Registered Nurses to Health Care Assistants.

Maternity Dashboards

Diana, Princess of Wales Hospital

DPOW Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023
Midwife to Birth Ratio	24.8 ↘	26.5 ↗	26.5	25.6 ↘	25.5 ↘	23.3 ↘	24.8 ↗	25.4 ↗	24.3 ↘	23.9 ↘	23.9 ↘	23.9 ↘
Red Flags	2.0	7.0 ↗	9.0 ↗	5.0 ↘	3.0 ↘	3.0	2.0 ↘	2.0	1.0 ↘	1.0	4.0 ↗	11.0 ↗
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0 ↗
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	1.0 ↗	2.0 ↗	0.0 ↘	1.0 ↗	1.0	0.0 ↘	0.0	0.0	0.0	1.0 ↗	1.0	1.0
(c) Missed medication during an admission to hospital	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0	1.0 ↗	0.0 ↘
(d) Delay of more than 30 minutes in providing pain relief	0.0	2.0 ↗	2.0	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	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	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	1.0 ↗	2.0 ↗	4.0 ↗	2.0 ↘	0.0 ↘	1.0 ↗	0.0 ↘	1.0 ↗	1.0	0.0 ↘	1.0 ↗	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.	0.0 ↘	0.0	2.0 ↗	2.0	2.0	1.0 ↘	1.0	1.0	0.0 ↘	0.0	0.0	6.0 ↗
Continuity of Carer %	21.0	23.0 ↗	24.0 ↗	24.0	25.0 ↗							
In Receipt of %	15.0 ↗	13.0 ↘	14.0 ↗	15.0 ↗	15.0							
CoC In Receipt of %	72.0 ↘	89.0 ↗	72.0 ↘	68.0 ↘	66.0 ↘							
Continuity Team Caseload	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	0.0
Actual v Planned Staffing %	92.2 ↗	86.0 ↘	86.0	89.0 ↗	89.5 ↗	97.9 ↗	91.9 ↘	89.9 ↘	91.6 ↗	93.3 ↗	95.3 ↗	95.1 ↘
Labour Co-ordinator Supernumerary Status %	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	19.1 ↘	20.2 ↗	20.3 ↗	26.3 ↗	20.7 ↘	20.5 ↘	20.1 ↘	22.4 ↗	21.3 ↘	19.4 ↘	-3.0 ↘	-4.5 ↘
Vacancies - Registered	17.5 ↗	17.7 ↗	17.8 ↗	19.5 ↗	19.1 ↘	16.1 ↘	16.2 ↗	17.9 ↗	18.0 ↗	16.5 ↘	-0.8 ↘	-1.5 ↘
Vacancies - Unregistered	1.5 ↘	2.5 ↗	2.5	6.8 ↗	1.5 ↘	4.4 ↗	3.9 ↘	4.5 ↗	3.3 ↘	2.8 ↘	-2.2 ↘	-3.0 ↘
Serious Incidents	0.0	0.0	1.0 ↗	1.0	0.0 ↘	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	1.0
Complaints	1.0	2.0 ↗	1.0 ↘	0.0 ↘	0.0	1.0 ↗	0.0 ↘	0.0	1.0 ↗	1.0	0.0 ↘	1.0 ↗
PALS	3.0 ↘	1.0 ↘	5.0 ↗	2.0 ↘	2.0	3.0 ↗	2.0 ↘	2.0	2.0	2.0	1.0 ↘	1.0

Please note that there is incorrect data submitted on the GRIMSBY maternity dashboard (vacancies -3) therefore the vacancies overall are also incorrect.

Scunthorpe General Hospital

SGH Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023
Midwife to Birth Ratio	25.5 ↗	25.8 ↗	25.8	26.0 ↗	23.8 ↘	22.4 ↘	23.4 ↗	21.6 ↘	22.1 ↗	20.2 ↘	20.5 ↗	20.3 ↘
Red Flags	15.0 ↘	27.0 ↗	6.0 ↘	4.0 ↘	14.0 ↗	6.0 ↘	14.0 ↗			2.0	1.0 ↘	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)	1.0 ↗	5.0 ↗	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)	2.0	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	0.0	1.0 ↗	0.0 ↘	1.0 ↗
(c) Missed medication during an admission to hospital	0.0	1.0 ↗	0.0 ↘	0.0	0.0	2.0 ↗	0.0 ↘	0.0	0.0	0.0	1.0 ↗	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	5.0 ↘	11.0 ↗	1.0 ↘	2.0 ↗	5.0 ↗	2.0 ↘	9.0 ↗	0.0 ↘	0.0	1.0 ↗	0.0 ↘	2.0 ↗
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	1.0 ↗	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.	7.0 ↘	10.0 ↗	4.0 ↘	1.0 ↘	9.0 ↗	2.0 ↘	4.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0
Continuity of Carer %	13.0 ↘											
In Receipt of %	5.0 ↘	3.0 ↘										
CoC In Receipt of %	30.0 ↘	33.0 ↗										
Continuity Team Caseload	174.0	0.0 ↘	0.0	0.0	0.0							
Divert / Unit Closures	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	82.7 ↘	81.4 ↘	81.4	80.9 ↘	88.3 ↗	94.0 ↗	89.8 ↘	97.5 ↗	93.2 ↘	102.4 ↗	101.0 ↘	102.3 ↗
Labour Co-ordinator Supernumerary Status %	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	98.9 ↘	100.0 ↗	100.0	100.0
Vacancies	25.1 ↘	24.9 ↘	25.5 ↗	26.1 ↗	21.5 ↘	21.2 ↘	21.0 ↘	20.6 ↘	20.4 ↘	15.0 ↘	19.0 ↗	15.1 ↘
Vacancies - Registered	21.9 ↘	22.7 ↗	23.4 ↗	23.2 ↘	21.3 ↘	18.9 ↘	19.0 ↗	19.0 ↗	19.3 ↗	13.9 ↘	18.4 ↗	15.5 ↘
Vacancies - Unregistered	3.2 ↘	2.2 ↘	2.0 ↘	2.8 ↗	0.3 ↘	2.3 ↗	2.1 ↘	1.6 ↘	1.1 ↘	1.1	0.6 ↘	-0.4 ↘
Serious Incidents	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0
Complaints	2.0 ↗	0.0 ↘	2.0 ↗	1.0 ↘	3.0 ↗	1.0 ↘	0.0 ↘	1.0 ↗	1.0	0.0 ↘	1.0 ↗	0.0 ↘
PALS	1.0 ↘	0.0 ↘	1.0 ↗	3.0 ↗	3.0	1.0 ↘	1.0	1.0	1.0	0.0 ↘	0.0	5.0 ↗

Trustwide

Trustwide Maternity Dashboard

Indicator	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023
Midwife to Birth Ratio	25.0	26.2	26.2	25.8	24.8	22.9	24.2	23.7	23.4	22.2	22.4	22.3
Red Flags	18.0	34.0	16.0	9.0	17.0	9.0	19.0	3.0	1.0	3.0	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)	1.0	5.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	3.0	2.0	2.0	1.0	1.0	0.0	3.0	1.0	0.0	2.0	2.0	2.0
(c) Missed medication during an admission to hospital	0.0	2.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	2.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	2.0	2.0	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	1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	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	6.0	13.0	5.0	4.0	5.0	3.0	9.0	1.0	1.0	1.0	1.0	3.0
(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	1.0	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.	8.0	10.0	6.0	3.0	11.0	3.0	5.0	1.0	0.0	0.0	0.0	6.0
Continuity of Carer %	18.0	12.0	12.0	12.0	14.0							
In Receipt of %	11.0	9.0	8.0	9.0	8.0							
CoC In Receipt of %	58.0	70.0	72.0	68.0	66.0							
Continuity Team Caseload	488.0	305.0	305.0	295.0	311.0							
Divert / Unit Closures	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	88.1	84.1	84.1	85.5	89.0	96.2	91.0	93.1	92.3	97.2	97.8	98.2
Labour Co-ordinator Supernumerary Status %	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	99.5	100.0	100.0	100.0
Vacancies	43.5	44.5	45.2	51.8	41.6	41.1	40.4	42.2	41.7	34.4	16.0	10.5
Vacancies - Registered	38.8	39.8	40.6	42.2	39.8	34.4	34.4	36.0	37.3	30.5	17.6	13.9
Vacancies - Unregistered	4.7	4.7	4.6	9.6	1.8	6.7	6.0	6.1	4.4	3.9	-1.6	-3.4
Serious Incidents	0.0	0.0	2.0	1.0	0.0	0.0	2.0	0.0	0.0	0.0	1.0	1.0
Complaints	3.0	2.0	3.0	1.0	3.0	2.0	0.0	1.0	2.0	1.0	1.0	1.0
PALS	5.0	1.0	6.0	5.0	6.0	4.0	3.0	3.0	3.0	3.0	1.0	6.0
Sickness Absence (Division) %	5.8	6.8	6.4	6.0								

Key – Maternity Dashboards

IOL	**Induction of Labour**	**El LSCS**	**Elective Lower Segment Caesarean Section**	**ARM**	**Artificial Rupture of Membranes**	**SROM**	**Spontaneous rupture of membranes**
CoC	**Continuity of Carer**	**PALS**	**Paediatrics Advice & Liaison Service**				

2. Patient Experience/Service User Feedback

The following section details the feedback received via Formal Complaints, Patient Advice & Liaison Service (PALS) concerns and the Friends and Family Test (FFT). This information is taken from May 2023 and includes performance data and themes.

Formal Complaints and PALS Data

Overall Family Services Data	Jan-23	Feb-23	Mar-23	Apr-23	May - 23
Number complaints open/ongoing	9	9	13	11	8
Number of open complaints out of timescale	0	0	0	1	0
Number complaints closed this month	3	4	2	6	6
Number of new complaints	5	5	5	6	3
	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Number of PALS open	8	8	10	5	11
Number of PALS out of timescale	4	4	4	1	10
Number of PALS closed this month	22	23	25	18	16
Number of new PALS	24	23	23	11	22
	Jan-23	Feb-23	Mar-23	Apr-23	
% of complaints closed within timescale (KPI 85%)	67%	75%	100%	83%	80%
Average length of time to respond to complaints closed (working days)	35	47	44	42	45
% of PALS closed within timescale (KPI 60%)	59%	69%	44%	28%	50%
Average length of time to respond to Pals closed (working days)	8	5	7	14	8

This data can be further broken down into the respective groups :

New of new complaints	Mar-23	Apr-23	May-23
Gynaecology	0	0	0
Obstetrics	1	2	2
Paediatrics (including neonates)	3	4	1
Breast	1	0	0

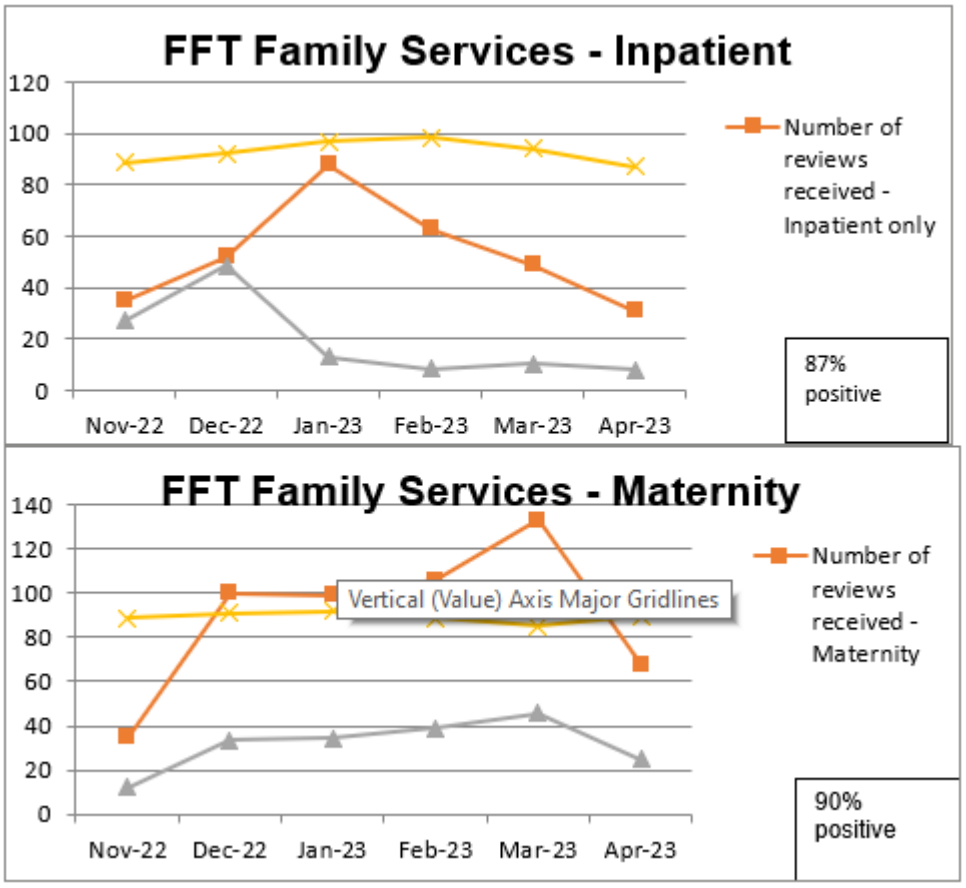
New of new PALS	Mar-23	Apr-23	May-23
Gynaecology	10	5	8
Obstetrics	3	1	6
Paediatrics (including neonates)	9	4	8
Breast	1	1	0

Whilst there was a decrease in overall formal complaints across Family Services in May, there was a significant rise in PALS within Gynaecology, Paediatrics (there were zero neonatal PALS) and Obstetrics. Themes related to:

Delays or pathway issues, communication, and staff attitude – Gynaecology
Midwifery care and communication - Obstetrics
Clinical care, including outpatient management, communication, and discharge – Paediatrics

There were positives to note across the division. The National Maternity Survey for 2022 highlighted high levels of positive feedback around communication and support of mental health during pregnancy. One of the areas for improvement was that partners were allowed to stay overnight and during labour, and this has now been reinstated, in line with pre Covid arrangements. The success of the Maternity Triage Telephone line has meant the hours have been extended. The Hospital at Home pilot in paediatrics has been approved to progress at Grimsby and parent facilities have been updated at Rainforest.

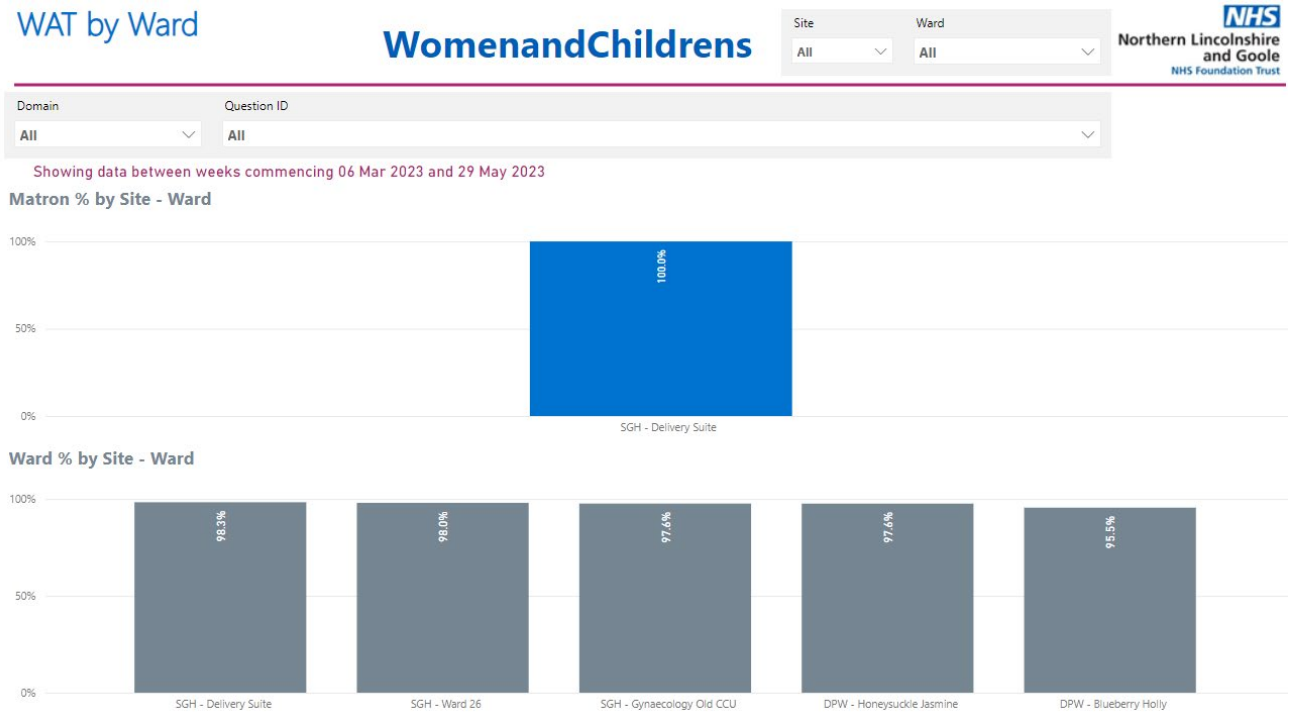
Friends & Family Test Feedback (April data)



The graph data above highlights the Friends and Family Test (FFT) feedback responses collected during April. Continued engagement work with managers is being undertaken by the temporary Patient Experience Manager to increase feedback levels . The main theme arising from the limited feedback was that of delays in care and getting information . Junior medical staff and their clinical competencies and communication was highlighted however, caution needs to be applied to generalising due to the low numbers collected.

3. Assurance

There were no Maternity or Neonatal visits within the 15 Steps Schedule for May 2023. Included in the report is the most recent WAT (Ward Assurance Tool) compliance data for the period 6 Feb – 24 April 2023. Completion of WAT surveys are variable dependant on the area with a possible 12 during the date period. Low completion of the survey has been discussed in the Nursing Metrics Panel and is being addressed, however it is noted that where the surveys have been completed, compliance is high.



SGH – Scunthorpe General Hospital
DPOW – Diana, Princess of Wales Hospital

Managers WAT SGH:

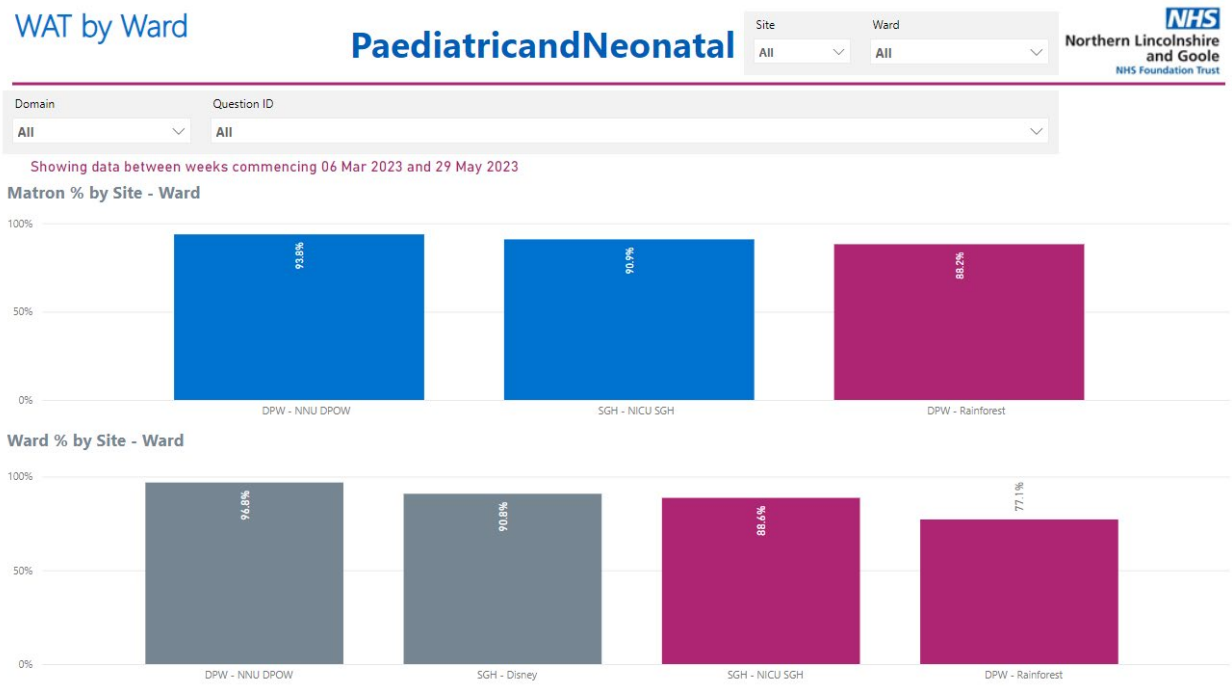
- Delivery Suite 98.6% compliance with questions asked (9/12 WAT completed)
- Ward 26 98% compliance with questions asked (1/12 WAT completed)

Managers WAT DPOW:

- Honeysuckle Jasmine 97.5% compliance with questions (12/12 WAT completed)
- Blueberry Holly 95% compliance with questions (11/12 WAT completed)

No Matron WAT surveys reported

Neonatal Areas across Scunthorpe and Grimsby



Manager Ward Assurance Tool (WAT) SGH

- Neonatal Unit (NNU) 89.9 % compliance with questions (9/12 WAT completed)

Matron Ward Assurance Tool (WAT) SGH

- Neonatal Unit (NNU) 90.4% compliance with questions (8/12 WAT completed)

Manager Ward Assurance Tool (WAT) DPOW

- Neonatal Intensive Care Unit (NICU) 96.8% compliance with questions (2/12 WAT completed)

Matron Ward Assurance Tool (WAT) DPOW

- Neonatal Intensive Care Unit (NICU) 95.5 % compliance with questions (1/12 WAT completed)

4. Feedback

Maternity & Neonatal 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, Local Maternity and Neonatal System (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 walkaround for June was undertaken on the Grimsby site. This was a positive walkaround and staff were keen to share with us the positives about their areas. This included an Internationally trained midwife describing support given to her as she settles into her new working and living environment.

Escalated Issues:-

- Perinatal Mental Health midwife described concerns with regard to workload

Safety Mailbox and Shout Out Actions

Staff can raise safety concerns through a Safety Mailbox and via Shout Out Wednesday, which occurs monthly cross site. This is a short gathering on the clinical areas where all grades of staff are encouraged to attend to express any safety concerns that they may have. A summary of concerns raised actions and evidence of progress is detailed in the table below. All are progressing and there are no areas for escalation.

	Overdue or Incomplete
	In Progress
	Completed

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Date Raised	How concern was raised	Site DPOW/SGH/ Trustwide	Concern Raised	Actions Required	Responsible Person	Action by Date	Status	Evidence Of Completion
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	31/08/2023		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. 27/04/23 Update from Iona, Claire shipley is now dealing with this and will be chasing up. 24/05/23 email sent to Claire Shipley for further update, still awaiting reply. 27/06/23 Natalie Jenkin working with Claire Shipley regarding this.
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 Tracy Martin	31/08/2023		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.27/04/23 Update from Iona, Claire shipley is now dealing with this and will be chasing up. 24/05/23 email sent to Claire Shipley for further update, still awaiting reply.27/06/23 Natalie Jenkin working with Claire Shipley regarding this.
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. 18.04.23 in process of choosing them. 23/05/23 The position remains the same for this action. 21/06/23 The lamps have been ordered now. Awaiting arrival.
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	30/06/2023		15/03/2023. Partosures have been ordered. 18.04.23 point of care have removed the fibronectin monitor due to there being no fibronectin cartridges in the country. Training has been paused due to no equipment avalible to use. 08/06/23 still awaiting delivery. 10.07.23 Cartridges now available in all areas however CDS have had to order a control and are awaiting its delivery
30/03/2023		SGH	Lack of refreshments for patients waiting for appointments or medical professionals	Hydration station for staff and patients to be purchased through Health Tree Foundation	Donna Airey & Ellie Monkhouse	30/06/2023		Chief Nurse enquiring with Health Tree Foundation for bid.
18.04.22		SGH	The tiles on the wall in the sluice are falling off and have narrowly missed hitting a member of staff. They have been on since 1992 and the estates have said the recent hot weather has probably affected them	emailed ward manager to ask if it could be followed up for remedial work to be carried out for safety of staff using the area	Claire Brothwell & Shaliny Majara	31/01/2023		managers emailed 17/08/22 6/12/22 update requested. There is a mini refurbishment for ward 26 and should have this issue resolved. 18.01.23 update from manager- coflict in avalibility of funds between estates and division buisness manager so no further progress. 15.03.23 The mini refurbishment of ward 26 is underway and the wall area will have been resolved. 18.04.23 The tiles have not been replaced as planned and concerns are the old tiles will continue to fall off. Ward manager will issue a job requestion again to have the area made safe. 21.04.23 tiles have been re-secured but a request is being entered to replace with the plastic boarding which will be safer. 21.06.23 Ward 26 manager has applied for the perspex wall

17/05/2023		DPOW	Lack of community appointments available due numerous clinics being cancelled. Resulting in women having to wait weeks for an appointment.	Escalated concern to Head of Midwifery via email.	Nicky Foster	17/08/2023		17/05/23 HOM reviewing potential changes to shifts to encourage other staff to pick up vacant shifts.27/06/23 Expressions of interest for 12 hour bank shifts in community have been advertised.
17/05/2023		DPOW	Flooring to several areas in Jasmine/Honeysuckle are raised and lifting.	Email sent to facilities	Carla Siviter	17/08/2023		18/05/23 Confirmation and log number from estates (420308)
17/05/2023		DPOW	Damage to 'crashbars'/handrails on jasmine	Ticket logged with facilities	Carla Siviter	17/08/2023		18/05/23 Confirmation and log number from estates (420310)
17/05/2023		DPOW	Ward mobile phones should be taken into delivery rooms when caring for labourers, co-ordinators are receiving calls other staff members without correct information and sbar.	Email sent to ward managers	Vicki Booth Carla Siviter	17/08/2023		This is being discussed at the team meeting with all staff and ward managers are purchasing a second phone for each ward. 24/05/23 Vicki Booth in discussion with Keeley Gaunt & Wayne Woolrdige re purchasing further phones and improving the quality of the network.
29/05/2023		SGH	Raised on Safety Champions Walkround about the allocation of management time for larger ward areas.	Escalated concern to Head of Midwifery via email.	Nicky Foster	30/11/2023		29/05/23 Email sent to Nicky Foster. 27.06.23 HOM will be having a discussion with the chief nurse.
21/06/2023		SGH	the desk chairs covers are split and coming off and are scratching the staffs legs and are an infection risk	New chairs required and old ones disposed of.	Kendra Thomas	31/08/2023		21/06/23 email to Courtney Herron to help to order 3 new chairs. 27.06.23 chairs ordered
21/06/2023		SGH	Flooring around the door entry of the cleaners cupboard is coming away and will beome a trip hazard	Requesition to be sent to be repair	CDS manager	30/09/2023		21/06/23 requisition to be sent
08/06/2023		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 requesting update. 28/02/23.25/04/23. Colleen has re-sent an email to Iona to see if there is an update. 05/05/23 update from Iona Johnson, the need for the new system is in the Divisional Business Plan in the Capital requirements section as priority number 1 and was highlighted in the recent Business Planning round how important this is. Iona has not heard back on the decision re capital investment for next year so still waiting for outcome on this. Static Systems have been contacted to assess and provide a quote in readiness if funding is allocated. Remains on risk register with colleen as handler and claire shipley as owner now as Iona on maternity leave. 23/06/23 at Governance it was felt that until the system had been adjusted to completly erradicate the issue it would remain as a non resolved risk
		DPOW	Perinatal Mental Health midwife described concerns with regard to workload	To explore feasibility of further support	Nicola Foster	30/11/2023		

Key – Maternity Sustainability Plan

QI	**Quality Improvement**	**SMART**	**Specific Measurable Achievable Timebound**	**PMA**	**Professional Midwifery Advocate**	**HOM**	**Head of Midwifery**
O&G	**Obstetrics & Gynaecology**	**SOP**	**Standard Operating Procedure**	**NED**	**Non Executive Director**	**CN**	**Chief Nurse**
MVP	**Maternity Voices Partnership**	**HRBP**	**Human Resources Business Partner**	**COO**	**Chief Operating Officer**	**GD**	**Staff member**
JL/TM	**Staff member**						

6 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 Northern Lincolnshire and Goole NHS Foundation Trust, that utilises a Nationally recognised Triage Model (BSOTS). In order to enhance the patient experience and care.

Following the successful rollout of Phase 1 & 2 – Telephone triage – the 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 includes 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.

Two key elements that need to be addressed before a go live date can be agreed is the resolution of a Union challenge by affected Health Care Assistants which is been worked through with the support of Human Resources colleagues. Following a meeting with the Human Resources Director, Unions and Associate Chief Nurse for Maternity a proposal to board is been prepared for approval.

The second element is to agree the estates changes that are required to meet BSOTS requirements and allow a productive flow of patients. Estates are working with the service to explore all options and provide quotes and timescales for completion.

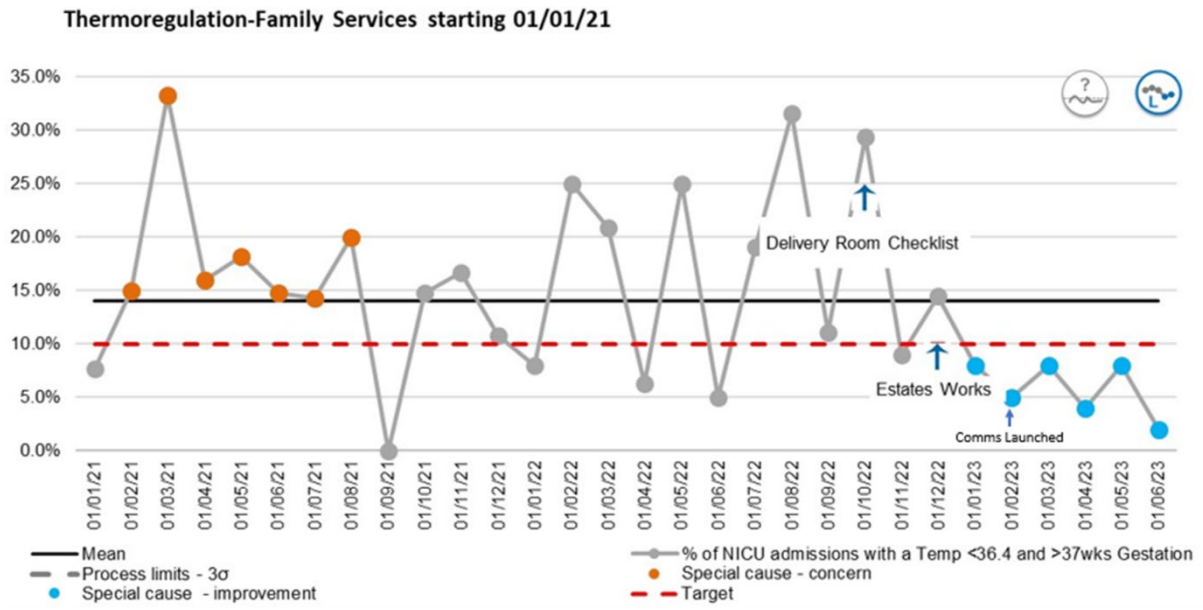
Both elements have been escalated have been escalated through the project governance to Maternity Transformation and Improvement Board and are actively engaged in finding resolutions. Pending successful resolution to the two key issues outlined above a tentative go live date of October 2023 has been proposed.

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 the Newborn Intensive Care Unit (NICU).

This Quality Improvement project's aim is to have no more than 10% of Newborn Intensive Care Unit (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 (mean) position is ~16% the Statistical Process Control (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.



Further estates works were concluded on Jasmine Ward at Grimsby during the reporting period to fix / replace two draughty windows that were contributing to the difficulties in maintaining the unit temperatures.

The SPC chart continues to show a measurable improvement with 6 data points below the mean with 6 data points below the 10% target. This has resulted in fewer patients been admitted to NICU for this condition improving babies and family experience whilst saving trust resources. This data will continue to be monitored to ensure sustainability especially throughout the colder months.

<u>Induction of Labour (IOL) Improvement</u>
This projects focus is to standardise the care pathway for Induction of Labour by complying with current National Institute for Health and Care Excellence (NICE) recommendations and standardise the information given to patients. This is to ensure that they receive evidence-based information and the information givers (midwives and clinicians) are all giving consistent information to patients.

Initial audits showed that standardised practise and information were not always adhered to. This initiated a quality improvement project that has been clinically led to update the current guidance, engage medical teams and provide training to ensure understanding with the update guidance as approved by the divisional governance process.

This updated guidance and process is due to go live from the 22nd June 2023 where it will be audited to ensure correct standards are met.

Data collection has commenced to capture measurable improvements post standardisation, this will be compared to baseline data captured at the start of this quality improvement project in due course.

7 Serious Incident Reporting

Open Maternity Serious Incident Investigations as at 08.06.23

There are currently 5 Maternity Serious Incidents (SIs) open in the Trust. One of these is being investigated by the Healthcare Safety Investigations Branch (HSIB).

STEIS Ref	Site	Description	Stage	Immediate Actions	Deadline date
2022 20796	GRIMSBY	Unexpected baby death	Investigation	The neonatal resus pro forma is being reviewed as it is not user-friendly for an emergency situation.	HSIB investigation
2022 26951	SGH	Intrauterine Device (IUD) Delayed Induction	Approval Process	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.	20.06.2023
2022 18557	GRIMSBY	Birth injury – fractured skull	Approval process	To add to safety huddle re: use of fetal pillow for full dilatation lower segment caesarean section (LSCS) and not to manually disimpact fetal head.	12.06.2023
2023 8658	GRIMSBY	Maternal Cardiac Arrest	Investigation	Reviewing the issues relating to referral and acceptance for Interventional Radiology (Hull University Teaching Hospital NHS Trust (HUTH) Investigating the decision making and potential disagreements between staff during the cardiac arrest.	20.07.2023

2023 10062	GRIMSBY	Intrauterine Device (IUD)	Investigation	Matron discussed the case with the midwife regarding escalation. Educational supervisors discussed the case with the two registrars involved.	11.08.2023

Maternity Serious Incident Completed Reports (June 2023)

STEIS Ref	Site	Description	Stage	Learning
2023 398	GRIMSBY	Healthcare Safety Investigation Branch (HSIB) – Intrauterine Device (IUD)	Action Plan Ongoing	• Patients who are pregnant must be put on the correct care pathway, reflecting their risk status, including where there are concerns about fetal growth. • Staff to invite mothers who contact the triage service with concerns about fetal movements, for assessment in line with national guidance (Saving Babies Lives Care Bundle version 2 (2019)). • Staff should be able to recognise concerns with maternal and fetal wellbeing in a timely manner. • Fetal scalp electrode leads must be available at a location on each ward where these can be easily located in an emergency. • Staff must use the emergency call system to escalate concerns, and be supported to urgently expedite birth if needed, when a baby's heart rate cannot be monitored. • Staff to be conscious of situational awareness.

Risks and themes

- Risk of unavailability of second obstetric theatre in Scunthorpe - potential of delayed access or unavailability of a second obstetric theatre for use in an emergency (for example emergency caesarean section).
- Abnormal cardiotocography (CTG) require immediate escalation to the registrar or consultant and a clear plan to be made with potential decision for delivery.

Maternity Serious Incident Completed Reports (May 2023)

STEIS Ref	Site	Description	Stage	Learning points
2022 2522	GRIMSBY	Maternal Cardiac Arrest	Action Plan Ongoing	• Administer antihypertensive medication in severe hypertension, in a timely manner. • Avoid administration of Syntometrine and Ergometrine to patients with hypertension. • Full drug names, not abbreviations, to be written on handover boards. • All clinical rooms must be able to accommodate resuscitation equipment and trollies, including bereavement rooms if these are used as clinical rooms.
2022 7551	Grimsby	Neonatal Death	Action Plan Ongoing	• When there is a lack of agreement between staff regarding the interpretation of a cardiotocography, escalate to a Senior Clinician. • A new antenatal cardiotocography interpretation sticker to be created and used, that incorporates an action plan to aid better focus on the whole clinical picture. • All cardiotocography reviews should be performed using either antenatal cardiotocograph (CTG) classification sticker or intrapartum cardiotocograph (CTG) classification as appropriate, and not to be written in freehand. • Emphasis on defining types of fetal decelerations to be shared at both sites. • There should be shared communication between the anaesthetic team and the obstetric team of the fetal heart rate and maternal pulse on commencing cardiotocography in theatre and regular communication thereafter.
2022 10750	Grimsby	Fractured skull following instrumental delivery	Action Plan Ongoing	• Written consent to be taken for all instrumental births (undertaken in both the operating theatre and the birth room). • Staff to be aware of the rare complication of subgaleal haematoma and neonatal clinical presentation.
2022 6473	GRIMSBY	Healthcare Services Investigation Branch (HSIB) – Hypoxic Ischemic Encephalopathy (HIE)	Closed	• All women / birthing people should be risk assessed on admission to ensure mothers / birthing people are assigned the correct care pathway with the appropriate fetal monitoring. • When carbon dioxide levels are unresponsive, further measures to be used to reduce the Baby's respiratory efforts to help achieve normal levels promptly and maintain them.
2022 17384	SGH	Pre-term birth neonatal death	Closed	• Maternity notes must be available to all midwives for booking appointments. • All women who meet the criteria must be referred to the Pre-Term Birth Prevention Clinic (PTBPC) using the referral form within the guidance. All women following their first scan (dating scan) must be seen by a registered health professional (Midwife/ Doctor), to ensure relevant advice, guidance, information and referral for further diagnostic testing or medication is provided. • The Vaginal Birth After Caesarean (VBAC) Checklist to be completed fully and referrals made to Pre-Term Birth Clinic as required.

8 Sustainability Plan

The Trust is moving towards an exit from the Maternity Safety Support Programme. As part of this process the initial gap analysis diagnostic undertaken in 2021 has been reviewed. This gap analysis and Maternity Self-Assessment Tool has been amalgamated into a Maternity Sustainability Plan (please see **Appendix I**.) The plan needs to be supported by the Trust Board in order to progress the exit plan external process. As identified in the diagnostic review, the Trust has achieved, with evidence, the majority of the initial actions identified. Our Maternity Improvement Advisors and our regional maternity team, including the Regional and Deputy Chief Midwife are supporting us with this process. There is an expectation as part of our exit plan that the Board are kept up to date on the progress on delivery of the plan and this was presented at the Trust Board meeting in June 2023.

These actions are 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 Maternity Sustainability Plan will be monitored through the Maternity Quality Improvement meeting and Maternity Transformation & Improvement Board.

9 Three-year delivery plan for maternity and neonatal services (Single Delivery Plan)

The national plan was published in March 2023. The delivery plan is directed at frontline staff and leadership and describes the building blocks that need to be in place to ensure the needs of women, babies and families are at the heart of services. It summarises responsibilities for each part of the NHS including Trusts, Integrated Care Boards and Systems including Local Maternity and Neonatal Systems and Operational Delivery Networks, and NHS England. Maternity deliverables and action plan completed. Work will now progress on developing for all themes and achieving compliance with the plan.

10 Clinical Negligence Scheme for Trusts (CNST) Evidence

Maternity Incentive Scheme (CNST) - year four

Following a robust confirm and challenge process both internally and with the Integrated Care Board (ICB)/Local Maternity & Neonatal System (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, has been published. Maternity services are currently undertaking a benchmarking exercise to understand the changes from year four and expectations for year 5. The latest Clinical Negligence Scheme for Trusts (CNST) update is attached as **Appendix II**.

11 Upcoming External Visit

The planned National Maternity Team assurance visit will be replaced by an assurance visit from the Local Maternity and Neonatal System (LMNS) (3 November 2023).

12 Conclusion

The oversight report highlights all the work being undertaken within the maternity services. Seven internationally educated midwives arrived at the Trust in March and May 2023 and have all passed their midwifery Objective Structured Clinical Examination (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.

Complaints and Patient Advice & Liaison Service (PALS) concerns remain low, and these are investigated and resolved within the expected time limits. The Friends and Family Test (FFT) shows excellent feedback with an average score of 4.92 (increased from 4.78) and an 93.9% (increased from 88.3%) positive experience.

There were no 15 Steps Challenge Visit during May 2023.

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 Maternity Voices Partnership 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. A positive meeting between the Trust, Integrated Care Board (ICB) and Local Maternity and Neonatal System (LMNS) to highlight the need for urgent recruitment into the Maternity Voices Partnership Lead post has led to a planned interview date in July 2023 (role currently advertised widely)

There are a number of on-going quality improvement projects including maternity triage services, induction of labour and neonatal thermoregulation All 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.

Maternity deliverables and action plan completed. Work will now progress on developing for all themes and achieving compliance with the plan

Year 5 Clinical Negligence Scheme for Trusts (CNST) requirements have been released and a benchmarking exercise to understand the changes from year four and expectations for year 5 is being undertaken.

Serious incidents (SI’s) and Healthcare Safety Investigation Branch (HSIB) cases remain low with one newly reported serious incident (SI) in May 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 Local Maternity and Neonatal System (LMNS) Perinatal Quality Safety and Assurance (PQSAG) meeting.

Appendix I – Maternity Sustainability Plan

Action ID	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date / Timeline	Evidence
MSAT2	Maternity strategy, vision and values	Maternity strategy in place for minimum 3-5 years	14/4/23 Draft document, awaiting illustration to be added prior to wider circulation for comments. 15/6/23 Strategy written and in governance process - due for ratification O&G Governance June 23. 23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy
MSAT3	Maternity strategy, vision and values	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	14/4/23 as above 15/6/23 As above. 23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy
MSAT4	Maternity strategy, vision and values	Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	14/4/23 as above 15/6/23 As above. 23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy
MSAT5	Maternity strategy, vision and values	Maternity strategy aligned with trust board LMNS and MVP's strategies	14/4/23 as above 15/6/23 As above. 23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy
MSAT6	Non-executive maternity safety champion	NED appointed as one of the board level maternity safety champions and working to national role descriptor	14/4/23 NED in post, working to national role descriptor. Core member of Safety Champion monthly walk-rounds				Chief Nurse	Apr-23	In h/family services/divisional managers/maternity/self assessment tool
MSAT7	Multi-professional engagement workshops	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality improvement plans	Evidence required 15/6/23 Proposing formal meeting 2/12 based on framework - incorporatiing Trust patient safety culture (including maternity PSIRF)				Division Tri	01/06/2023 Amended target date 31/12/23	
MSAT8	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place	Evidence required 15/6/23 Evidence sent (DS)				Dave Sprawka	Feb-23	EvidenceWBB
MSAT9	Multi-professional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	Evidence required 15/6/23 RD to contact BC (LMNS)	Intention for a 6 monthly review of the maternity patient safety profile and its link to the Patient Safety Incident Response Plan. Risk Profile and theming being taken forward, with a view to arrange a meeting with LMNS to progress during July/August and when inital plan agreed, to review 6 monthly with with learning and review of safety profile. PSIR policy in draft, setting out the PSIRP monitoring approach and orgnisation wide safety			Richard Dickinson, Associate Director of Quality Governance	Sep-23	

	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date / Timeline	Evidence
MSAT10	Clearly defined behavioural standards	Schedule of focus for behavioural standards framework across the organisation	Evidence required. Divisional framework in development. 15/6/23 Evidence required from GD 5/7/23 •Leadership & management behavioural framework available through the leadership academy at national level (attached) •In line with our Trust strategic plac (p9) our Values based leadership development programme focusses on compassionate & inclusive leadership : oLeading self (self awareness, unconscious bias, personal values) oleading others (situational leadership, just & learning culture), oachieving results (clear direction, coaching & feedback, inclusive leadership), oleading & managing change				HRBP	Jul-23	Leadership and management behavioural framework
MSAT11	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	Evidence required. In progress at divisional level. 15/6/23 Evidence required from GD. Have maternity behavioural charter 5/7/23 •Leadership and management behavioural framework available through the leadership academy at national level (attached) •In line with our Trust strategic plac (p9) our Values based leadership development programme focusses on compassionate & inclusive leadership : oLeading self (self awareness, unconscious bias, personal values) oleading others (situational leadership, just and learning culture), oachieving results (clear direction, coaching & feedback, inclusive leadership), oleading and managing change (change management and quality improvement methodology).				HRBP	Jul-23	Leadership and management behavioural framework
MSAT12	Maternity governance structure	Maternity governance and leadership team roles review	Review underway supported by MIA. Recruitment in progress for additional leadership roles 15/6/23 Review undertaken. Appointed to Maternity Audit and Compliance Manager role and Deputy Governance Lead post currently out to advert.				Division Tri	May-23	
MSAT13	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.	Evidence required 15/6/23 Update from RD - Sharing Learning document currently under review	Existing Learning Strategy document reviewed, consulting on through Quality Governance Group and PSIRF implementation Group. Awaiting responses as of 7/7/2023. Annual review date being applied to this version as last version was in 2020 on a 3 year cycle. Relaunch of Trust learning group to follow, with refreshed membership and focus.			Richard Dickinson, Associate Director of Quality Governance	Aug-23	http://nlgnet.nlg.nhs.uk/DocumentControl/Documents/Learning%20Strategy%20(DCP363).pdf#search=learning%20strategy
MSAT14	Safety huddles	Audit of compliance against safety huddle guideline/SOP	Evidence required 15/6/23 JL/TM completing SOP and audits. 30/6/23 SOP in governance process (out for comments to governance group)7/7/23 SOP ratified and on HUB - audit to be regisitered	SOP ratified and available on the HUB			Division Tri	Jun-23	SOP
MSAT15	Trust wide Swartz rounds	Annual schedule for Swartz rounds in place	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz
MSAT16	Trust wide Swartz rounds	Multi-professional attendance recorded and supported as part of working time	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz
MSAT17	Trust wide Swartz rounds	Broad range of specialties leading sessions	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz

Red	Overdue
Amber	On track
Green	Completed

Key – Maternity Sustainability Plan

QI	**Quality Improvement**	**SMART**	**Specific Measurable Achievable Timebound**	**PMA**	**Professional Midwifery Advocate**	**HOM**	**Head of Midwifery**
O&G	**Obstetrics & Gynaecology**	**SOP**	**Standard Operating Procedure**	**NED**	**Non Executive Director**	**CN**	**Chief Nurse**
MVP	**Maternity Voices Partnership**	**HRBP**	**Human Resources Business Partner**	**COO**	**Chief Operating Officer**	**GD**	**Staff member**
JL/TM	**Staff member**						

Appendix II

Northern Lincolnshire and Goole NHS Foundation Trust

Family Services Division

NHS Resolution –

Clinical Negligence Scheme for Trusts, Year Five

Nicola Foster

Associate Chief Nurse – Midwifery, Gynaecology and Breast

July 2023

1.0 Introduction

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

The Maternity Incentive Scheme Year 5 outlines a requirement to demonstrate they have achieved all of the ten safety actions as of 1 February 2024 and would therefore recover the element of their contribution relating to the CNST maternity incentive fund and would also receive a share of any unallocated funds. The Trust has submitted full compliance to the year three and year four scheme.

What is evident throughout the scheme is the need for the Trust Board and Integrated Care Board (ICB) to be cited on the safety of maternity services, therefore this report will be completed on a quarterly basis to ensure the Quality and Safety Committee (acting on behalf of the Trust Board) has sight on the position, work undertaken and future plans.

This report will present the progress on the 10 safety actions in respect of Maternity Incentive Scheme – Year Five.

2.0 Current position as of July 2023 – Exception report

No	Maternity safety action	Progress	Challenges/ Actions
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Meet action with embedded process	None at present – anticipated achievement
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Working towards submission of data	-Requires accurate data submission in July 2023 -Transfer to new Electronic Maternity System in Autumn 2023
3	Can you demonstrate that you have transitional care services to minimise separation of mothers and their babies?	On-going audits / review mtgs	None at present
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Anaesthetic / Neonatal staff on-going	Additional requirements relating to locum medical staff with 6 month audit requirements
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	On-going monthly audits	To undertake 6 monthly workforce review
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Awaiting implementation tool from NHS England	Extensive and involved work across 6 elements.
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Co-production embedded	To establish process for seeking themes and actions in respect of feedback.
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	On-going training continues	On-going monitoring
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	On-going	Maternity and Neonatal Oversite Report
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?	Embedded process	None at present -anticipated achievement

HSIB – Healthcare Safety Investigation Branch
CQC – Care Quality Commission
MNSI – Maternity & Newborn Safety investigations Special Health Authority

Maternity Incentive Scheme, Year Five

Requirements

Safety Action 1 – National Perinatal Mortality Review Tool

The National Perinatal Mortality Review Tool reviews perinatal deaths to a required standard.

Required Standard

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

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

*c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30 May 2023.** 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.*

*d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.***

Current position

The Perinatal Mortality Review Tool (PMRT) is well embedded and currently meets the expected standard. All eligible deaths have been notified to MBRRACE-UK within seven working days and parents are invited to participate and have their perspective and questions included in the review.

***MBRRACE – Mothers & Babies: Reducing Risk through Audits & Confidential Enquiries**

Safety Action 2 – Maternity Services Data Set (MSDS)

Required Standard

This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.

1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.

2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)

3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:

Midwifery Continuity of carer (MCoC)
Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.

i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.

ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.

These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation.
Final data for July 2023 will be published in October 2023.

If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information).
4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.

5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.

Current position

The Maternity Incentive Scheme, Year five is requiring confirmation that the data set for maternity submits accurate data and measurement of the safety action is for data submitted in July 2023. This data will be published in October 2023. There is a need that 10 out of 11 Clinical Quality Improvement Metrics are met as well as at least 90% of women booked within that month have a valid ethnic category.

A Scorecard – *Clinical Negligence Scheme for Trusts: Scorecard* is published which will provide evidence for the standard to be met in that part. The Trust is implementing a new Maternity Information System which will commence later in the year. The embedding of the system will take time and therefore there is a risk that the submission data could be askew initially. The Maternity Incentive Scheme does make reference to Trusts that may not meet this criterion by supporting the monthly use of a Data Quality Submission Summary Tool supplied by NHS England and which we will be utilising.

Midwifery Continuity of Carer (MCoC) is included within Safety Action 2 and it is anticipated that with the Poppy Team at Grimsby continuing the expectation within the safety action will be met.

Safety Action 3 – ATAIN

Required standard

a) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU (Neonatal Unit) of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided.

An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS (Local Maternity Neonatal System) and ICB (Integrated Care Board).

c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM (British Association of Perinatal Medicine) Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.

Current position

The Maternity Incentive Scheme, year five builds on the work undertaken for year three and four. The on-going ATAIN (Avoiding Term Admissions Into the Neonatal Unit) multi professional team process continues with learning cascaded across the service. Auditing of Transitional Care and those babies admitted to the Neonatal Unit who are 37 weeks and over with a focus if separation could have been avoided is on-going.

The Trust continues to work with the BAPM framework for practice and pathways and evidence will be submitted as part of that work.

Safety Action 4 – Clinical Workforce

Required Standard

a) Obstetric medical workforce

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota
or
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
or
c. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf

3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

rcog-guidance-on-compensatory-rest.pdf

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

Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.

b) Anaesthetic medical workforce

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

c) Neonatal medical workforce
The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing

*If the requirements **have not been met** in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies.*
*If the requirements **had been met** previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies.*

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

*If the requirements **have not been met** in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies.*
*If the requirements **had been met** previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies.*

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

Current position

Obstetric Medical Workforce – the Trust is in the process of establishing that the employment of short- and long-term locums meets the requirements as set out in the Royal College of Obstetrics and Gynaecology guidance. Once established a 6-month audit is to be undertaken.

Required to produce and ratify a Standard Operating Policy for Compensatory Rest for Consultants / SAS (Specialty and Specialist) Dr's. Evidence can also be included from feedback received regarding compensatory rest.

A 6-month audit is also required.

Anaesthetic medical workforce – the required standard is similar to year four and the Trust meets the criteria.

Neonatal medical / nursing workforce – a review of compliance against the BAPM national standards is required to be undertaken within the year five timeframe.

Safety Action 5 – Midwifery workforce planning

Required Standard

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

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

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

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

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.

Current position

This safety action is similar to the one in year four and therefore there has been a continuation of the audits in respect of 1:1 care in labour and supernumary status of the labour co-ordinator both of which the Trust consistently achieves 100% for.

There requires to be an oversight report that covers staffing/safety issues to the Trust Board every 6 months during the year 5 period. This is undertaken annually led by the Chief Nurse and which will be completed in the next few months.

Safety Action 6 – Saving Babies' Lives Care Bundle Version Three

Required Standard

1) Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.

2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available

Current progress

Saving Babies Lives Care Bundle Version Three which aims to reduce perinatal mortality includes a further element – management of pre-existing diabetes in pregnancy.

Elements –

1. Reducing smoking in pregnancy
2. Fetal growth – risk assessment, surveillance and management
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour
5. Reducing preterm births and optimising perinatal care
6. Management of pre-existing diabetes in pregnancy

There will be a newly developed implementation tool which is due for publication which will enable the Trust to track and evidence improvement as well as compliance with the requirements set out in the Care Bundle. The implementation tool is based on the interventions, key process and outcome measures identified within each element.

There is an expectation that the Trust will demonstrate implementation of 70% of interventions across all 6 elements overall and implementation of at least 50% for each element.

There is a requirement that there will be be two quarterly quality improvement discussions between the ICB and the Trust using the implementation tool with progress against locally agreed improvement aims and evidence of sustained improvement where high levels of reliability have already been achieved. In addition, there is to be a review of local themes and trends with regard to potential harms in each of the elements.

The implementation tool will support the evidence collated however the requirement for this Safety Action is large and therefore it has been possible to appoint to a post to specifically support this and the other actions. The tool is anticipated in the near future which will enable the on-going audits and evidence to be collated and form part of the overarching achievement of this safety action.

Safety Action 7 – Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Required Standard

1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.
2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.
3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.

Current progress

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

Process to be established and embedded in respect of service user feedback being collated and acted upon within the neonatal and maternity service and reviewing themes and subsequent actions.

The Trust has had a long standing excellent joint working relationship in co-production, which is anticipated will continue with a newly appointed chair for the local MNVP (interviews planned for July 2023) It is expected that this safety action will be achieved.

Safety Action 8 – Evidence 3 elements of local training plans and 'in-house', one day multi professional training

Required Standard

1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.
2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.
3. The plan is developed based on the "How to" Guide developed by NHS England.

Current progress

Training continues as previous years with collation of attendance on-going and includes all staff groups as set out in the maternity incentive scheme. There is an expectation that the 12 consecutive months from the year four end date is used to calculate the % compliance, however the training continued without any gap which should not create an issue with achieving the 90% of each staff group compliance rate.

Safety Action 9 – Robust processes to provide assurance to the Board on maternity and neonatal safety and quality issues

Required Standard

a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.

b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.

c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.

Current progress

a) Perinatal Quality Surveillance model under reviewed)
b) Evidence available with regard to discussions relating to safety intelligence and concerns raised by staff and service users. Plan for the Trust to implement Patient Safety Incident Response Framework later in the year.
c) Third of quad currently undertaking Perinatal Culture and Leadership Programme.

Safety Action 10 – Reporting of all qualifying cases to HSIB / CQC / MNSI and to NHS Resolution Early Notification Scheme

Required Standard

*A) Reporting of all qualifying cases to HSIB/CQC//MNSI from **30 May 2023** to **7 December 2023.***
*B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from **30 May 2023** until **7 December 2023**.*
C) For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the Trust Board are assured that:

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

Current progress

The maternity service work closely with relevant departments to ensure that all relevant cases are reported to HSIB / CQC / MNSI as well as the NHS Resolution Early Notification scheme. It is anticipated that this safety action will continue and be compliant.

NLG(23)136

Name of the Meeting	**Trust Board**
Date of the Meeting	1 August 2023
Director Lead	Fiona Osborne and Kate Truscott, Non-Executive Directors
Contact Officer/Author	As above
Title of the Report	**Highlight report of Quality and Safety Committee meetings held on 20 June and 25 July 2023**
Purpose of the Report and Executive Summary (to include recommendations)	To provide the Trust Board with a summary of the issues and matters considered by the Quality & Safety Committee at its meetings on 20 June and 25 July 2023. Key elements to note are captured below: • the Annual Reports had been received for Learning from deaths and Complaints • the current situation on the Paediatric Audiology issue • the National Dementia Audit reported a lower than benchmark rate outlier alert for delirium screening as highlighted to the committee from the Quality Governance Group
Background Information and/or Supporting Document(s) (if applicable)	Highlight report
Prior Approval Process	☐ TMB ☐ Divisional SMT ☐ PRIMs ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/a
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/a

Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	7 August 2023
Report From:	Incorporating Quality & Safety Committee meetings held on 20 June and 25 July 2023

Highlight Report:

Maternity sustainability plans were discussed, recognising the goal of coming out of the Maternity Safety Support Programme. The Clinical Negligence Scheme for Trusts (CNST) standards for Maternity have been released and the team are focusing their attention on development of a prioritised action plan for the time dependent elements being in place for July 2023. The Maternity Voices Partnership lead role was currently vacant, with plans to fill this post being pursued with involvement of the Local Maternity and Neonatal Systems (LMNS). This vacancy carries some risk due to it being part of the CNST requirements.

The Learning from Deaths Annual Report was received, including the Summary Hospital-Level Mortality Indicator (SHMI) mortality indicators and Structured Judgement Review (SJR) learning points, developed to align to the National Quality Board guidance. The Committee are assured that SJR themes are identified, tracked and actions are being taken linked to end-of-life quality improvement activities. The Committee will receive quarterly updates going forward.

Facing The Future progress was presented by the paediatric service, bringing informative oversight of a series of measures taken to manage the quality of services, with a refreshed approach intended to take forward the remaining compliance actions where required.

Path Links highlight report was comprehensive, illustrating a series of compliance inspections and assessments had taken place, with actions described to remedy any issues identified.

To support and seek assurance on the Quality Priorities delivery the Committee has received deep dive reports for two of the Quality Priority areas. Medication Safety was presented in June 2023 with a key focus on weight recording on the electronic prescribing system, so that weight related doses can be appropriately managed. Software solutions to optimise data availability are being explored as well plans for engagement with the nursing and medical staff to ensure the weight is recorded. Mental Capacity was presented in July 2023, outlining the steps of a working group and focus on project wards improving their practice, once recruitment processes had concluded to the Mental Capacity Specialist Nurse, to work with the newly appointed Named Nurse.

Two national patient surveys were shared as part of the patient experience report, the Urgent and Emergency Care survey and Inpatient survey were both carried out during November 2022. The majority of responses were rated similarly to the previous surveys, with some improvements and deterioration seen also. The action planning process is underway with involvement of divisional teams. The Inpatient survey ranked the Trust at 48 of the 70 trusts that Picker also survey. The Urgent and Emergency Care survey Picker ranking was 49 from 62 trusts. The specific details of the surveys are yet to be published by the Care Quality Commission (CQC). The patient experience report included the launch of a quality improvement initiative, Carol's Campaign, based on learning from the family's

experiences. There have been challenges to resources for Patient Advice and Liaison Service (PALS) which has improved. The Committee referred a request for consideration for a Patient Experience Manager to the Trust Management Board (TMB).

The Complaints annual report was presented, illustrating sustained improvement in timely responses and assurance on resolution attempts being optimal, with low rate of recommendations from the ombudsman.

The safeguarding report illustrated progress with training compliance and highlighted collaborative working on Learning Disability registers. The team had been nominated for a Health Service Journal (HSJ) award.

As part of the Nursing Assurance report discussion of improved community nursing vacancy position, with ongoing recruitment, including international registered nurses and midwives, the care camp support approach and targets to improving the staffing position. Further discussion was expected on the bank and agency usage at the August Trust Board meeting.

Serious Incidents were discussed, including those in maternity. The Audiology cluster of cases was discussed further with the Trust investigation described, following the British Academy of Audiology (BAA) report. The scope of this incident and challenges in re-assessing patients was acknowledged, with ongoing management through internal operational management day to day and NHS England (NHSE) led Incident Co-ordination Group 2-4 weekly.

The Patient Safety Incident Response Framework (PSIRF) implementation progress was reported, with the wider impact for the Trust discussed, leading to a recommended action for a briefing for Board and TMB.

The Mortality Improvement Group have escalated concern about the coding team resource, due to turnover and loss of skilled personnel, linking to the impact on mortality metrics which could adversely impact on progress made over recent years, and the clinical engagement that exists. This matter was referred to TMB for their consideration.

Quality Governance Group have highlighted that the National Dementia Audit has reported a lower than benchmark rate outlier alert for delirium screening. This national report is awaited, with a plan for a working group to focus on improving compliance.

Confirm or Challenge of the Board Assurance Framework (BAF):

BAF entry 1.1 was discussed and view that the target risk score should be increased to 15, based on the challenges that remain with vacancies and other quality challenges, while recognising a range of improvements have taken place.

Action Required by the Governor Assurance Group:

The Trust Board is asked to note:

- the Annual Reports have been received for Learning from Deaths and Complaints
- the current situation on the Paediatric Audiology issue
- the National Dementia Audit reported a lower than benchmark rate outlier alert for delirium screening as highlighted to the committee from the Quality Governance Group.

Fiona Osborne and Kate Truscott
Non-Executive Directors

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	1st August 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 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. • Improvement in the Ambulance Handover and Emergency Department (ED) 4-hour performance, despite attendances continuing to rise. Delayed discharges continue to affect flow in ED, resulting in more 12 hour waits. • Diagnostic Capacity remains a concern and additional Magnetic Resonance imaging (MRI) capacity has been arranged until Community Diagnostic Centre (CDC's) are in place. • Oncologist workforce recruitment issues are a risk to Cancer improvement plans. • Limited progress so far on reducing unnecessary outpatient follow-up appointments. • The Committee recommend Board acceptance of the Elective Care 2023/24 Priorities submission.
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other:
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working ☐ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	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:	1st August 2023
Report From:	Finance & Performance Committee – 21-06-23 and 19-07-23

Highlight Report:

Unplanned Care

- Improvement in the Ambulance Handover and ED (Emergency Department) 4-hour performance against improvement trajectory can be seen, linked to the SDM (Senior Decision Maker) at the front door implemented recently.
- ED attendances have increased by approximately 10% compared to last year, with a five-year peak in May. However, the level of admissions into hospital has been maintained, demonstrating good processes in operation.
- Challenges in moving patients with care packages swiftly into the community have added to bed pressures and resulted in patients waiting over 12 hours in ED.
- Diagnostic Capacity for ED and SDEC (Same Day Emergency Care) continues to be a concern, but this will improve when the CDC (Community Diagnostic Centres) are operational. Additional investment into MRI capacity to bridge the gap until CDC capacity is available has been made.

Planned Care

- There continues to be issues with recruiting Oncologists. Overseas recruitment is not an option due to differences in medical training.
- Cancer performance is being affected by Tertiary Care and Diagnostic issues, but a regional review is ongoing with a project lead in place until 31 July 2025.
- Green shoots of improvement are starting to be seen in Cancer Performance. Whilst only 1 of the 9 Cancer standards were met in the latest month's performance, the Trust is very close to meeting the 75% Faster Diagnosis standard.

- The Outpatients Transformation Programme is focused on the lack of progress in reducing unnecessary outpatient follow-up appointments.
- Theatre utilisation is close to full capacity which limits the possibility of delivering additional activity to recover lost capacity due to industrial action or generate additional income to reduce the organisation's financial gap. Plans for weekend utilisation of theatres are in place.

Health Inequalities

- The report was received by the Committee who were assured by the initiatives delivered by the Trust despite the system wide challenges in coordinating activity to ensure waiting list management recognised and supported patients at risk of health inequalities.

Elective Care 2023/24 Priorities Letter

- The Committee recommend that the Board accept the Elective Care 2023/24 Priorities submission.

Confirm or Challenge of the Board Assurance Framework:
The Committee reviewed the Board Assurance Framework Strategic Objective 1-1.6. The Committee identified a duplicate action which needed to be removed but felt assured by the actions and agreed with the current risk rating.
Action Required by the Trust Board:
The Trust Board is asked to note the key items highlighted above and accept the Elective Care 2023/24 Priorities for submission. Gill Ponder Non-Executive Director / Chair of Finance and Performance Committee

NLG(23)138

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	01 August 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. Audit & Governance Committee Request: Apprenticeship Levy. 2. Occupational Health Service Update. 3. Disclosure and Barring Service Update. 4. Trust Strategic Objective 5 – To provide good leadership. 5. Mandatory and Role Specific Training. 6. Guardian of Safe Working Q4 and Annual Report. 7. Medical Appraisal and Revalidation Report. 8. Industrial Action. 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:	01 August 2023
Report From:	Susan Liburd, Non-Executive Director, and Chair of Workforce Committee
Highlight Report: Workforce Committee – 18 July 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. Audit & Governance Committee Request: Apprenticeship Levy

Workforce Committee received a request from the Audit Committee on 10th July enquiring whether the Trust is maximising the apprenticeship levy, or whether there were further opportunities for its utilisation. In July 2023 estimated expired levy funds are £42,563. This summary provides an update to the Apprenticeship Levy Annual Workforce Report last presented to the Board in December 2022.

There has been a history of Apprenticeship income nationally and locally being returned to the government as unused after the 24 months limitation period. The NLaG People Directorate are proactive in delivering its plan to reduce this occurrence. This is being achieved through the following areas of prioritisation:

Assurance:

- The newly formed Workforce Development Portfolio Governance Board have apprenticeship planning and development as a core agenda item.
- Monthly apprenticeship quality and data meetings have been established.

Marketing and Promotion:

- There is ongoing marketing of apprenticeship opportunities to staff to provide a qualification for their job role, notably in administration, management, and customer service roles.
- There are 156 continuing apprentices with a further 110 projected apprenticeship starts to 31 March 2024.

Development:

- HR are driving the use of the apprenticeship levy in the creation of new roles and career pathways. All new roles are to be assessed for their suitability as apprenticeships. There is a particular focus on structured career pathways.
- The nursing pathway framework enables an individual to move from Healthcare Assistant Level 2/3 to Advanced Care Practitioner Level 7.
- Work is being undertaken with corporate departments to identify specific technical apprenticeships for their teams.
- Level 7 Management and Leadership Apprenticeship is being rolled out as part of the leadership and development roll out.
- Access to functional skills training for English and Maths is occurring as it is a mandatory element of all apprenticeships.
- Application for GMC sponsorship for a scheme for the development of medical staff recruited from Kerala has been submitted and the outcome is awaited.

Partnership provision:

- NLaG non allocated levy spend is used to support other health organisations such as GP practices in the local region. In recent years the levy transfer has taken place for 40 apprenticeships within the local health and social care sector. It is recognised there remains more to do here.

3. Occupational Health (OH) Service Update

With the recruitment of new OH staff and adoption of new working practices the service continues to show a steady improvement. The substantial backlog of more than three months was cleared. OH, has a target of 25 days for recruitment referrals, in February and March achieved 22 and 21 days respectively. Data for Q1 of this financial year is being collated however it is anticipated to be in alignment with KPIs. OH, also receives management referrals, there is a fluctuation in demand and complexity. Timeframes vary between 12 working days extending to five weeks. The OH team prioritise the most urgent or impactful. A clinical triage service is being designed which supported by remote assessments and an updated IT system, will improve working practice efficiencies, and further reduce waiting times.

4. Disclosure and Barring Service (DBS)

DBS timescales are not currently negatively impacting recruitment timescales and KPIs of 25 days are being met. In the first 6months of 2023 a total of 802 applications were made. The average time of return of a check was 8.08 working days. Where it has taken longer this has been attributed to undisclosed convictions and/or multiple entries on police databases and/or multiple previous addresses across different geographical regions.

5. Strategic Objective 5 – To provide good leadership

Workforce Committee welcomed receipt of a progress report on leadership development. A comprehensive values-based leadership programme bespoke to NLaG is being rolled out. In addition, Royal College of Nursing and Faculty of Medical Leadership & Management development programmes for clinical leaders are being delivered. There is an aspiration to continue to deliver one cohort (30 leaders) per month. However, current funding is non recurrent and currently covers 9 cohorts. Future funding is required and is being sought.

6. Mandatory and Role Specific Training

Workforce Committee found there is limited assurance for the completion of role specific and mandatory training. This presents a risk to achievement of Trust set standards of 85% and delivery of CQC improvement plans. Whilst improvement was noted in some areas a notable outlier is Safeguarding Leads training. The Leads are required to complete Level 3 Safeguarding for children, and levels of compliance are at 34.6%. Mitigations are in place, these include task and finish groups, targeted promotion of the training and ensuring training availability. This will continue to be monitored by Committee.

7. Guardian of Safe Working Q4 and Annual Report

The Annual Report of the Guardian of Safe Working Hours shows the exception report information for the annual period of April 2022 to March 2023. Exception reporting is deemed to be a valuable instrument that provides up to date information regarding pressure points in the system. It ensures safe working hours and improves the morale of doctors in training, the quality of medical training and patient safety. Workforce Committee noted the rate of exception reporting followed

roughly the same patterns for much of the year. Workforce Committee has sought assurance that these patterns are utilised in the provision of safe staffing and medical staff wellbeing planning going forward.

8. Medical Appraisal and Revalidation Annual Report

Workforce Committee received the Medical Appraisal and Revalidation report for information and noting. The process is designed to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety, and increasing public trust and confidence in the medical system.

Workforce Committee sought greater understanding of inclusion and exclusion criteria for appraisals. The total number of appraisals not undertaken between 1 April 2022 and 31 March 2023, was 51. Assurance has been provided that 45 of the exclusions comprised of International Medical Graduates. These doctors have a delay to their first appraisal which ranges up to 12 months from their start date. The reason being a doctor must bring a significant amount of supporting information and evidence which matches their scope of work that demonstrates they are safe, engaged with professional standards, and participate in continued improvement within their service area, and provide the supporting information to contribute to lifelong professional development. These doctors are engaged by the appraisal and revalidation co-ordinator and have a 1:1 medical appraisal support session, which aims to induct the doctors into the medical appraisal process and therefore can begin work on their portfolio.

The remaining 6 appraisals not undertaken related to long term sickness and maternity leave. The Workforce Committee noted that the Board through the Chief Executive Officer are required to sign a statement of compliance.

9. Industrial Action

The Workforce Committee noted nationally the Consultants and Junior Doctors strike action is ongoing. Balloting is taking place to extend strike action into the Autumn.

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)139

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	1 August 2023	
Director Lead	Lee Bond, Chief Financial Officer	
Contact Officer/Author	Brian Shipley, Deputy Director of Finance	
Title of the Report	**Finance Report – Month 3**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights the reported financial position of Month 3 of the 2023/24 reporting period. The Trust Board are asked to note: • The Finance Report, Month 3 • The Trust reported an in month deficit for month 3 of £2.5m	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Finance & Performance Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	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.

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Finance Report Month 3

June – 2023/24

Finance Overview

In month Income and Expenditure (I&E) Performance – pages 4 to 7

£0.1m The Trust reported an in-month deficit for month 3 of £2.5m, £0.1m favourable against plan.

I&E Forecast Outturn – page 8 to 9

(£12.2m) An adjusted straight-line projection at month 3 would result in a deficit of £25.6m, £12.2m adrift of plan.

Underlying I&E – page 11

(£41.5m) The Trust underlying position included in its plan submission is estimated at circa £41.5m.

Capital Expenditure – page 15

(£3.4m) Capital spend is £3.4m below plan.

Elective Recovery Performance (ERP) – page 20

TBC The Trust is ahead of its plan to the end of June. However, Elective Recovery Fund (ERF) baselines and profiles are still to be agreed. No penalties have been assumed year-to-date.

Year to Date (YTD) I&E Performance – pages 4 to 7

£1.4m The Trust reported a year-to-date deficit for month 3 of £6.9m, £1.4m favourable versus plan.

YTD Cost Improvement Plan (CIP) Delivery – page 10

(£0.5m) The Trust delivered £3.4m in CIP against a target of £3.9m.

System Performance – page 13

N/A The Integrated Care Board (ICB) System Financial performance is not yet available.

Balance Sheet & Cash – page 16 to 17

£44.9m The Trust cash balance at 30th June 2023 was £44.9m. However, the Trust is highlighting a potential requirement for external cash support.

Temporary Staffing – page 21 to 23

(£0.8m) The Trust has spent £14.9m on agency and bank pay. This is £0.8m more than the same period in 2022/23.

Key Risks

- ❑ Unidentified CIP Stretch Target £10.0m.
- ❑ Slippage on Core CIP Programme.
- ❑ Non-delivery of Elective Recovery Target.
- ❑ Continued reliance on unfunded Escalation Beds.
- ❑ Further Strike Action.
- ❑ Inflationary Pressures

Key Actions

Key actions to achieve financial plan/targets in 2023/24:

- ❑ Reducing cost pressures - reliance on premium agency, minimising escalation beds and greater control of non-pay consumables.
- ❑ Maximising planned care activity, reducing reliance on Independent Sector (IS) and Waiting List Initiative (WLI) premium costs.
- ❑ Delivering a challenging stretch CIP programme - conversion of non-recurrent savings into recurrent delivery schemes and identifying new schemes.
- ❑ Compliance with Humber and North Yorkshire (HNY) Financial Controls Checklist.

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Income and Expenditure Performance

Financial Performance Summary

The Trust ended June with a year-to-date deficit of £6.9m, £1.4m better than plan.

- The Trust reported a £2.5m deficit in June 2023, £0.1m ahead of plan. **However, the position is supported by non-recurrent benefits including slippage on independent sector expenditure, reserves and on depreciation and interest received due to capital plan delays. The CIP plan is also much more challenging in the second half of the financial year.**
- Income was £0.6m below plan year-to-date. Clinical Income was £0.5m below plan due to virtual ward tranche 2 funds and depreciation support waiting confirmation. Lung Health Check activity was £0.3m below plan, only partly offset by £0.2m expenditure underspends. Research and Development (R&D) income was also only partly offset by pay underspends (net £0.01m pressure).
- Clinical Pay was break-even year-to-date. £1.3m Medical Staff overspends were due to temporary staffing premiums covering vacancies, sickness, on-call cover, strike impacts (£0.5m year-to-date, £0.2m in June), additional Rapid Assessment & Treatment (RAT) shifts, undelivered recruitment and productivity CIP, premium waiting list capacity and weekend Intensive Treatment Unit (ITU) cover. These were partly offset by £1.0m nursing and £0.3m Allied Health Professional (AHP) underspends due to vacancies across several areas including Maternity, Neonatal Intensive Care Unit (NICU), Pharmacy and Community. There were £0.5m escalation bed costs year-to-date for circa 43 beds, partly offset by acute bed capacity funding of £0.4m.
- The above pressures were offset by some admin underspends, and slippage on investment and elective recovery reserves.
- Non-pay was £0.7m underspent year-to-date due to underspends on Independent Sector and estates maintenance, which offset an overspend of £0.3m on energy costs.
- Depreciation and Non-operating Items were £1.0m underspent due to Acute Assessment Unit (AAU), Emergency Department (ED) and theatre scheme delays, and due to interest received from cash balances.

£million	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Income						
Clinical Income	41.0	40.0	(1.0)	119.6	119.1	(0.5)
Other Income	3.8	3.6	(0.2)	11.0	10.9	(0.1)
Total Operating Income	**44.8**	**43.6**	**(1.1)**	**130.6**	**130.0**	**(0.6)**
Pay Costs						
Clinical Pay	(25.4)	(24.9)	0.5	(74.1)	(74.1)	0.0
Other Pay	(7.0)	(6.7)	0.3	(20.0)	(19.6)	0.4
Total Pay Costs	**(32.4)**	**(31.6)**	**0.8**	**(94.1)**	**(93.7)**	**0.4**
Clinical Non Pay	(6.8)	(6.8)	(0.0)	(20.1)	(19.7)	0.4
Other Non Pay	(6.0)	(5.9)	0.1	(18.4)	(18.1)	0.3
Total Non Pay Costs	**(12.8)**	**(12.7)**	**0.1**	**(38.5)**	**(37.8)**	**0.7**
Total Operating Expenditure	**(45.2)**	**(44.3)**	**0.9**	**(132.5)**	**(131.5)**	**1.1**
EBITDA	**(0.5)**	**(0.7)**	**(0.3)**	**(1.9)**	**(1.5)**	**0.4**
Depreciation	(1.6)	(1.5)	0.1	(4.9)	(4.5)	0.4
Non Operating Items	(0.5)	(0.3)	0.2	(1.5)	(0.9)	0.6
Surplus/(Deficit)	**(2.6)**	**(2.5)**	**0.1**	**(8.3)**	**(6.9)**	**1.4**

EBITDA = Earnings Before Tax, Depreciation & Amortisation

Financial Performance – Divisions

See Appendix A on page 19 for a summary of the in-month and year-to-date positions for all Divisions and Corporate Directorates.

Divisions	YTD Performance	Key Actions
Operations Directorate **£0.1m** In-month Variance **£0.0m** YTD Variance **£0.3m** YTD CIP Variance	• £(0.3)m Pathology overspends due to activity over-performance netted off by £0.1m additional income (note circa 50% Clinical Commissioning Group (CCG) activity on block) . • £0.3m pay underspend due to vacancies in Pathology and Pharmacy. • £0.1m overspend on transport costs for ambulance discharges.	• Conclude Site Management restructure. • Monitor costs of Pathology Links Over-performance on activity on block. • Monitor effectiveness of new controls on transport expenditure
Family Services **(£0.17m)** In-month Variance **(£0.48m)** YTD Variance **(£0.16m)** YTD CIP Variance	• Medical staff (£0.20m deficit): Continued improvement locum costs of cover and reduced additional sessions. Strike costs £0.13m pressure. Failure against CIP target for agency M1 & 2 – now delivering. • Nursing (£0.06m Surplus): Significant vacancies in paediatrics and midwifery, which have overachieved against the non recurrent CIP targets set against these. • CIP £0.22m adverse variance in month against unmet CIP target.	• Continued close management rota cover costs, reduce sickness and special leave, implement cross site working, address exempt from on call where possible. Reduce follow-up outpatient activity. • Continue to recruit to substantive posts in order to reduce reliance on bank and agency. • Continue working to replace non recurrent benefits with sustainable recurrent CIP plans.
Surgery & Critical Care **(£0.8m)** In-month Variance **(£2.0m)** YTD Variance **(£0.3m)** YTD CIP Variance	• £1.6m overspent on Medical Staff mainly due to pay premiums covering vacancies alongside restricted duties and on-call cover. Includes £0.2m due to covering Junior Doctors' strike. Medical vacancies have increased by 5 Whole Time Equivalent (WTE) in month. • £0.3m overspent on non pay. £150K High Cost Drugs (HCD) adverse variance due limited delivery of CIP on biosimilars • £125K nursing overspend due to escalation bed cover of £102K unfunded in Q1 (quarter 1)	• 13 medical staff on restricted duties . Meetings with individuals to agree ending of restrictions • Recruitment of medical staff to vacancies 40.46 wte a key priority alongside staff retention • Alternative CIP plans being developed to mitigate for limited delivery of biosimilar savings • Focus on theatre productivity in line with Getting It Right First Time (GIRFT) targets

Financial Performance – Divisions continued

Divisions	YTD Performance	Key Actions
Medicine **(£0.47m)** In-month Variance **(£1.52m)** YTD Variance **£0.06m** YTD CIP Variance	• Medical Staff (£0.99m deficit) ; 55wte vacancy premium ; -£0.19m unfunded strike cover costs ; -£0.477m additional ED / Urgent Care Service (UCS) shifts , -£0.37m Acute vacancies & oncall gaps; long-term (LT) Sickness cover & Gastro-intestinal (GI) bleed on-call gaps. • Nursing Staff (£0.58m deficit of which £0.48m is ED); vacancy premium 128wte RN & 61wte Healthcare Assistant (HCA); escalation beds part funded -£0.06m pressure; additional allocation on arrival shifts. • Drugs overspent £0.16m ; UCS GP £0.137m underspend off-setting medical staff ED spend.	• Medical Staff : Review ED rotas & additional shifts (paper to Exec Team); continue recruitment & retention & mitigate gaps with floater posts ; review of oncall & GI bleed rota gaps. • Nursing : Regular ED monitoring; reduce agency spend ; to confirm bed plan to enable reduction of agency usage covering escalation beds, continuation of recruitment & retention; review out of hours (OOH) agency authorisation.
Therapy & Community Services **£0.07m** In-month Variance **£0.02m** YTD Variance **£0.03m** YTD CIP Variance	• Acute Therapy teams (£0.04m deficit): Team struggling to cope with demand, significant increased duties in recent two years. Use of bank to cover vacancies and create additional capacity. • Community Equipment: (£0.01 surplus) improved spend on equipment though no reduction in demand, pressure now in staffing costs with team struggling to meet demand. • Goole District Hospital (GDH) Medical & Nursing (£0.08m deficit): Very significant vacancies – covered by locums with high premium cost. • CIP: heavy reliance on non recurrent plans – targets against Allie Health Professional (AHP) & nursing vacancies, but currently over-delivering.	• Review Capacity and Demand (C&D) for acute teams – redirect resource from other areas • Work to streamline processes and maximise collections and refurbishments to reduce pressure on equipment spend and optimise staff time to meet increased pressure • Recruitment efforts suggest vacancies could be addressed by the autumn. • There are sustainable recurrent opportunities to replace non recurrent plans which are being worked up and progressed.

Financial Performance – Divisions continued

Divisions	YTD Performance	Key Actions
Corporate Directorates & Central Reserves **£1.5m** In-month Variance **£5.4m** YTD Variance **(£0.53m)** YTD CIP Variance	• Estates & Facilities (£0.36m deficit) due to increased period on period energy consumption, increasing Facilities Services non-pay costs and unidentified CIP. Chief Nurse was (£0.02m) overspent due to a net R&D I&E deficit position and maternity leave cover. Chief Medical Officer is (£0.01m) overspent due to unidentified CIP and unfunded audiology review costs. All other Corporate Directorates were break-even or in surplus mainly due to non-recurrent CIP over-delivery. • Central Income was (£0.8m) Clinical Income was £0.5m below plan due to virtual ward tranche 2 funds and depreciation support waiting confirmation, and strike impacts (£0.2m year-to-date, £0.1m June). Lung Health Check activity was £0.3m below plan, only partly offset by £0.2m expenditure underspends. • The position is supported through slippage on Investment & ERF reserves and centrally held agency premium reserves, plus positive variances on interest and depreciation due to capital plan delays and high cash balances.	• Deep dive into non-pay – Facilities Services, postage and text reminder cost drivers and overspending areas including electricity, water, sewerage and provisions. • Review of recurrent CIP gaps by individual Corporate Directorates, working up plans to close the gaps. • Review Investment and ERF reserves and expenditure plans.

Financial Performance – Forecast Outturn (FOT)

The Trust is forecasting a deficit of £25.6m based on an adjusted straight-line projection of Q1, £12.2m adverse to plan. Forecast CIP improvements and Technical Support reduce this to the planned deficit of £13.4m

The Trust is currently £1.4m ahead of plan at the end of month 3 with a year to date deficit of £6.9m.

A straight-line forecast projects a potential deficit of £27.5m. This has been adjusted for known seasonal variation in energy costs, planned completion of Capital programme, increasing depreciation charges, and the release of provisions included in the Q1 position to an adjusted deficit of £25.6m, £12.2m adverse to plan.

The Trust has technical support available of £3.3m, and is expected to be able to release its annual leave provision of 6.0m.

CIP delivery is expected to improve on the current run rate delivery by a further £1.4m. The Trust is awaiting formal confirmation of additional funding for Depreciation support and Tranche 2 capacity (agreed in the plan but not yet transacted) of £1.5m, reducing the deficit to £13.4m in line with plan.

£m	Income	Expenditure	Post EBITDA	Excluded Items	Surplus / (Deficit)
Month 3 Actual	130.0	(131.5)	(5.6)	0.2	(6.9)
Straightline FOT	**519.9**	**(525.9)**	**(22.5)**	**0.9**	**(27.5)**
Seasonal Utilities		(1.1)			(1.1)
Depreciation		(0.8)			(0.8)
Release of Provision	0.3	3.5			3.8
Adjusted Run Rate	**520.2**	**(524.3)**	**(22.5)**	**0.9**	**(25.6)**
Technical Support		3.3			3.3
A/L Provision		6.0			6.0
CIP Run Rate Improvement	0.4	1.0			1.4
Income Support Income	1.5				1.5
Total	**522.1**	**(513.9)**	**(22.5)**	**0.9**	**(13.4)**
Plan	522.9	(509.7)	(27.5)	0.9	(13.4)
Surplus / Deficit	**(0.8)**	**(4.3)**	**5.1**	**0.0**	**0.0**

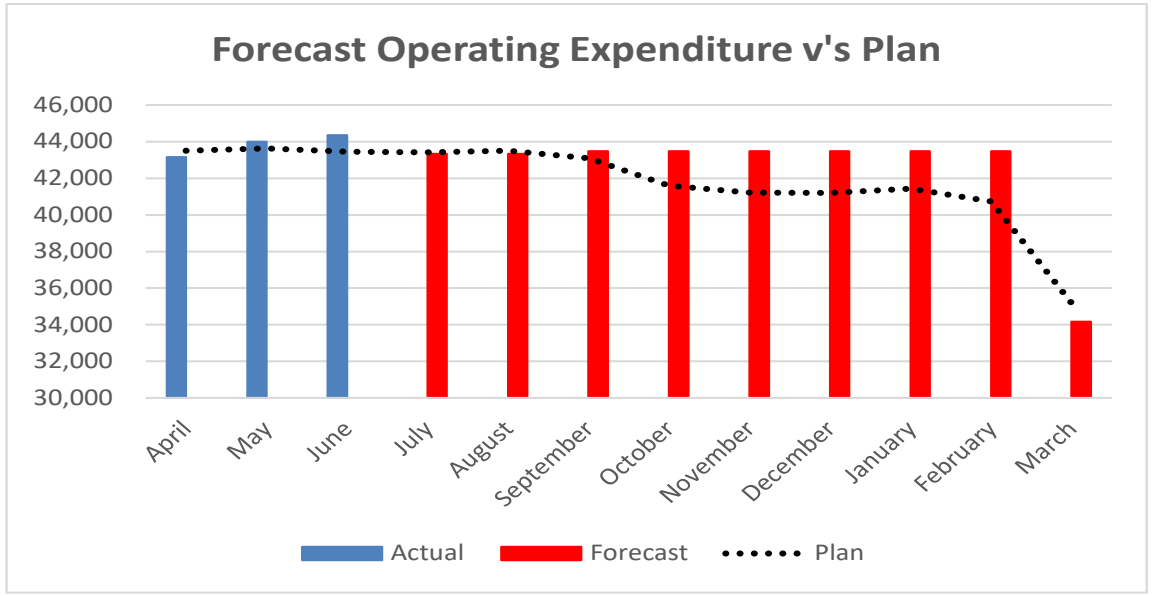
Financial Performance – Forecast Outturn Continued

Key Risks to primary forecast are as follows:

- Unable to release full annual leave (A/L) provision
- Failure to deliver CIP run rate improvements
- Failure to deliver Elective Recovery targets
- Further Strike Actions
- Additional Inflationary Pressures
- Bed Capacity – Increased Non Elective & Emergency Demand

Description of Risk	Likelihood	Potential Impact £m
A/L Provision	LOW	(0.60)
CIP Delivery	MEDIUM	(1.41)
Elective Recovery Risk	HIGH	(2.83)
Strike Action	HIGH	(2.22)
Inflation	HIGH	-
Bed Pressures	HIGH	(0.40)
TOTAL		**(7.46)**

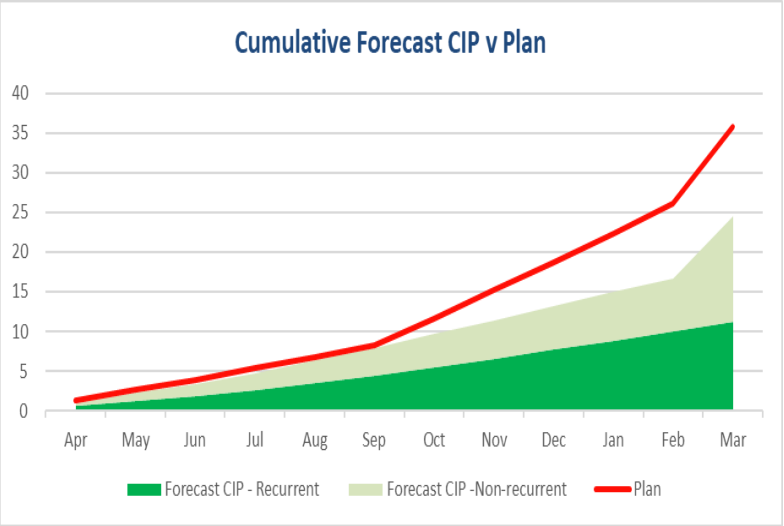
Forecast Operating Expenditure v's Plan



Financial Performance – CIP delivery

The Trust has delivered £3.38m CIP year to date against a target of £3.92m. This has been driven by unidentified plans within the core programme as well as a £0.59m under-delivery on non-recurrent technical reserves.

£million	Current Month			Year to Date			Forecast Year-end		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
CLINICAL WORKFORCE									
Medical Staff	0.2	0.1	(0.0)	0.4	0.4	(0.1)	2.7	2.2	(0.5)
Nursing and Midwifery	0.2	0.4	0.2	0.6	1.0	0.4	4.9	4.9	0.0
AHP Staff	0.0	0.2	0.1	0.1	0.6	0.4	0.6	1.5	0.9
TOTAL CLINICAL WORKFORCE	**0.4**	**0.7**	**0.3**	**1.2**	**1.9**	**0.7**	**8.2**	**8.5**	**0.3**
Corporate and Non-Clinical	0.1	0.1	0.1	0.2	0.5	0.3	0.8	1.3	0.5
Non-Pay and Procurement	0.1	0.1	0.0	0.3	0.3	0.1	1.3	1.5	0.2
COVID Expenditure Reduction	0.0	0.0	0.0	0.1	0.1	0.0	0.3	0.3	0.0
Other CIP	0.6	0.1	(0.4)	1.6	0.6	(1.0)	6.7	4.1	(2.6)
TOTAL CORE PROGRAMME	**1.1**	**1.1**	**(0.0)**	**3.3**	**3.4**	**0.0**	**17.3**	**15.9**	**(1.4)**
Non-recurrent Technical	0.2	0.0	(0.2)	0.6	0.0	(0.6)	8.4	8.6	0.3
ICS Stretch	0.0	0.0	0.0	0.0	0.0	0.0	10.1	0.0	(10.1)
TOTAL PLAN	**1.3**	**1.1**	**(0.2)**	**3.9**	**3.4**	**(0.5)**	**35.7**	**24.5**	**(11.2)**



- The Trust is £0.04m ahead of its £3.34m Core CIP plan at the end of the first quarter. This is despite unidentified year to date plans of £268k in Surgery, £163k in Family and £53k in Estates & Facilities.
- Additional pressures on the Clinical Productivity and Medical Staff Rota Efficiency schemes have been mitigated by over deliveries on most other workstreams but in particular Corporate and AHP vacancies, Nursing Recruitment and Agency usage. In-month Pathology income assumptions had to be reduced with a £388k impact on the year-end position.
- There wasn't a requirement for any non-recurrent technical reserves in-month this is reflected in the CIP delivery with the total Trust efficiency position remaining £0.54m short of the £3.92m plan for the period.
- The Core Programme is forecasting a year-end shortfall of £1.44m due to a continuation of the pressure areas identified to date and reduced mitigation provided by other schemes. No progress has been made on the Integrated Care System (ICS) stretch target of £10.1m and as a consequence only £24.51m of savings are forecast against the annual £35.7m plan leaving a forecast deficit of £11.23m

Underlying Position

The Trust underlying position has deteriorated from its 2023/24 plan submission deficit of £41.5m to £47.8m

- The Trust's underlying position reported within its 2023/24 plan submission is was estimated deficit of £41.5m. This has been updated for in year development to £47.8m and is driven by the following:
- Confirmation of Inflation and Depreciation support funding to be treated as non recurrent - £4.3m
- Forecast slippage on Recurrent CIP programme - £1.2m
- Recurrent funding shortfall of Agenda For Change (AfC) Pay Award £0.9m

£million	Plan	Update
2023/24 - Surplus/(Deficit) Plan	**(13.4)**	**(13.4)**
Non-recurrent Adjustments		
Non Recurrent Savings Delivery Core Programme	(5.7)	(4.7)
Non Recurrent Savings Delivery Technical	(8.4)	(9.3)
Unidentified Stretch Target	(10.1)	(10.1)
Recurrent Savings Core Programme Slippage		(1.2)
FYE Investment Programme	(4.0)	(4.0)
Non Recurrent Depreciation & Inflation Support		(4.3)
2023/24 Pay Award Shortfall		(0.9)
Underlying Deficit	**(41.5)**	**(47.8)**

Northern Lincolnshire and Goole NHS Foundation Trust

System Financial Performance

System Financial Performance – May 2023

Information currently not available for Month 2

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Capital and Balance Sheet

Capital Expenditure

Year-to-date capital expenditure is £1.7m against a £5.0m YTD plan, including IFRS16 and donated spend.

£million	Year to Date		
	Plan	Actual	Var.
Estates Major Schemes			
Emergency Department/AAU	3.4	0.5	(2.9)
DPOW & SGH Theatres TIF	0.2	0.0	(0.2)
SGH Fire Alarm	0.6	0.6	0.0
Discharge Lounge	0.0	0.1	0.1
N Lincs CDC	0.1	0.1	0.1
Unallocated	0.0	0.0	0.0
Total Estates Major Schemes	**4.2**	**1.2**	**(3.0)**
Other Estates Schemes	0.1	0.0	(0.1)
IM&T Programme	0.3	0.3	(0.0)
Pathology LIMS	0.0	0.0	0.0
Equipment Renewal	0.2	0.0	(0.2)
Facilities Maintenance	0.2	0.0	(0.2)
Other Capital Expenditure	0.0	0.1	0.0
Total Capital Programme	**5.0**	**1.7**	**(3.3)**
Funded By:			
Internally Generated	4.9	1.4	(3.5)
PDC Funded	0.1	0.2	0.0
Donated	0.0	0.0	0.0
IFRS16	0.0	0.0	0.0
Disposals - Net Book Value	0.0	0.0	0.0
Total Funding	**5.1**	**1.7**	**(3.4)**

The Trust capital funding for 2023/24 is £47.8m. Including donated £0.1m and International Financial Reporting Standard 16 (IFRS16) leases £1.2m. £1.46m of the funding this financial year relates to ICS slippage from York which will have to be repaid in 24/25.

The actual spend to 30th June was £1.4, £3.4m behind plan. Key variances are detailed below:

- The AAU schemes are now forecasting to be completed during November 2023 for Diana Princess of Wales Hospital (DPOW) and February 2024 for SGH. The ED/AAU schemes in total are currently forecasting additional costs and risks of **£4.14m,** all of which has now been included in this years capital plan. Additional costs have been identified and included for digital project management. The forecast deficit is under constant review.
- Scunthorpe General Hospital (SGH) theatre came into use during June with the theatres at DPOW planned for early July. The electrical infrastructure work is continuing, with the forecast spend in line with capital plan.
- SGH Fire Alarm – work and spend is in line with plan.
- North Lincs Community Diagnostic Centre (CDC) – procurement of the scheme is progressing.
- Facilities Maintenance – additional priorities have been identified for fire hydrant and steam safety works, funding has been reallocated.
- The Equipment group has identified priorities to be funded, a number of orders have already been placed. Divisions are working with procurement to agree specifications and obtain quotes.
- TIF = Targeted Investment Fund. LIMS = Laboratory Information Management System. PDC = Public Dividend Capital.

Balance Sheet

£ million	Actual 31-Mar-23	Actual 31-May-23	Actual 30-Jun-23	In month movement
Fixed Assets	278.9	277.0	276.0	(0.9)
Current Assets				
Inventories	4.0	4.3	4.0	(0.3)
Trade and Other Debtors	25.4	30.6	20.1	(10.4)
Cash	41.5	32.2	44.9	12.7
Total Current Assets	**70.8**	**67.0**	**69.0**	**1.9**
Current Liabilities				
Trade and Other Creditors	64.8	55.3	48.2	(7.0)
Accruals	16.0	22.4	20.6	(1.8)
Other Current Liabilities	5.3	7.2	19.7	12.5
Total Current Liabilities	**86.1**	**84.9**	**88.5**	**3.6**
Net Current Liabilities	**(15.3)**	**(17.9)**	**(19.5)**	**(1.7)**
Debtors Due > 1 Year	0.98	0.98	0.98	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	12.29	12.31	12.31	0.00
Provisions - Non Current	4.04	4.04	4.04	0.00
Total Assets/(Liabilities)	**241.3**	**236.8**	**234.2**	**(2.6)**
TOTAL CAPITAL & RESERVES	**241.3**	**236.8**	**234.2**	**(2.6)**

Key Movements:

Current Assets

- Stock balances has reduced in month in pharmacy and pathology.
- Debtors have also reduced, the Trust reduced in the income for the 2022/23 pay award.
- The Trust cash balance has increased in month, the increase is due to a payment in advance of July block contract income.

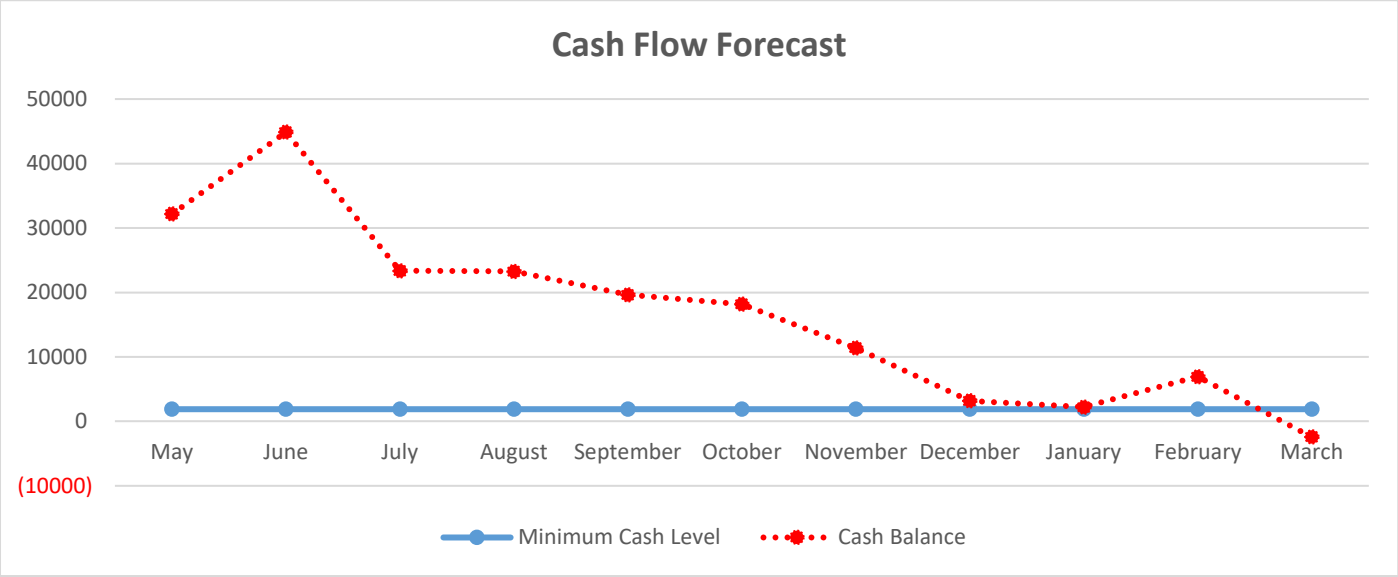
Current Liabilities

- The deferred income has increased, The Trust received £14m in advance for July block contract income.
- Trade and other creditors have reduced following the payment of the 2022/23 and 2023/24 pay award.

The total Better Payment Practice Code (BPPC) figures for the Trust continue to be above 90%; year to date figures are, 94.2% for value of NHS invoices paid with 30 days and 91.84% for number paid, this is a fall from the rates quoted for May. Non NHS invoices is 96.7% for value paid within 30 days and 93.5% for number paid. Monitoring of BPPC and communication to staff of the importance of authorising invoices will continue.

Cash Flow

Based on the current unmitigated forecast deficit of £25.6m, which includes the release of non-cash backed technical savings of £8.5m, the Trust would expect to require central cash support in March 2024 of £4.3m to maintain minimum cash level requirements.



£000's	April	May	June	July	August	September	October	November	December	January	February	March
Minimum Cash Level	1900	1900	1900	1900	1900	1900	1900	1900	1900	1900	1900	1900
Cash Balance	34885	32181	44887	23377	23265	19640	18172	11374	3174	2215	6924	(2424)

Northern Lincolnshire and Goole NHS Foundation Trust

Appendices

Appendix A – Divisional Financial Performance & Reserves Summary

£million	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Operations						
Operations Directorate	(4.2)	(4.1)	0.1	(11.4)	(11.4)	0.0
Family Services	(4.1)	(4.2)	(0.2)	(11.4)	(11.9)	(0.5)
Surgery & Critical Care	(10.9)	(11.7)	(0.8)	(30.9)	(33.0)	(2.0)
Medicine	(11.5)	(12.0)	(0.5)	(32.1)	(33.7)	(1.5)
Therapy & Community Services	(3.5)	(3.5)	(0.0)	(9.7)	(9.6)	0.1
Total Operations	**(34.2)**	**(35.6)**	**(1.4)**	**(95.6)**	**(99.5)**	**(3.9)**
Corporate Directorates						
Trust Management	(0.1)	(0.1)	0.0	(0.4)	(0.3)	0.0
Chief Medical Officer Directorate	(1.9)	(1.9)	(0.0)	(5.8)	(5.8)	(0.0)
Chief Nurses Office	(0.5)	(0.5)	(0.0)	(1.4)	(1.5)	(0.0)
Finance	(0.4)	(0.4)	0.0	(1.2)	(1.1)	0.1
People Directorate	(0.5)	(0.5)	0.0	(1.3)	(1.3)	0.1
Estates & Facilities	(3.4)	(3.5)	(0.1)	(9.7)	(10.0)	(0.4)
Strategic Development	(0.1)	(0.1)	0.0	(0.3)	(0.3)	0.1
Digital Services	(1.0)	(0.9)	0.1	(2.7)	(2.6)	0.1
Central Income	42.3	42.2	(0.1)	123.5	122.7	(0.8)
Technical Central & Capital Charges	(2.2)	(1.9)	0.3	(6.5)	(5.5)	1.1
Central CIP	0.4	0.0	(0.4)	1.0	0.0	(1.0)
Trust Reserves	(1.0)	0.7	1.7	(8.0)	(2.0)	6.0
Total Corporate Directorates	**31.5**	**33.0**	**1.5**	**87.0**	**92.4**	**5.4**
Excluded Items	0.1	0.1	(0.0)	0.2	0.2	0.0
Trust Total	**(2.6)**	**(2.5)**	**0.1**	**(8.3)**	**(6.9)**	**1.4**

£million	Opening Allocation	Residual Annual Budget	YTD Budget	YTD Expenditure	YTD Variance
Investments Reserve	10.6	5.7	0.7	0.0	**0.7**
Inflation Reserve	20.3	10.5	2.5	1.7	**0.8**
Agency Premium Reserve	12.7	5.5	3.2	0.0	**3.2**
Elective Recovery Reserve	12.0	10.1	1.6	0.3	**1.3**
TOTAL	**55.7**	**31.8**	**8.0**	**2.0**	**6.0**

Appendix B – Elective Recovery

Elective Recovery Funding baselines and profiling are still to be agreed with NHSEI (NHS England and Improvement). Performance against plan is detailed in the following table.

	YEAR TO DATE - Elective Recovery Price (£'k)																	
	DAYCASE			ELECTIVE			OP FIRST ATTENDANCE			OP FIRST PROCEDURE			OP F/UP PROCEDURE			ALL ACTIVITY TYPES		
Specialty	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance
Community and Therapies	90	36	-54	-	2	2	-	-	-	-	-	-	-	-	-	90	37	-52
Medicine	1,362	1,798	435	150	169	19	1,952	1,492	-459	45	34	-11	197	199	1	3,706	3,691	-14
Surgery and Critical Care	2,779	3,407	628	2,743	2,947	204	1,911	1,910	-1	386	441	54	744	1,064	320	8,563	9,768	1,205
Family Services	440	410	-30	549	543	-7	1,340	1,073	-267	468	405	-63	164	187	23	2,961	2,618	-344
Surgery Endoscopy	1,817	1,934	118	-	-	-	-	-	-	27	56	29	-	-	-	1,844	1,991	147
Grand Total	**6,488**	**7,584**	**1,096**	**3,441**	**3,660**	**219**	**5,203**	**4,476**	**-727**	**926**	**936**	**10**	**1,105**	**1,450**	**344**	**17,163**	**18,105**	**942**

	Spells/Attendances					
POD	2019/20	2020/21	2021/22	2022/23	2023/24	Variance to 2019/20
Elective	1,703	523	1,156	1,098	1,092	(611)
Daycase	13,448	5,413	12,365	12,985	13,857	409
OPD New	23,405	16,021	24,355	28,892	23,031	(374)
OPD New Procedure	6,732	1,908	5,356	5,398	5,151	(1,581)
OPD Follow Up	48,021	40,214	48,683	53,889	45,175	(2,846)
OPD Follow Up Procedure	13,399	4,843	10,286	11,968	10,870	(2,529)
Total	**106,708**	**68,922**	**102,201**	**114,230**	**99,176**	**(7,532)**

	Spells/Attendances														
POD	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Elective	345	400	353	399	417	426	482	476	357	389	455	407	375	337	380
Daycase	3,990	4,747	4,248	4,538	4,633	4,356	4,456	4,897	4,338	4,668	4,435	5,098	4,253	4,711	4,893
OPD New	9,064	10,146	9,682	9,304	9,048	9,847	9,491	9,538	7,949	8,940	7,851	9,085	6,349	8,016	8,666
OPD New Procedure	1,718	1,978	1,702	1,795	1,806	2,081	2,021	2,139	1,762	2,140	1,931	2,182	1,557	1,891	1,703
OPD Follow Up	16,546	18,993	18,350	16,929	17,418	18,173	18,738	20,669	16,334	19,741	17,597	18,435	13,737	16,122	15,316
OPD Follow Up Procedure	3,804	4,374	3,790	3,865	3,980	4,419	4,563	5,243	3,808	5,263	4,679	4,639	3,187	3,885	3,798
Total	**35,467**	**40,638**	**38,125**	**36,830**	**37,302**	**39,302**	**39,751**	**42,962**	**34,548**	**41,141**	**36,948**	**39,846**	**29,458**	**34,962**	**34,756**

Appendix C – Temporary Staffing Summary

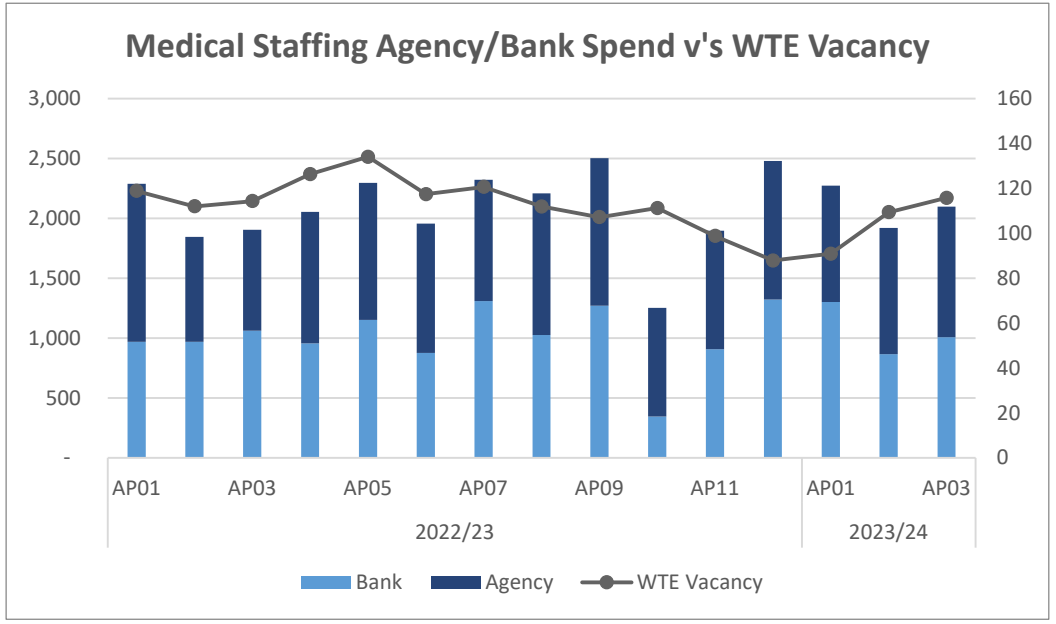
Subjective Sub category	2022/23 (£k)	2023/24 (£k)	Variance (£k)
Medical Staff	6,037	6,288	(251)
Nursing Staff	6,346	6,797	(451)
Scientific, Therapeutic & Technical Staff	607	711	(104)
Admin & Clerical Staff	611	566	46
Maintenance Staff	-	-	0
Other Staff	1	1	(0)
Support Staff	532	569	(37)
Grand Total	**14,135**	**14,931**	**(797)**

Division / Directorate	2022/23 (£k)	2023/24 (£k)	Variance (£k)
Operations Directorate	671	852	(182)
Community + Therapy Services	792	788	4
Family Services	1,265	1,485	(220)
Medicine	6,787	7,105	(318)
Surgery + Critical Care	3,953	4,030	(78)
Sub Total Operations	**13,467**	**14,261**	**(794)**
Chief Medical Officer Directorate	2	4	(2)
Chief Nurses Office	34	24	9
Digital Services	119	61	58
Estates And Facilities	502	544	(42)
Finance	2	-	2
People Directorate	9	38	(29)
Strategic Development	1	-	1
Sub Total Corporate	**668**	**671**	**(2)**
Grand Total	**14,135**	**14,931**	**(797)**

Type	Subjective Sub category	2022/23 (£k)	2023/24 (£k)	Variance (£k)
Agency	Medical Staff	3,038	3,112	(73)
	Nursing Staff	3,414	3,740	(327)
	Scientific, Therapeutic & Technical Staff	417	442	(26)
	Admin & Clerical Staff	120	40	80
	Maintenance Staff	-	-	0
	Other Staff	1	1	(0)
	Support Staff	-	1	(1)
Agency Total		**6,990**	**7,336**	**(346)**
Bank	Medical Staff	2,999	3,176	(177)
	Nursing Staff	2,933	3,057	(124)
	Scientific, Therapeutic & Technical Staff	191	269	(78)
	Admin & Clerical Staff	491	526	(35)
	Maintenance Staff	-	-	0
	Other Staff	-	-	0
	Support Staff	532	568	(36)
Bank Total		**7,145**	**7,596**	**(451)**
Grand Total		**14,135**	**14,931**	**(797)**

Appendix C – Temporary Staffing Medical Staffing

Division / Directorate	2022/23 (£k)	2023/24 (£k)	Variance (£k)	%
Operations Directorate	276	325	(48)	17%
Community + Therapy Services	184	245	(61)	33%
Family Services	470	496	(26)	6%
Medicine	3,009	3,249	(240)	8%
Surgery + Critical Care	2,098	1,973	125	-6%
Sub Total Operations	**6,037**	**6,288**	**(251)**	**4%**



Agency Ceiling Rate Compliance 12 Months

12.1%

Agency Ceiling Rate Compliance YTD 2023/24

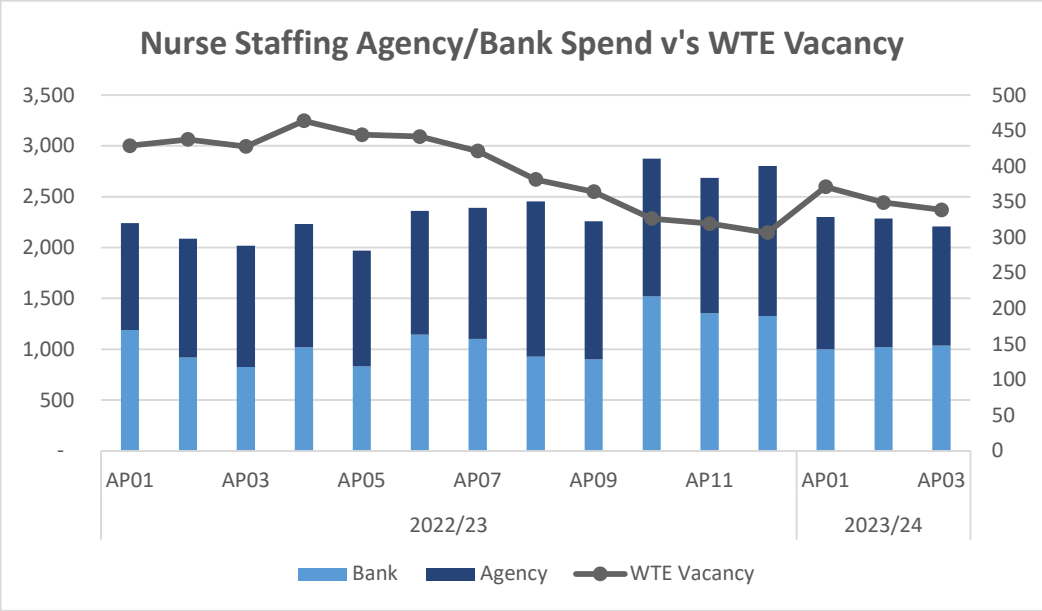
9.5%

Top 10 Specialty by Expenditure

Specialty	Cost	Hours
Emergency Department	£1,451,418	15,259.16
Acute Care	£1,069,982	12,143.43
Anaesthetics	£557,205	6,500.50
Ophthalmology	£372,683	3,739.50
Orthopaedics	£327,833	4,752.93
General Surgery	£285,072	3,790.92
Paediatrics & Neonates	£276,108	3,337.50
General Internal Medicine	£213,739	2,012.43
Ent	£192,026	2,652.00
Pathology	£181,688	1,497.50

Appendix C – Temporary Staffing Nursing

Division / Directorate	2022/23 (£k)	2023/24 (£k)	Variance (£k)	%
Operations Directorate	170	159	11	-7%
Community + Therapy Services	446	334	112	-25%
Family Services	784	973	(188)	24%
Medicine	3,666	3,781	(115)	3%
Surgery + Critical Care	1,258	1,527	(269)	21%
Sub Total Operations	**6,325**	**6,773**	**(449)**	**7%**
Sub Total Corporate	**21**	**24**	**(3)**	**12%**
Grand Total	**6,346**	**6,797**	**(451)**	**7%**



Top 20 Nurses 1/06/22-01/06/23

Pseudonym	Cost	Hours	Cost/ Hr
Temp Nurse 1003	£138,627	1,497	£92.58
Temp Nurse 3054	£137,083	2,629	£52.14
Temp Nurse 3258	£122,437	1,327	£92.24
Temp Nurse 3107	£120,605	2,622	£45.99
Temp Nurse 2445	£107,685	2,260	£47.66
Temp Nurse 3925	£107,476	2,759	£38.96
Temp Nurse 2548	£105,734	2,718	£38.91
Temp Nurse 983	£104,624	2,224	£47.04
Temp Nurse 1517	£103,091	2,272	£45.37
Temp Nurse 2296	£102,028	2,139	£47.70
Temp Nurse 3266	£102,011	2,678	£38.10
Temp Nurse 2774	£101,340	2,610	£38.83
Temp Nurse 1920	£101,260	2,577	£39.29
Temp Nurse 2617	£99,721	2,081	£47.92
Temp Nurse 2984	£99,169	2,572	£38.56
Temp Nurse 3691	£97,074	2,120	£45.80
Temp Nurse 3605	£95,092	1,105	£86.06
Temp Nurse 3216	£94,920	2,497	£38.01
Temp Nurse 2986	£94,414	2,484	£38.01
Temp Nurse 2342	£93,467	888	£105.31

Note – Over 83 Nurses have worked on average over 25 hours every week in the last year

Agency Ceiling Rate Compliance 12 Months

57.7%

Agency Ceiling Rate Compliance YTD 2023/24

58.6%

% of Hours by Tier

Tier	2022/23	2023/24
T1	58%	60%
T2	31%	31%
T3	11%	9%

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(23)140

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	1st August 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 and Estates and 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. • The Trust are forecasting a potential £4m cash deficit by the year end. • The Trust still has an unidentified Cost Improvement Program (CIP) Stretch Target of £10 million and the underlying deficit position has deteriorated • The availability of more granular cost data would improve the accuracy of costing submissions and benchmarking. • Risk mitigation is in place until the Scunthorpe Ring Main for medical gases provision can be replaced. • Priority 60-minute protection fire door repairs and replacements are underway across the Trust. • The Committee recommended that communications were issued to remind staff that domestic appliances must not be used at work, as these had caused 2 fires.	
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting	
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.

HIGHLIGHT REPORT TO TRUST BOARD

Report for Trust Board Meeting on:	1st August 2023
Report From:	Finance & Performance Committee – 21-06-23 and 19-07-23

Highlight Report:

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

- There is a financial gap within the annual plan that still needs to be closed.
- The Trust still has an unidentified Cost Improvement Program (CIP) Stretch Target of £10m and is currently forecasting a £1.4m shortfall on the core CIP programmes.
- Concerns were raised around the delivery of the medical workforce plans that do not appear to be significantly different from previous years' plans.
- The Trust is currently forecasting a requirement for £4.0m cashflow support in March 2024.The underlying deficit position has worsened due to non-recurrent depreciation and inflation support, a funding shortfall on the pay award and slippage on CIP plans.

Recovery Support Program for finance (RSPf)

- The Trust has exited from level 4 of the Recovery Support program for finance.

National Cost Collection

- There are gaps in costing information and data which will affect the accuracy of the submission of national costing data, as some assumptions will have to be made. The Committee received the proposed plans for submission, but expressed concern that the Trust did not have sufficient details of actual costs to enable meaningful comparisons to be made between the Trust and similar Trusts, or between similar wards within the Trust. The lack of this data is a constraint on identifying and delivering possible future efficiencies.

Medical Gases

- Risk mitigations are in place daily at Scunthorpe until the Ring Main for the provision of Medical Gases can be replaced, but they do not totally remove the risks from high demand for high flow rates across the site.

Fire Report

- An Authorised Engineer (AE) for fire has been appointed who will review all fire procedures, including drills.
- Fire doors across the Trust are being inspected and, where necessary, repaired or replaced. Priority is being given to 60-minute protection doors to target the highest risks first. The risk from doors that have not yet been repaired or replaced is being mitigated by ensuring that staff have attended fire training and that horizontal and vertical evacuation plans are in place.
- Domestic white goods being used in the workplace have caused two fires at the Trust in the previous 12 months. The Committee recommended further communications to staff to advise them of the cause of these fires and to reiterate that domestic appliances must not be used at work.

Confirm or Challenge of the Board Assurance Framework:
The Committee reviewed the Board Assurance Framework Strategic Objective 3-3.1. The Committee discussed a potential gap in control of Recruitment and Retention but felt assured by the actions and agreed with the current risk rating.
Action Required by the Trust Board:
The Trust Board is asked to note the key points highlighted above. Gill Ponder Non-Executive Director / Chair of Finance and Performance Committee

NLG(23)141

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 1 August 2023
Director Lead	Ivan McConnell, Director of Strategic Development / Humber Acute Services Programme
Contact Officer/Author	Kerry Carroll, Deputy Director of Strategic Development
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: • decision of the Integrated Care Board and region to decouple obstetrics and neonates • approval from the Integrated Care Board (12/07/23) to progress to public consultation for Urgent and Emergency Care and Paediatrics • the progress through the NHS England Gateway review and Joint Health Overview Scrutiny Committee • further staff briefing sessions scheduled for August • planning for Decision Making Business Case and implementation plans To note the outcome of the New Hospitals Programme announcement and the progress that is being made on the development of the draft Capital plans to support the implementation plans for the Humber Acute Service programme. 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 Grimsby case 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: • Potential political or representative group challenge to decision • The risk of not being selected on 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

Updated Board Report: Strategic Development - August 2023

This report provides the Board with an update on the key actions that are in place to support the delivery of three key strategic priorities for the Trust.

- **Strategic Objective 1: To Give Great 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.

- **Strategic Objective 3: To Live Within Our Means**
  3.2 To secure adequate capital investment for the needs of the Trust and its patients.

- **Strategic Objective 4: To Work More Collaboratively**
  4:1 To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale (HCV) Health Care Partnership (HCP) (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan (LTP): to make best use of the combined resources available for health care, to work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally, to work with partners to secure major capital and other investment in health and care locally, to have strong relationships with the public and stakeholders, to work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: make best use of the human capabilities and capacities locally; offer excellent local career development opportunities; contribute to reduction in inequalities; contribute to local economic and social development.

The Board is asked to note:

- The leadership role that the Trust is taking in delivering these objectives not only internally but at Place, Sub System and System Level, particularly in relation to:
  - Trust
    - Humber Clinical Collaboration Programme
  - Sub System / Place
    - Humber Acute Service Programme
      - Clinical Pathway Redesign
      - Strategic Workforce Planning
    - Community Diagnostic Centres
    - Strategic Capital Investment
    - Place Boards
  - System
    - Collaboration of Acute Providers
    - Planned Care Strategy Development

The Board is asked to note the significant progress that has been made on these programmes, the external assurance they have undertaken and the leadership roles that have led to at a system and national level for some of our team.

It is important that the Board recognise that the successful delivery of these programmes is not without risk. This falls into a number of categories:

- Political/representative group challenge
- Capital/revenue affordability
- Deliverability within required timescales

The tables below provide a summary of the status, achievements and key risks associated with each strategic objective.

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
1.3, 3.2 and 4.1	**Humber Acute Services:**	The Humber Acute Services is reaching a critical stage in its development. Over the past 20 months the programme has engaged with over 12,000 people and developed a range of options for the delivery of Urgent and Emergency Care, Maternity, Paediatrics and Neonatal Care. The Programme has been through multiple external assurance reviews and is now in the final stages of concluding a Pre-Consultation Business Case to support a Statutory	• Humber and North Yorkshire (H&NY) Integrated Care Board (ICB) Private Board (14/6/23) and informal NHS England (NHSE) review of proposals. Outcome to decouple obstetrics and neonates due to services requiring a wider regional review. • H&NY ICB Public Board (12/7/23) – proposals submitted. Outcome to proceed to consultation with a preferred option (mid Sept 23) • Progressing through NHSE Gateway review • Clinical Senate Report published: Highest Level of Assurance – "Reasonable" on all three Questions Asked • Independent Consultation Institute Review undertaken of Engagement to date – No major areas of weakness identified • Place Boards, council and MP briefings undertaken in North East Lincolnshire, North Lincolnshire, Hull • Joint Health Overview Scrutiny	• Ensuring effective resourcing and leadership consultation • NHSE Gateway Review: Finance focus – capital affordability and revenue savings • Joint Health Overview Scrutiny Committee (JHOSC) approval of consultation documents and plan • Potential challenge of process to date • Potential challenge/opposition to consultation options • Potential challenge to decision post consultation: Independent Review Panel(IRP)/Secretary of State(SoS)/Judicial Review (JR)	• **Failure to gain ICB/NHSE approval to consult** ***Impact:*** *Delay to implementation leaving unsustainable services on the Southbank and potential increased revenue costs* ***Mitigation:*** *ICB/NHSE briefings – capital affordable on preferred option internally / Consider move to split programme and deliver incrementally as a Plan B* • **Political / representative group challenge to decision** ***Impact:*** *Potential delays due to referral to SoS/IRP or JR* ***Mitigation:*** *Pre engagement work*

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk

		Consultation from Summer 2023.	Committee (JHOSC) plans being agreed with Scrutiny Officers
			• Ongoing Monthly NHSE Assurance Reviews
			• Pre-consultation Business Case (PCBS) submitted to Integrated Care Board (ICB) and NHS England (NHSE)
			• Consultation Document and Narrative in draft – refinement continuing.
			• Planning for Decision Making Business Case and Implementation Plans (inc. detailed workforce planning)
			• Further staff briefings in place throughout August 23 (speciality focused and all staff forums)
			• HAS team been recognised for exemplar work and currently delivering training to NHSE Transformation/Workforce teams nationally on:
			  • Reconfiguration
			  • Workforce Planning
			  • Engagement
			  • Inequalities
					programme, Overview Scrutiny Committee (OSC) approval to date, Independent Assurance provided on approach, evidence packs prepared and continued engagement

1.3, 3.2 and 4.1	**Humber Clinical Collaboration Programme**	The Humber Clinical Collaboration Programme has been born out of the Interim Clinical Plan which has been through three iterations of development over the past 18 months.	• Programme Stocktake scope and approach agreed
			• Joint Board presentation on findings to date:
			  • Timeline
			  • Outputs
			  • Status
			• Activity aligned to Consultant engagement events
			• Updated Heatmap being prepared on
				• Heatmap may show both progress or deterioration in performance within specialties
				• Programme structure needs to align to Group Operating Model
				• Programme needs appropriate support: Leadership/Programme
					• ***Potential delay to the stocktake or inconclusive results***
					
					Mitigation:
					Detailed preparation and planning to support the timescales and resource for the stocktake review

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
		The Programme is currently undergoing a stocktake review to identify the potential options on the way forward as the Group Structure emerges The Stocktake is aligned to a Programme of activity on Consultant Engagement being undertaken by the Chief Medical Officer(s)	10 specialties – current status • Feedback being collated • Options to progress presented to Committees in Common (CiC) and Boards (end June 23) • Joint Board agreed to pause programme following discussion , awaiting new Chief Executive Officer appointment	Management Office (PMO)/Enabling workstreams • Programme enablers – digital/Organisational Development in particular will be essential to "make it happen" • Programme needs to focus on "Making it Stick" – implementation resource • Risk of potential performance deterioration during any period of future change • Leadership structures cannot duplicate – need to reduce cost • Focus may need to be more incremental and micro over short periods of time	
1.3 and 4.1	**Community Diagnostic Centre (CDC)**	The Community Diagnostic Centre (CDC) Programme is part of a National Policy Initiative to deliver an increased volume if diagnostics in a community setting NLaG has led the delivery of two business cases with a total value of c£29.4m on the	• Secretary of State (SoS) approval of the Scunthorpe Hub case - £19.4m ○ Planning Application Submitted ○ Procurement Strategy Designed ○ Plan to Procure in Place • Grimsby Spoke case - £10m – approved • Integrated Governance Structure implemented covering both North and North East Lincolnshire ○ Programme Implementation and	• SoS requires something to be delivered on each site – 1 December 2023 • SoS requires full service opening by end of March 2024 • Resourcing: ○ CDC workforce plan developed – rotational posts planned – recruitment risk for some roles – will need National support (Insourcing contract)	• **Scunthorpe delays to planning or build due to lack of build/equipment capacity in timescales** ***Impact:*** *Reduced capacity available to meet backlog / loss of political goodwill and central challenge from NHS England* ***Mitigation:*** *Planning pre-engagement/ Phased procurement /*

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
		South Bank The SoS has formally approved the Scunthorpe Hub case at a value of £19.4m The Grimsby Spoke case has been submitted at a cost of £10m and is awaiting NHSE National CDC Team approval	Oversight Board established ○ Workstreams established and resourced ○ Reporting agreed to ICB Diagnostics Board/Collaborative Acute Providers Board and Place Boards • Programme team established for procurement • Programme team established for build	• Workforce to deal with demand arising – Primary/Community/Acute/ Mental Health – workstream established • Funding – revenue funding on going for service – risk of failure of tariff to cover costs • Funding – on going capital costs not covered • Potential delays to build – supplier and kit availability • Potential cost increases – inflation / scope creep/cost overruns • Resourcing – programme design/implementation	*potential to use National Contracts for equipment* • **Inability to meet demand** ***Impact:*** *Increased waiting lists / increased complaints* ***Mitigation:*** *Implementation Programme Team established at sub system level to review capacity/demand gaps and actions required* • **Inability to find workforce** ***Impact:*** *Inability to open/run service in accordance with agreed plan – impact on waiting lists and potential increased complaints* ***Mitigation:*** *Strategic workforce plan developed, rotational posts will be in place, use of national contract to insource and international recruitment*
3.2	**Strategic Capital Investment**	The Trust has a 6 Facet Capital gap of c£117m – of which £107m relates to Backlog Maintenance The Trust Board	• New Hospital Programme (NHP) application submitted – not approved • Strategic capital options discussed at CiC, and Joint Boards – potential options identified to move forward • Agreement with Place Board to have an aligned Strategic Capital Plan at Place	• Strategic Capital Programme needs to reflect multiple programme priorities and risks: • Humber Acute Service implementation • Backlog maintenance (BLM) and Critical	• **Do not get access to funding to cover BLM/CIR risk in short term** ***Impact:*** *continued risk of capital failure, inability to implement structural pathway changes*

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
		agreed to submit a Strategic Capital Investment Expression of Interest (EOI) in September 2021 to be part of the New Hospitals Programme The Programme announcements have been delayed and a wide range of developments have happened in parallel to support capital investment in the Trust Additionally, the Trust has secured upwards of £150m over the past two years in strategic capital in particular with a focus on Emergency Departments/Acute Assessment Units and Diagnostics. Linked to this is additional funding to improve energy efficiency	• HAS implementation capital requirements drafted	infrastructure risks (CIR) • Capital affordability and prioritisation • Digital risks • Equipment risks • BLM and CIR issues mean time cannot be wasted on large scale developments – short term spend not affordable or deliver Value for Money (VFM) • Options need to be accelerated within Group model to look at smaller scale incremental schemes • Will need to align with Place Strategies and be supported Politically to be successful	*required to keep services sustainable, poor patient and staff experience* ***Mitigation:*** *developed Strategic Outline Case and business cases to support phased investment and agreed with Joint Board need to look at smaller business cases aligned to planned care, HAS and Humber Clinical Collaborative Programme strategies*
1.3 and 4.1	**Planned Care Strategy**	The Trust is providing leadership through the CAP for	• Planned Care Strategy Framework approach, assumptions and deliverables agreed at CAP Board	• Dependencies with other projects at Trust/Sub System and Place	• Management of conflicting priorities across ICS, Sub System,

Strategic Objective Ref	Programme	Summary Status	Update	Areas to Consider	Strategic Risk
		the development of a Planned Care Framework for the delivery of Planned Care across the Integrated Care System (ICS) The Programme Plan, Structure and Assumptions have been agreed	• Leadership and Programme team identified • Data structure/sharing arrangements in place • Briefings of Place Boards undertaken and engagement approach identified • Network engagement approach agreed • Engagement with wider workstreams – outpatients/diagnostics/digital – commenced • Workshops scheduled to socialise opportunities linking to Clinical Networks/existing programmes	• Need to ensure don't duplicate effort of other teams – e.g. Getting it Right First Time (GIRFT) programme • Data availability/and analytics resource	Collaboratives, Place, Organisation ***Impact;*** *System pressures create a change in focus from long to short term action* ***Mitigation;*** • *Ongoing engagement with CAP, Clinical Networks, relevant elective Programmes, Place Boards*
1.3, 3.2 and 4.1	**Collaboration of Acute Providers (CAP)**	The Trust is an active member of the CAP and is taking a leadership role in a number of workstreams • Diagnostics: CDCs • Planned Care	• Active engagement in CAP Board and leadership groups • Work plans and resources in place	• Delivery timescales of programmes • Competing delivery priorities • Multiple programme reporting to Trust, sub system, Place, CAP and ICB – duplicates effort	
1.3, 3.2 and 4.1	**Place Boards**	The Trust is an active member of the Place Boards in: • North Lincolnshire • North East Lincolnshire • East Riding of Yorkshire	• Leadership of multiple Place workstreams including • Workforce planning • Capital Investment/Planning • Clinical change and pathway design	• Multiple competing priorities – demand on team and ability to serve multiple relationships • Tension of priorities of Trust, Sub System, Place and ICB	

NLG(23)142

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	August 1, 2023
Director Lead	Shauna McMahon, Group CIO
Contact Officer/Author	Shauna McMahon
Title of the Report	**Digital Services Highlight Report**
Purpose of the Report and Executive Summary (to include recommendations)	Digital services report to the board on digital progress. Focus since the last board update: 1. Highlight report of Digital priorities and service delivery 2. Development of the single Electronic Patient Record (EPR) for HUTH and NLaG 3. Submission of the 2022/23 Data Security and Protection Toolkit return 4. Collaboration of Business Intelligence across the Integrated Care System (ICS) to reduce the duplication, support and Pop Health Management, Elective Recovery, Mutual Aid and system working, and measuring outcomes. 5. Information Technology Infrastructure assessment is underway to map options to join up the infrastructure for seamless working. Recommendations for discussion: 1. As we move into our Group model a more joined up approach across operational areas will best leverage the benefits digital will bring. 2. We cannot digitise old paper processes; we must transform how we work with clear sight on performance expectations. 3. The refreshed strategy will need to focus on using Artificial Intelligence (AI), virtual care, and higher demands for responsive digital enabling foundations. 4. Board and Executive should have agreed priorities with accompanying investment plan to deliver the transformation required to achieve good or excellent service delivery (moving out of Care Quality Commission (CQC) requires improvement).
Background Information and/or Supporting Document(s) (if applicable)	Digital Strategy 2021-24
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)	Digital team is now preparing to bring forward a single digital strategy and this will include a 5 yr digital financial plan. It will be the financial plan we believe is required to achieve a good level of support for our clinical and corporate teams to have an improved experience, support home monitoring, and enable more flexibility to scale up and support Artificial Intelligence (AI) and future needs.	

Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None Identified for this reporting period	
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, focusing 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

Digital Services

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Report

August 2023

Shauna McMahon, Group Chief Information Officer, shauna.mcmahon@nhs.net

Contents

Executive Summary

Our Digital Vision:

"To embrace digital technologies so we can provide a workplace that enables our staff to deliver the best possible care for our patients and to improve health outcomes in our community.

Building upon previous Board briefing sessions, this document serves as a written update on NLaG's advancements aligned with the digital strategic framework and goals set for the 2023/2024 period. This report also includes data on the broader national digital initiatives currently underway.

In the last 6 months, Digital Services has begun the detailed work around alignment to a single group service. Staff have been engaged through several workshops in Spring 2023. The relatively new senior leadership team became fully established with the Group Chief Technology Officer (CTO) starting in post in April 2023. Our focus is on our people, and we continue to work with our employees and stakeholders to consolidate digital services so we can leverage the talent, expertise, and improve resiliency for service delivery. We are transitioning to a non-site-specific model of delivery within the next 6 months through a consultation process with our staff.

The establishment of the Integrated Care System (ICS) has meant that several team members now support the Integrated Care System (ICS) projects which has placed an increase stress on the team. Even with that expanded demand, we focused on implementing the following major four programmes of work this past year:

- We initiated the deployment of a single Patient Administration System (PAS) for HUTH & NLaG. This project continued into 2023/24, with a projected completion date of January 2024.
- We commenced collaboration with NHSE and Integrated Care System (ICS) to construct the rationale for an Electronic Patient Record (EPR). While initially we had hoped to establish a singular solution for the four acute care facilities within the Integrated Care System (ICS), this proved not to be the best approach as the digital environments at Harrogate and York and their objectives were quite different than NLaG and HUTH. They favour a modular / Best of Breed approach with gradual roll out over time, keeping some of their current systems. NLaG and HUTH are looking for a single unified enterprise EPR with core EPR functions that will deliver HIMSS Level 5 at go-live date. To not have an enterprise approach would be regressive step for NLaG and HUTH.
- We are building the business case for electronic document management system (EDMS) for approval early August 2024.
- We've helped support to the Humber Clinical Collaboration Programme (HCCP) by facilitating access to WebV (NLaG) and Lorenzo (HUTH), thus enabling care providers to access patient data at the two Trusts.
- Scan4Safety continues to be deployed with a focus now on Radio Frequency ID (RFID) to track people and objects.
- The implementation of Single Sign On (SSO) at NLaG is improving the ease and speed of access to systems for clinical users.
- Completed NLaG migration to Medicode 360 (May 2023)
- We have Robotic Processing Automation (RPA) bots built and testing them in with Human Resources (HR) trac in recruitment intake and Patient services advice and guidance. Early indications show significant efficiency improvements with potential cost savings.

These are just a small example of the digital areas of success this year.

Challenges
We continue to have two major challenges affecting our ability to deliver at pace: workforce and funding.

We struggle to attract talented professionals, particularly in specialist roles and this represents a widespread challenge across the NHS. We believe that investments in enhancing our digital environment will create some positive ripple effects. However, we must also address the wage disparity experienced by our digital staff. The competition we face is not confined to other Trusts alone; we're also varying with the private sector. Home-based and flexible working arrangements has increased the appeal of other employment options which we are unable to match with our current infrastructure and estates. NHS England has been trying to address this issue and realize the current agenda for change is not meeting the current employment needs of the NHS, especially for the digital professions.

The challenge that we continue to grapple with involves successfully navigating the internal demands of both organisations. Managing these competing priorities and ensuring a balanced approach remains a complex task as we try to develop an environment of robust service delivery and continuous improvement. The reactive and unplanned demands from the Integrated Care System (ICS) and NHS further impedes our ability to deliver our programmes on schedule, as we have to re-assign people to address what is often short-term demands to help with bids, or support consultants that the NHS has hired.

The Priorities for 23/24:

- Complete PAS and Data Warehouse projects
- Complete Single Sign On implementation
- Complete NLAG Integrated Care System (ICS) Maternity implementation
- Complete EPR OBC, procurement and FBC
- Complete the EDMS OBC, procurement and FBC
- Complete eObs escalations and task management roll-out
- Complete Patient Knows Best (PKB) pre assessment roll-out (patient engagement)
- Continue to consolidate the Digital and Information Technology services
- Continue to level up the RFID and Scan4Safety environment across both Trusts

Developing and Supporting our Digital Workforce

Our dedication to nurturing our most valuable resources - our team members - remains a top priority. The services we offer must be developed to meet the needs of the organisations we serve, and it's crucial that our staff possess the necessary skills and training to fulfil these requirements. The past year has been a period of transition which is set to persist into 2023/24. Our team has demonstrated extraordinary resilience and performance under considerable stress when juggling multiple projects. The consolidation of our service delivery like any significant change has caused some apprehension. We are continuing to work through feedback from staff through the curated set of workshops we undertook with an external Organisational Development consultancy involving staff from both locations. These efforts are building on the comments in the Picker staff survey, and we are collectively working (management and staff) to target areas where we can improve.

We're continuing to work by targeting efforts to address those areas that have been flagged by our team within the staff survey. A score of 40.6% emerged for involvement in decision-making that affects individual roles. Through our work transitioning to a single service, the team have been assured that their insights will help shape the future of the department. The level of engagement has been encouraging and staff members continue to collaborate more with their colleagues at the other sites. Together the directorate will keep striving to enhance the areas highlighted in the survey. We acknowledge the need to update job descriptions and clarify roles, and this work will continue in this fiscal year as part of restructuring plans.

Supporting Professional Development and Technical Training

We've previously implemented pathways for our team to pursue both professional accreditations and technical competencies. These programs are intended to aid professional growth and deliver up-to-date training tailored to each role. By becoming a part of the British Computer Society (BCS) Chartered Institute for Information Technology, staff members have the opportunity to earn a Registration for Information Technology Technicians (RITTech), Federation for Informatics Professionals (FEDIP), or Chartered Engineer Registration (CEng). With the consolidation of the two Trusts Digital Services, we are working toward HUTH to attain the organizational Platinum standing that NLaG achieved last year.

We will continue to earmark funds dedicated to the digital progression of our staff, as this plays a crucial role in employee retention. Moreover, it is imperative for us to invest in our team's development, equipping them to navigate effectively in the dynamic digital environment. We are continuing to process staff access through to the latest technical training through online platforms such as Udemy which was renewed in 2023/24. Our staff will also be undertaking training in ITIL best practice which will help align to professional practices as processes become standardised across both Trust's.

Financing Innovation and Transformation

The Board has had previous presentations on how the funding allocation has struggled to keep up with the escalating demands and expectations placed on our department. While conversations on digital investment will continue in the various forums, we are continuing to maximise every digital asset we can and use systems to their full capability. Channeling our limited resources towards areas that yield the most significant benefits should form a core part of our strategy. These hurdles we face can be mitigated with a more strategic approach to digital investment and implementations. Such a strategy would encompass concentrating our efforts on fewer projects that promise substantial benefits and expediting their delivery timeline, while placing other, less impactful initiatives on hold. In doing so, we can optimise our resources while simultaneously enhancing our service efficiency and effectiveness.

Within our restructuring plans, we created a Digital Innovation function under our Clinically facing services to help promote digital innovation and work with clinical and corporate staff to drive transformation forward. Our aspiration is to build on this by helping create digital champions across the organizations.

Data Security and Protection Toolkit (Cyber Security) (DSPT)

The Data Security and Protection Toolkit return demonstrates the increasing focus on cyber security and data protection by design, and the need for more engagement with staff to understand their training needs and support mandatory training completion.

The Trust submitted the DSPT return on the 30th June 2023. For the 2022/2023 submission, the Trust has only 1 action on its improvement plan which is to attain 95% of staff undertaking Data Security Training. At the time of submission, the Trust had reached 90%, which in itself is a fantastic achievement. The Trust will now need to achieve the 95% by the end of August 2023. Until the Trust achieves compliance with the training requirement its status will be 'Approaching Standards Met'.

Following the internal audit review, there were a number of low and medium risks, these will be monitored on an internal action plan and not on the improvement plan as these reflect improvements which can be made to current practice.

The findings of both the Internal Audit review on the toolkit return show the continued improvements being made in the Data and Security area. All actions will be monitored through the Information Governance Steering Group.

The 2023/2024 version of the DSPT is expected to be released in late July 2023. The only significant change will be around the training requirement, giving the organisation more control in how it develops its Data Security training need analysis, delivery of the training and then how it evaluates the delivery and understanding.

Digital & Infrastructure Services

We continue to build on our digital foundations with a better understanding of our infrastructure and where to target and share investment based on our recent review. As part of the digital aspirant funding, we engaged an external Information Technology specialist consultancy company to undertake a review of NLaG and HUTH Information Technology infrastructure to assist us with future planning. The findings were shared in a joint board presentation and in summary our focus is on continuing to deploy modern devices and hardware for staff. We are actively improving our network connectivity, expanding Office365 to support collaboration and productivity as well as implementing a new Information Technology service management system as a single service across both Trusts that will streamline our ability to support services more efficiently.

We have successfully joined Information Technology networks enabling cross-site working and are reviewing clinical and corporate applications to ensure functionality from any group site.

The Clinical Coding and Information Governance service continue to operate effectively under one management structure. The Managers continue to support the team and are now working on levelling up to deliver a more standardised service across both Trusts. A further recent example of this is successful implementation of Medicode 360 at NLaG in May 2023 which allows both Trusts to operate the same Clinical Encoder solution. This type of development continues to strengthen links across Trust coding teams and supports the work on process alignment. The challenge in Coding is retaining staff. Many organizations that are fully digital are recruiting coding staff, enabling them to work remotely and often offering sign on bonus, and / or higher banding. The need for us to have a full electronic patient pathway (EPR & paperless working) has never been more critical.

Progress on NLAG 22/23 Strategic Priorities Against the Strategic Framework

We are continuing to work to deliver strategic priorities within both Trusts across the following workstreams:

Completing significant in-flight digital projects that have already initiated in previous years – Patient Administration System (PAS), Data Warehouse and implementation, Robotic Process Automation (RPA) of Single Sign On (SSO), internal system integration and WebV enhancements.

- Key projects are expected to be concluding over the next two quarters (Q3 2023/24 and Q4 2023/24) including Lorenzo PAS, RPA and the new Data Warehouse

We expect key projects to deliver a range of benefits both in Cash Releasing and non-cash releasing savings. As an example, our PAS migration means we can consolidate system costs with a single supplier saving the Trust £155k per annum. The introduction of RPA across 4 initial area will allow release of 8.81 WTE across the following area once fully live.

Trust	Area	Process	WTE Saved	Go Live
HUTH	Patient Admin	ERS Advice and Guidance - Outcome A&G to be added to Lorenzo. Process to be repeated at NLaG once PAS migration complete.	2.97	Complete

HUTH	Patient Admin	ERS to Lorenzo - move referrals across with docs and close the ERS ref down. Process to be repeated at NLaG once PAS migration complete.	3.89	Aug 23
NLaG	ePMA	Creation of user accounts - Creation of the EPMA User account and emailing user details and one time password to the requesting user.	0.17	Sep 23
NLaG	People Directorate	EC to Trac - Approved via the establishment control process (EC), data automatically transferred to TRAC	1.78	Sep 23

Digitising Health Records as a priority, followed by corporate paper processes to support paper-lite/paperless working (including introducing an Enterprise Document Management System during 2023-24).

- Agreement to stop printing copies for electronic letters/results approved by Digital Strategy Board.
- Joint EDMS Business Case being finalised by the end of July 2023, with anticipated procurement and implementation during Q3/4 23/24.

Working with national and regional teams to implement mandated system level digital solutions (e.g., Maternity Information Technology system, Eye Referral System, Diagnostic Hubs, Integrated Care System (ICS) Electronic Patient Record, continuing integrations to YHCR).

- Maternity Badgernet implementation underway at both Trust's. Go-live being agreed for 2023/24 subject to the completion of the PAS migration project.
- EPR Convergence Programme entering procurement phase subject to Trust approvals in Sept. 2023. Procurement to begin in October 2023 and final contract award in June 2024.

Collaboration with acute partners in the Integrated Care System (ICS) to improve access for clinicians to clinical information through digital interoperability between trusts and by supporting digital processes is ongoing.

- Both Integrated Care System (ICS) EPR Convergence proposal and Regional Shared Care Records have had significant progress in 2022/23.
- HUTH have seen the new provision of appointments data and support of the first-of-type subscriptions project with City Health & Care Partnership (CHCP).
- NLAG have seen the first data provision (discharge summaries) go-live, with emergency department encounters to follow imminently, as well as making GP Connect available to view for clinicians across the trust.

We will improve digital literacy through a focused communications and education approach engaging with end-users to foster a culture that embraces technology and leverages digital champions to support sustained digital transformation.

- HUTH/NLaG Digital training functions, knowledge transfer and virtual training platform alignment completed in (Q4 2022/23)

In addition to our core objectives, we've delivered several key elements in support of the **Humber Clinical Collaboration Programme (HCCP)** over the last 6 months:

- Lorenzo WebV click through integration complete
- Streamlined access process in place for Lorenzo & WebV
- Cross site business intelligence (BI) access in place
- ICP BI Dashboards developed
- Provision of specific dashboards to support transfer of NLaG Oncology patients to HUTH as part of ICP Programme
- Consolidated Patient Tracking Lists for services that are consolidating to single management approach (i.e.., neurology)

We have also completed the National Digital Maturity Assessment (What Good Looks Like -WGLL) survey to provide a benchmarked outline of the Trust's position against peers. This has identified areas of strengths and weaknesses and will feed into future investment plans for the Trust's.

Priorities for 23/24 as a Group Digital Service

- Complete PAS and DWH projects
- Complete Group EPR OBC, procurement and FBC
- Complete Group Integrated Care System (ICS) Maternity implementation
- Continue to consolidate the Group Digital and Information Technology Infrastructure & Service Management
- Complete NLAG SSO implementation
- Complete PKB pre assessment roll-out
- Complete eObs escalations and task management roll-out
- Complete HUTH ICNET Infection Prevention implementation
- Complete HUTH LIMS integration to Lorenzo

Clinical Leadership Team Update

Dr Alastair Pickering, Group Chief Medical Information Officer
Martin Sykes, Chief Nurse & Allied Health Professional information Officer, NLAG
Steve Jessop, Chief Nurse information Officer, HUTH

The mainstay of work for the last few months has been alignment of digital projects between NLAG and HUTH, planning priority areas for delivery into the end of the financial year and ensuring we (our senior digital team) are embedded at Integrated Care System (ICS) level. This is demonstrated with both the Group Chief Information Officer (CIO) and Chief Medical Information Officer (CMIO) being members of the Integrated Care System (ICS) Digital Executive and Strategy Boards, the Collaborative Acute Programme, and supporting the Integrated Care System (ICS) wide acute collaborative. In addition, the clinical team is highly active with the current EPR tender work and working with our Integrated Care System (ICS) colleagues and clinicians at both Trusts to ensure our motto of *making life easy* for our clinicians is met and that we deliver the best digital enabling tools we can with a focus on future needs. A good example of this approach is the successful implementation of Single Sign On (SSO) within DPoW ED (Emergency Department), which has improved system access times and removed the need for multiple logins.

A key priority area has been with the Interim Clinical Plan Specialties (now Humber Clinical Collaboration Programme - HCCP) to ensure we support the single service models being developed, and this links with the ongoing project work to deliver a single Patient Administration System across the two organisations. This work has delivered systems access across staff groups in each organisation as well as the in context click through links to the relevant areas of the patient's records. The Information Technology and network teams have also enabled staff to log in using a single device that will automatically access the local network and Trust specific drives at any site across HUTH and NLAG. The next phase of this is to support direct access to the relevant system applications when working cross-site.

We continue to roll forwards our paperless approach – reducing unnecessary printing and generating regular reports on high print use areas, expanding our digital clinical notes and outpatient pilots, as well as pre-assessment forms. The new maternity and eye referral systems that have been procured regionally will also enhance clinical teams working but will need clinician subject matter expertise through delivery to ensure they work as expected.

As we bring on more complex digital solutions there is an increasing need for clear communications with clinical staff specifically focusing on what these changes mean for services and individuals. To deliver the improvements that digital is expected to enable, it is critical that operational leaders work alongside digital colleagues and lead on the process changes required to leverage digital benefits. Transforming how we work is our greatest challenge. The digital services consolidation has resulted in us having three senior clinical leaders – Alastair Pickering, Steve Jessop, and Martin Sykes. They will require other digital champions to support the major programme of work e.g., new EPR and Enterprise Content Management System (to eliminate paper) and will be creating a clinical senate to provide wider input to the digital programme, and specifically the EPR procurement. As part of this expansion, we have procured the services

of an external company with expertise in Human Centered Design for digital solutions.

They are working closely with our frontline clinical areas to ensure that we procure solutions that are aligned to user needs. This will also support staff in understanding their own digital literacy and building their confidence with digital systems that can directly benefit them and the patients they care for.

Regional Digital Developments

Building on the previous work done by NHS Transformation, the Secretary of State for Health and Care released the latest plan for Digital health and social care at the end of June 2022. This focused on patients and the expansion of digital systems and services, while also supporting the recommendations in the Goldacre Report “Data Saves Lives”.

While each system Integrated Care System (ICS) is developing its costed plan for digital and data investment – these will be integrated into the wider operational planning process with extension to multi-year planning from the end of this year. The aim is to embed digital and data planning not only into multi-year operational planning, but
to then extend this, in the form of digital maturity assessments, into regulatory body assessments e.g., Care Quality Commission (CQC).

Digital Maturity at both Trust and Integrated Care System (ICS) level are already a focus for delivery by the end of 2023. A financial support plan was released defining where national and regional funding efforts will be targeted.

National funds will focus on:

- NHS App development as the single point of digital contact for patients
- A national Federated Data platform
    - Including Trusted Research Environments
- National Cyber Security support
- Cloud based services

Regional and local investment will be distributed to support:

- EPR convergence (in support of better digital processes and maturity)
- Implementation of the chosen data platform
- Patient engagement portals – linked to the NHS App
- Tech enabled remote monitoring (linked to virtual wards)
- Cyber security and connectivity
- Shared Care Records

With the tech elements of wider funding that has already been distributed being:

- Diagnostics programme (e.g., CDCs)
- Targeted Investment Funding
- Virtual Wards
- Primary and Social Care support

A Federated Data Platform (FDP) will be an ecosystem of connected platforms, placed in and ultimately determined by individual NHS organisations and will provide decision makers with access to real time information to make informed, effective decisions to transform how we plan, manage, and sustain services. The WGLL framework for Digital Maturity has 7 success measures that we will be assessed against:

- Well led
- Ensure smart foundations
- Safe practice
- Support people

- Empower citizens
- Improve care
- Healthy populations

One of the tools launched in 2023 was an assessment framework which is used to measure our level of digital maturity (Digital Maturity Assessment – DMA). The aim is to help identify gaps and prioritise areas for local improvement. Assessments will be repeatable so organizations can track progress year-on-year. Frontline support in terms of funding and expertise will also be available. In addition, we have a regional maternity system recently procured so all women can access their maternity notes and information through smart phone or other device by 2023/24. The system will provide information in digital format to those that are supporting mums-to-be. We will remove paper processes for this population. HUTH and NLaG both have helped to shape the Integrated Care system (ICS) digital and data strategy, establish governance and working on "levelling up" plans for the region.

NLAG has worked with our Integrated Care system (ICS) colleagues to create our Integrated Care system (ICS) funding priorities. As an Integrated Care system (ICS) our digital strategy is based on the principle that we will adopt open standards and an open platform for our digital environment so data and information is within our control, and we can manage how we share our data. We are continuing to work with our Integrated Care system (ICS) colleagues to "level up" across our region and make the most of the funding opportunities with the target to have a new EPR procured by end of fiscal 23/24.

Other areas where our work aligns directly with national strategy is our systems integration with the regional shared care record and close working relationship with the regional cybersecurity lead. As the Integrated Care system (ICS) continues to mature, digital funding will be allocated through the partnership and place-based systems and collaboratives. It is essential that we maintain our presence at Integrated Care system (ICS) Digital Transformation Senior Leadership Team and strategic level to ensure we continue to align in our priorities and secure suitable financial support for local delivery. The need for local investment to support some projects will continue, but most of the transformation work will become funded through national and regional programs and our role is to ensure that not only our digital services, but also our staff are in the best position to use this when available to deliver the expected transformation.

Conclusion/Recommendations

This update was written to provide assurance that the digital teams are working on the strategic framework that was agreed. There has been significant positive improvements and achievements delivering what would be described in the digital world as major programs of work.

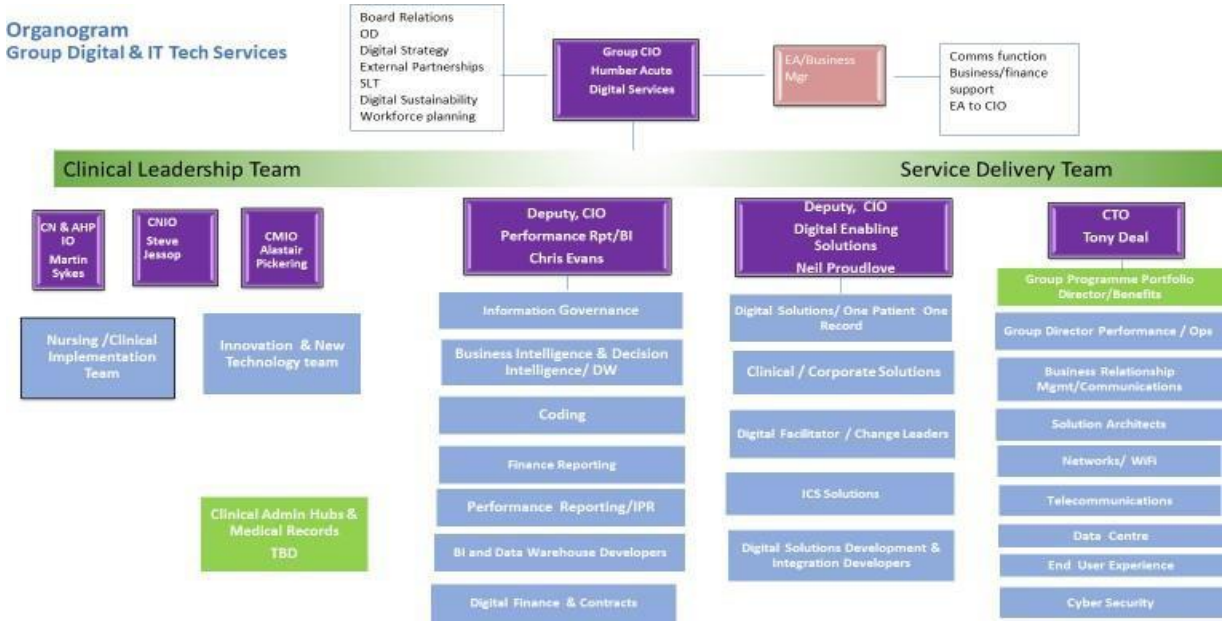
Areas of Focus next 6 Months:

- Continue to focus on our staff and working together through our transition to a single service
- Completion of the single PAS implementation
- Focus on the tender for a single EPR and EDMS
- Continue to reduce barriers to joined up working -focus on network integration
- Streamline governance processes for Digital Services with a single Group Digital Strategy Board and Digital Solutions Delivery Group
- Enable RPA across two priority processes to deliver measurable benefits
- Develop a single digital strategy for the Trusts
- Support operations to lead on business transformation to ensure the best possible benefits are being realized from digital and technology solutions.
- Establish a more consistent funding level to deliver on the EPR programme as well as the other transformational solutions prioritized.

The current period continues a trend of significant demand for digital enablement across the wider organisation. New and exciting technologies are being offered for use in care delivery which is creating exceptional demand for Digital in our front-line teams. Using robust governance processes, the Digital teams assess where digital initiatives fit within the wider strategy and priorities of the organisation. Our programme must remain ambitious but realistic to the challenges around capacity and funding, hence why prioritisation is key.

Our efforts remain focused on how to reduce the gaps in digital and make life easier for our end users and patients to work within the system. To achieve this, we will continue to balance the challenges around maintaining and improving existing Information Technology Infrastructure and systems, while ensuring we capture opportunities to digitally innovate within the Trust and with our key partners.

Consolidated Digital & Information Technologies Service Model



Digital Highlights

PAS Replacement Project

The consolidation to one PAS system (NLaG & HUTH) with Lorenzo is progressing forward. The work will streamline the patient administration processes, allowing far more effective coordination of care that support collaborative clinical models.

Teams from across both NLaG and HUTH have come together and focused on a go-live of the new system. We had hoped to go live in May however due to volume of records transferring over we have had to move the date to Sept. 2023. The dependencies on PAS for a wide range of other processes need to be carefully mapped out to ensure that unplanned consequences from such a major system change are minimised and that risks are managed appropriately.

Robotic Process Automation (RPA)

The Robotic Process Automation (RPA) project is designed to eradicate a significant portion of repetitive data entry tasks within the Trust, by employing 'bots' to assist staff and liberate their time for more value-adding tasks. Four distinct processes between NLaG and HUTH have been identified, with planned implementation in the first half of 2023/24.

The Trusts have successfully integrated into the NHSE RPA UIPath Infrastructure and completed local setup. Our initial focus was on Electronic Referrals (Advice & Guidance) and referrals into Lorenzo at HUTH, which became fully operational by June 2023.

Information Technology Service Management System (ITSM) Service Desk Plus

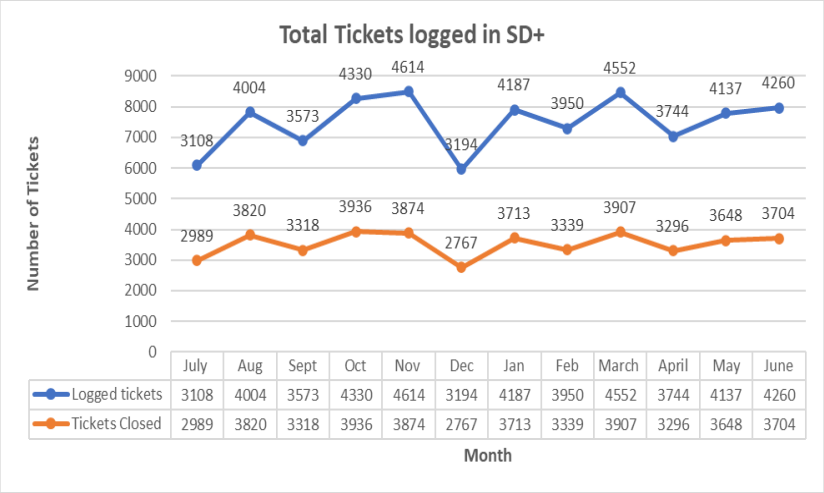
This solution initiates a major transformation across digital and infrastructure services. We have deployed and tested the core modules of the ITSM system & Service Desk Plus at NLaG and are bringing HUTH and NLaG together to level up on the one platform. This system now allows users to directly log a problem or service request with Digital Services by e-mail, but you can still use the telephone if you wish. Coming soon you will be able to use the self-service web portal to also access our services, this will help direct

you to the correct team in Digital Services and even get direct online help and assistance. We will be onboarding all Digital Services sections onto this new platform over the coming months so there will be a single point of contact to gain access to our services. This single service desk for both Trusts enables improved root cause analysis and the opportunity to leverage quality improvements and we will be able to pull out Key Performance Indicators for our services.

Digital Services Call Centre Stats

Information Technology Service Desk KPI's

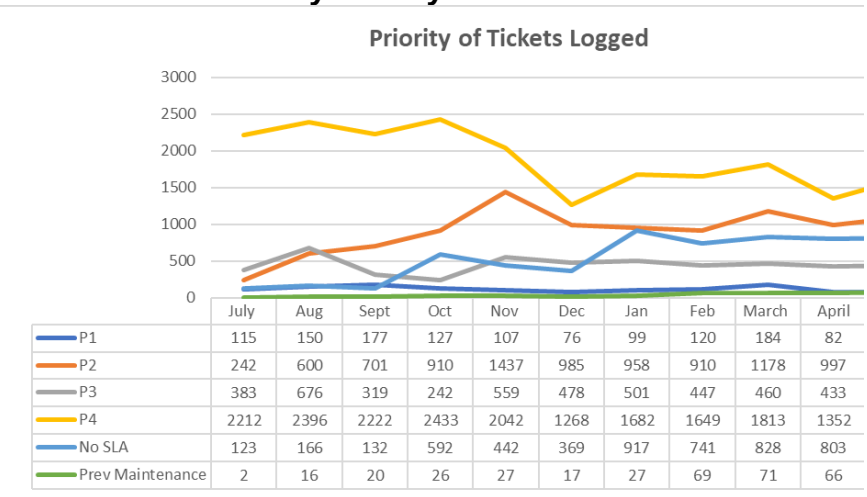
Total Calls raised and closed (YTD) to NLaG Information Technology Service Desk (Service Desk+)



From the period of July 2022 to June 2023 there were a total of 47,653 calls raised on the Information Technology service desk with 42,311 closed within the required period. This equates to 89% of all call fixed within SLA.

There are many reasons for calls breaching SLA including technical diagnosis delays, supplier delays and delays in user response.

Service Desk Calls by Priority



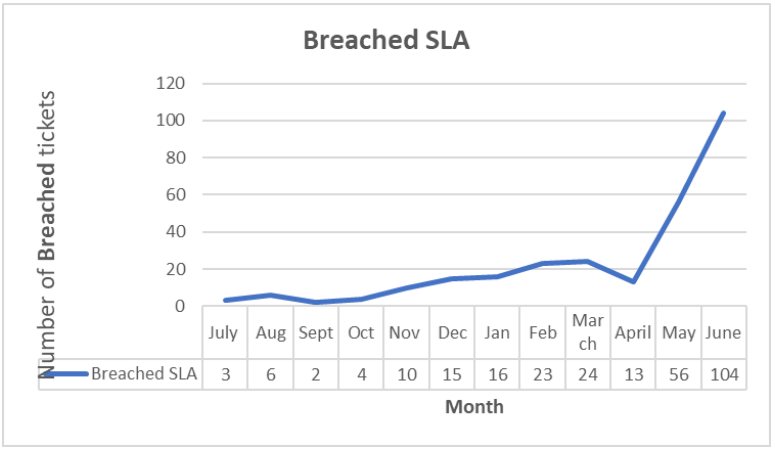
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
P1	115	150	177	127	107	76	99	120	184	82
P2	242	600	701	910	1437	985	958	910	1178	997
P3	383	676	319	242	559	478	501	447	460	433
P4	2212	2396	2222	2433	2042	1268	1682	1649	1813	1352
No SLA	123	166	132	592	442	369	917	741	828	803
Prev Maintenance	2	16	20	26	27	17	27	69	71	66

SLA Agreement time scales

P1 - 4 hours
P2 - 8 hours 30 mins
P3 - 3 days
P4 - 5 days

Top 5 Issues by Key Priority	
Priority 1	**Priority 2**
Dictate IT	PC issues (not high priority)
PC Issues High priority clinical (e.g. A&E)	VPN Remote access
Printer Faults	Printer (low priority)
Access to systems / Email	Laptop (low Priority)
Laptop issues	Smartcard RA

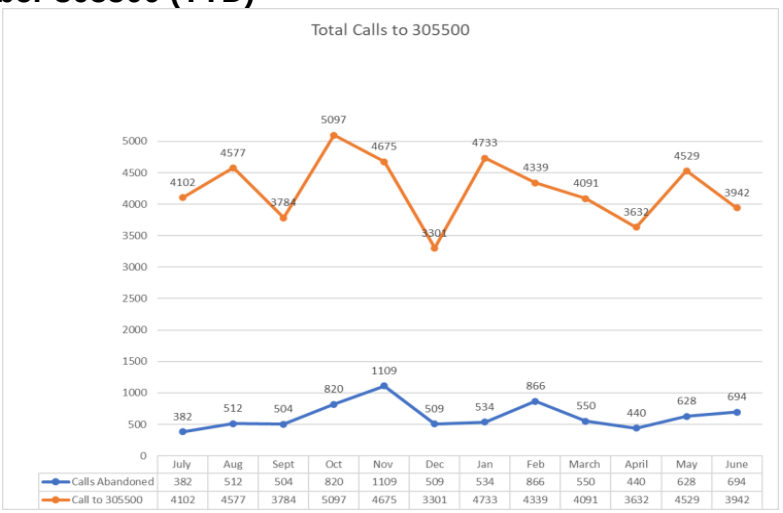
Service Desk Calls Breached SLA



	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Breached SLA	3	6	2	4	10	15	16	23	24	13	56	104

A significant increase in breached calls occurred in May / June 2023 during the rollout of single sign-on. The call centre received a higher than average of calls relating to password issues which although resolved quickly were not administered in a timely manner affecting the statistics. This process issue has now been resolved.

Service Desk Response Call Statistics to helpdesk number 305500 (YTD)



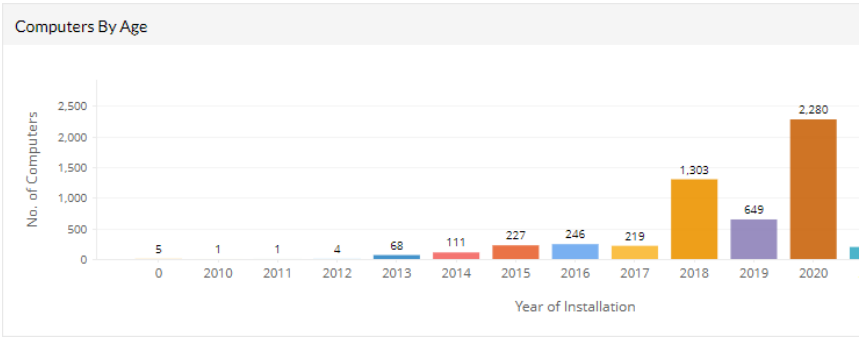
Total calls received to the Information Technology service desk phone number for period July 2022 to June 2023 were 50,802 averaging 4,233.5 calls per month.

During this period 7,548 calls were abandoned by the user, averaging 629 per month (15%).

November 2022 saw a significant increase in tickets logged and abandoned due the following reasons:

1) Sophos Antivirus software received a policy update causing wireless functionality on all devices to stop working requiring significant Information Technology support to resolve the issue.
2) Decommissioning of the Cisco VPN remote access software required users to migrate to the new service, causing an increase in calls from users requiring additional support.

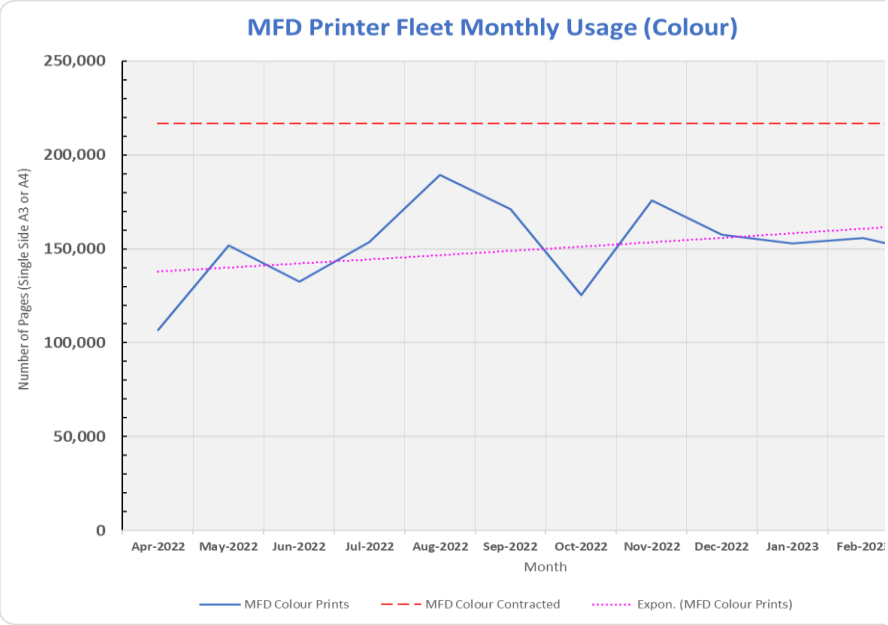
NLAG PC Estate by year of Installation



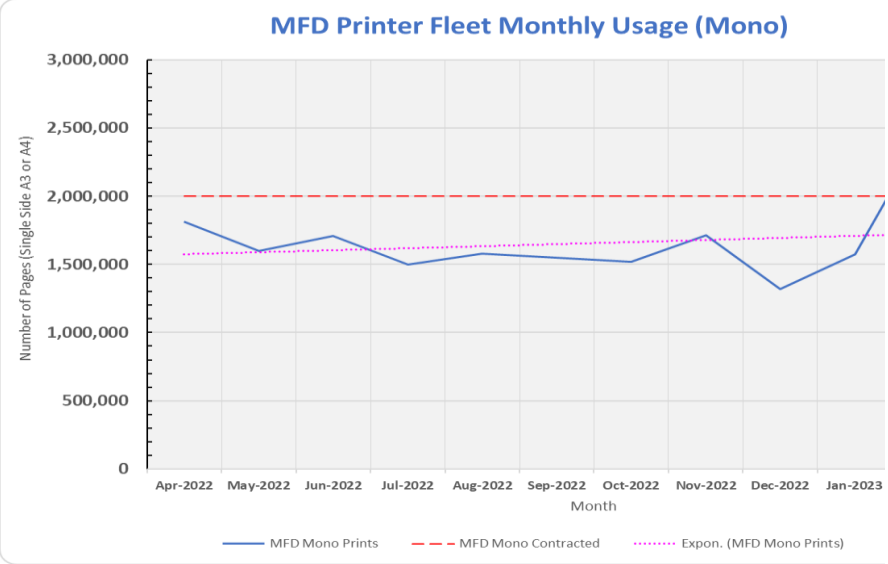
Total PC's & Laptops = 6,906

PC Estate by Age		
	#	%
>3 years	5114	74%
>5 years	2185	32%
>7 years	663	10%

NLaG Colour Printing per Page 22/23



NLaG Mono Printing per Page 22/23



Additional References

Government Papers on Digital
Digital transformation in the NHS - Health and Social Care Committee (parliament.uk)

A plan for Digital Health and Social Care
A plan for digital health and social care - GOV.UK (www.gov.uk)

Data Saves Lives: reshaping health and social care with data
Data saves lives: reshaping health and social care with data - GOV.UK (www.gov.uk)

What Good Looks Like?
https://www.nhsx.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/

Data Security and Protection Toolkit
https://www.dsptoolkit.nhs.uk/

Sustainable ICT and Digital Services Strategy 2020-2025
https://www.gov.uk/government/publications/greening-government-ict-and-digital-services-strategy-2020-2025/greening-government-ict-and-digital-services-strategy-2020-2025

Technology Code of Practice
https://www.gov.uk/government/publications/technology-code-of-practice/technology-code-of-practice

Digital Technology Assessment Criteria (DTAC)
https://www.nhsx.nhs.uk/key-tools-and-info/digital-technology-assessment-criteria-dtac/

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	1 August 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	**Health Tree Foundation Trustees' Committee (HTF) Highlight Report –** 6 July 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 6 July 2023 and worthy of highlighting to the Public Trust Board.
Background Information and/or Supporting Document(s) (if applicable)	Health Tree Foundation Trustees' Committee Terms of Reference
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: HTF Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Only on Health Tree Foundation Charitable Funds
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:	1 August 2023
Report From:	Health Tree Foundation Trustees' Committee held on 6 July 2023

Highlight Report:

Community Diagnostic Centre's (CDC)

- The Director of Estates and Facilities gave a short brief on the planned new build CDCs in Grimsby and Scunthorpe. He emphasised the partnership nature of the programme and highlighted the likely much wider footfall in such facilities compared with the hospital sites. This included passers by as well as patients attending diagnostic appointments. Discussion ensued and it was agreed by Trustees that this presented an opportunity to spread the Health Tree Foundation message eve further, including the potential to launch a fundraising appeal for the two new centres, like those recently held for the new Emergency Departments (ED) at each site. The HTF Charity Manager was asked to examine this idea and report back to Trustees.

Communications

- Trustees yet again emphasised the need to ensure that the work of The Health Tree Foundation was publicised effectively across the Trust, including patients, their families and friends and staff. The HTF Charity Manager and Communications Assistant agreed to re-examine their current plans with the aim of introducing new ideas to enhance such awareness across the Trust and wider community.

Annual Self-Assessment

- The Committee discussed their Annual Self-Assessment results and agreed that a more tailor-made assessment should be used in future. This, it was felt, would provide a set of questions that would be more relevant to the business of the HTF Trustees' Committee. It was agreed that these would be developed and reviewed at the next Committee meeting.

Confirm or Challenge of the Board Assurance Framework:

Action Required by the Trust Board:

The Trust Board is asked to note the decisions made by Trustees.

Neil Gammon
Independent Chair of Health Tree Foundation Trustees' Committee

NLG(23)145

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	1 August 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 (ARG) Highlight Report – July 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 20 July 2023: 1. **Internal Audit Draft Reports and Recommendations** – Some delays in responding to draft Internal Audit reports and internal audit recommendations should be actioned accordingly in line with the agreed timescale. **Board to note.** 2. **Mandatory Fire Training** – 77% of staff compliant with mandatory fire training in 2022/23, with the re-introduction of face-to-face training creating difficulties in staff being released from their areas to attend. **Board to note.** 3. **Clinical Audit Forward Programme 2023/24** – Observation that the number of planned clinical audits appeared to be a huge commitment and considered whether there is the capacity to conduct such levels of clinical audit work. **Board to note.** 4. **Data Protection and Security Toolkit Return 2022/23** – Commended the efforts of all those involved in the submission of this year's return, noting the improvements made. Final push being made to reach 95% compliance on IG training by the end of August 2023 which would move the Trust to 'Standards Met'. **Board to note.**
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk & Governance Committee Agenda Papers – 20 July 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.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	1 August 2023
Report From:	Audit, Risk & Governance Committee – 20 July 2023

Highlight Report:

1. **Internal Audit Draft Reports and Recommendations** – The Committee noted some delays in responding to draft Internal Audit reports and ask all those involved in providing responses to draft reports to do so in a timely manner. The Committee would also like to issue a general reminder that internal audit recommendations should be actioned accordingly in line with the agreed timescale.

2. **Mandatory Fire Training** – Only 77% of staff were compliant with their mandatory fire training in 2022/23 (a reduction on 2021/22 which saw 91% compliance) and the Committee heard that the re-introduction of face-to-face training (required once every 4 years, with eLearning in the other years) in 2022/23 involving a 90 minute session was creating difficulties in staff being released from their areas to attend.

3. **Clinical Audit Forward Programme 2023/24** – The Committee received the programme for assurance and made an observation that the number of planned clinical audits appeared to be a huge commitment for the organisation and considered whether there is the capacity to conduct such levels of clinical audit work. The Committee also considered the outcome value of the planned programme.

4. **Data Protection and Security Toolkit (DSPT) Return 2022/23** – The Committee commended the efforts of all those involved in working together on the submission of this year's DSPT return, noting the improvements made. The Committee heard that a final push is being made to reach 95% compliance for Information Governance training by the end of August 2023 – the Trust stood at 90% compliance at the time of the DSPT submission on 30 June 2023. If the Trust achieves 95% compliance it will move from 'Approaching Standards Met' to 'Standards Met'.

Confirm or Challenge of the Board Assurance Framework:

The Q1 BAF was presented to the Committee and heard that the Trust Board would be reviewing the risks previously reviewed by the Strategic Development Committee which has now been disbanded.

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

NLG(23)146

Name of the Meeting	**Trust Board – Public**
Date of the Meeting	1 August 2023
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Board Assurance Framework (BAF) 2023-24, Quarter One**
Purpose of the Report and Executive Summary (to include recommendations)	**Purpose of the Report** The BAF brings together all of the relevant information on the risks to the delivery of the board's strategic objectives, highlighting risks, controls and assurances. It is an essential tool for seeking assurance against delivery of key organisational objectives. It is envisaged that through appropriate utilisation of the BAF the Board can have confidence that they are providing thorough oversight of strategic risk. **Executive Summary** The Trust Board is asked to receive the BAF to gain assurance on the delivery of the Board's strategic objectives (SO). The Board is to note that the Committees have received and reviewed their respective strategic risks. The Board is to consider specific strategic risks due to the disbanding of the Strategic Development Committee and agree current risk scoring for SO1-1.3, SO1-1.5, SO3-3.2 and SO4 (the wording of the strategic risks can be found in Appendix A). **Recommendations** The Trust Board is asked to: a) review strategic risks: SO1-1.3, SO1-1.5, SO3.2 and SO4, b) agree the current strategic risk scores of: SO1-1.3 = 12 SO1-1.5 = 6 SO3-3.2 = 15 SO4 = 12, c) receive the report and the BAF to gain assurance on the delivery of the strategic objectives (Appendix A), d) note the high-level risk register (Appendix B), e) note the Finance and Performance Committee, Quality and Safety Committee, Workforce Committee and the Audit Risk and Governance Committees received and reviewed the BAF at their respective meetings in July 2023.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ Divisional SMT

	☐ PRIMs	✓ Other: Audit Risk and Governance Committee, Finance and Performance Committee, Quality and Safety Committee, Workforce Committee, Executive Directors
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) – Quarter One, 2023-24

1. Executive Summary

1.1. The Trust Board is asked to receive the BAF to gain assurance on the delivery of the Board's strategic objectives (SO).

1.2. The Board is to note that the Committees have received and reviewed their respective strategic risks.

1.3. The Board is to consider specific strategic risks due to the disbanding of the Strategic Development Committee and agree current risk scoring for SO1-1.3, SO1-1.5, SO3-3.2 and SO4 (the wording of the strategic risks can be found in Appendix A).

2. Purpose of the Report

2.1. The BAF brings together all of the relevant information on the risks to the delivery of the board's strategic objectives, highlighting risks, controls and assurances. It is an essential tool for the Board seeking assurance against delivery of key organisational objectives. It is envisaged that through appropriate utilisation of the BAF the Board can have confidence that they are providing thorough oversight of strategic risk.

2.2. The report will provide the Board with:
- clarity about what the strategic objective is and what is being measured,
- assurance that controls are in place to achieve the objective and that they lead to desired outcomes,
- assurance that the controls are implemented / adhered to,
- singular and cumulative risks graded consistently to each strategic objective,
- assurance that actions address the 'root cause',
- assurance that actions are being implemented and monitored.

3. Strategic Objective Risk Ratings: Quarter One 2023-24

2023-24						
Strategic Objective / Quarter	Risk Rating				Target Risk by 31/03/2024	Risk Appetite Score
	1	2	3	4		
SO1-1.1	15				15	4-6
SO1-1.2	20				15	4-6
SO1-1.3	12				8	4-6
SO1-1.4	20				20	4-6
SO1-1.5	6				6	4-6
SO1-1.6	12				8	4-6
SO2	20				15	4-6
SO3-3.1	20				10	8-12
SO3-3.2	15				15	8-12
SO4	12				8	8-12
SO5	12				8	8-12

4. The Board is asked to note the Audit Risk and Governance Committee received the BAF at is meeting on 20 July 2023. The Committee received the quarterly BAF and High Level Risk Register to gain assurance that it is operating as part of the Trust's overarching governance / control systems.

5. Principal Risks – Highlights and Lowlights, Quarter One, 2023/24

5.1.1. The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience - SO1-1.1

a) The Quality and Safety Committee reviewed the BAF at its meeting on 25 July 2023 and agreed the risk score of 15 for quarter one. The risk score is due to the strategic threats and the overall healthcare environment challenges.

b) The Committee noted there is a number of very high-level risks related to divisions and departments within the Trust, that may have an impact on the delivery of the strategic objective:
   i) No 3162 – quality of care and patient safety based on nurse staffing and,
   ii) No 3164 – nurse staffing (high number of registered nurse and support worker vacancies), both scored at 20.

5.1.2. The risk that the Trust fails to deliver constitutional and other regulatory performance targets - SO1-1.2

a) The Finance and Performance Committee reviewed the BAF at its meeting on 19 July 2023 and agreed the risk score of 20 for quarter one. The risk score is due to the review of clinical pathways linked to the Humber Acute Services programme, validation of Referral To Treatment clock stops and the signing-off of the Consultant Job Plans for 2023-24.

b) The Committee noted a key gap in control is the high levels of staff vacancies across registered nurses, doctors and allied health professionals in all service areas. This could impact on providing treatment, care and support which is as safe, clinically effective and timely as possible.

5.1.3. The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy - SO1-1.3

a) Due to the disbanding of the Strategic Development Committee, the Board is required to review and consider this strategic risk.

b) The risk has been reviewed by the Director of Strategic Development who has recommended the current risk score of 12. The Integrated Care Board approved the proposal to move forward to public consultation regarding the reconfiguration of certain services on the South Bank on 12 July 2023, subject to NHS England approval. The proposals recommend improving services at local Emergency Departments across the North and South Bank, enabling people to be treated quickly and tackling long waiting times.

c) The Board is asked to agree the risk score of 12.

5.1.4. The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate - SO1-1.4

a) The Finance and Performance Committee reviewed the BAF at its meeting on 19 July 2023 and agreed the risk score of 20 for the quarter one position.

b) The Committee noted that the risk score is due to the Capital Programme funding for 2023-24 being impacted by the Critical Infrastructure Risk and BLM: the Six Facet total figure is £117M and the Backlog maintenance of £107M.

5.1.5. The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources - SO1-1.5

a) Due to the disbanding of the Strategic Development Committee, the Trust Board agreed to have oversight of the risk to the delivery of the Digital Strategy.

i) The risk has been reviewed by the Chief Information Officer who has recommended a risk score of six.

ii) The Board is asked to review and consider the risk to the delivery of the Digital Strategy and to note the securing of resources to deliver the Digital Strategy and annual priorities remains off track with a completion date moved to the end of quarter two.

iii) The Board is asked to agree the risk score of six and note the delivery of the Digital Strategy remains off track.

b) The Board is asked to note, the Audit Risk and Governance Committee received and reviewed the updates to the BAF at its meeting on 20 July 2023. The Committee noted the:

i) IT Business Continuity Policy and Procedure has been further developed and gaps addressed which were identified in the audit in April 2020.

ii) number of planned actions that remain off track: the goal to meet Cyber Essentials Plus Accreditation, a review of the Integrated Performance Report and the running of the new Data Warehouse due to the rescheduling of the Lorenzo PAS go-live.

5.1.6. The risk that the Trust's business continuity arrangements are not adequate - SO1-1.6

a) The Finance and Performance Committee reviewed the BAF at its meeting on 19 July 2023 and agreed the risk score of 12 for quarter one.

b) The Committee noted:

i) a number of planned actions are to be continued during 2023/24: the relaunch of loggist training and continuous review of evacuation plan,

ii) the Bed Capacity challenges remain a gap in control. The Executive Led Bed Occupancy and Length of Stay Review meetings have only just been set up,

with the first meeting being Thursday 29th June 2023. These meetings have been set up to allow the Chief Operating Officer to Challenge the Divisional Medical Directors and Associate Chief Nurse's on any patients staying on a ward for longer than expected.

5.1.7. The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients - SO2

a) The Workforce Committee reviewed the BAF at its meeting on 18 July 2023 and agreed the quarter one risk score of 20.

b) The Committee noted the:

i) current score of 20 is due to the three planned actions to be achieved by quarter four 2023/24 as part of the People Plan: develop and care for our staff to improve retention, attract and develop new staff and improve our culture and staff engagement, and

ii) delivery of SO2 may be impacted due to the number of High-Level Risks, of note:

- No 2976, High registered nursing vacancy levels = 25
- No 3015, Insufficient estate resources to manage the workload demand = 20.

5.1.8. The risk that either the Trust or the Humber and North Yorkshire Integrated Care System fail to achieve their financial objectives and responsibilities - SO3-3.1

a) The Finance and Performance Committee reviewed the BAF at its meeting on 19 July 2023, agreed the quarter one risk score of twenty and the target risk score for 31 March 2024 of ten. The Committee undertook a deep dive and were assured of the controls and assurances in place.

b) The Committee noted:

i) the target risk score of ten for 31 March 2024 is due to the financial challenges for 2023/24, and

ii) four new planned actions have been added, which are on track to deliver: review of nationally specified control actions, complete the Cost Improvement Programme planning process, Humber Acute Services public consultation and the development of workforce plans.

5.1.9. The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate - SO3-3.2

a) Due to the disbanding of the Strategic Development Committee, the Board is required to review and consider this strategic risk.

b) The risk has been reviewed by the Director of Strategic Development who has recommended the current risk score of 15 for quarter one.

c) The Board is asked to agree the recommended risk score of 15. This is due to a significant risk with capital investment which is due to the availability of capital funding to meet our requirements, impact of capital decisions on accessing new hospitals programme funding and impact of national reports (Ockenden) on potential capital investment requirements.

5.1.10. The risk that the Trust is not a good partner and collaborator – SO4

a) Due to the disbanding of the Strategic Development Committee, the Board is required to review and consider this strategic risk.

b) The risk has been reviewed by the Director of Strategic Development who has recommended the current risk score of 12 for quarter one. The Integrated Care Board approved the proposal to move forward to public consultation regarding the reconfiguration of certain services on the South Bank on 12 July 2023, subject to NHS England approval. The proposals recommend improving services at local Emergency Departments across the North and South Bank, enabling people to be treated quickly and tackling long waiting times.

c) The Board is asked to agree the risk score of 12.

5.1.11. The risk that the leadership of the Trust 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 - SO5

a) The risk was reviewed by the Workforce Committee at its meeting on 18 July 2023 and agreed the current risk score of 12 for the quarter one period.

b) The Committee noted:

i) focus is on the delivery of the Trust Leadership Strategy 2020-24,

ii) there remains a gap with the ongoing investment specifically for staff training / courses to support leaders.

iii) there remains a threat to the delivery of the strategic objective, being, the higher turnover of staff due to poor levels of leadership.

6. Recommendations

6.1. The Trust Board is asked to:

a) review strategic risks: SO1-1.3, SO1-1.5, SO3.2 and SO4,

b) agree the current strategic risk scores of:
SO1-1.3 = 12
SO1-1.5 = 6
SO3-3.2 = 15
SO4 = 12,

c) receive the report and the BAF to gain assurance on the delivery of the Board's strategic objectives (see Appendix A),

d) note the high-level risk register (see Appendix B),

e) review strategic risks: SO1-1.3, SO1-1.5, SO3.2 and SO4, and agree the current risk scores,

f) note the Finance and Performance Committee, Quality and Safety Committee, Workforce Committee and the Audit Risk and Governance Committees received and reviewed the BAF at their respective meetings in July 2023.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Board Assurance Framework - 2023 / 24

Strategic Objective	Strategic Objective Description
1. To give great care	● To provide care which is as safe, effective, accessible and timely as possible ● To focus always on what matters to our patients ● To engage actively with patients and patient groups in shaping services and service strategies ● To learn and change practice so we are continuously improving in line with best practice and local health population needs ● To ensure the services and care we provide are sustainable for the future and meet the needs of our local community ● To offer care in estate and with equipment which meets the highest modern standards ● To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.
2. To be a good employer	● To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: - inclusive values and behaviours - health and wellbeing - training, development, continuous learning and improvement - attractive career opportunities - engagement, listening to concerns and speaking up - attractive remuneration and rewards - compassionate and effective leadership - excellent employee relations.
3. To live within our means	● To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse ● To keep expenditure within the budget associated with that income and also ensuring value for money ● To achieve these within the context of also achieving the same for the Humber and North Yorkshire (HNY) Integrated Care System (ICS) ● To secure adequate capital investment for the needs of the Trust and its patients.
4. To work more collaboratively	● To work innovatively, flexibly and constructively with partners across health and social care in the Humber and North Yorkshire Integrated Care System (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan ● To make best use of the combined resources available for health care ● To work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally ● To work with partners to secure major capital and other investment in health and care locally ● To have strong relationships with the public and stakeholders ● To work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: - make best use of the human capabilities and capacities locally; - offer excellent local career development opportunities; - contribute to reduction in inequalities; - contribute to local economic and social development.
5. To provide good leadership	● To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Board Assurance Framework - 2023 / 24

The Trust's risk appetite is:

• For risks threatening the safety of the quality of care provided – low (4 to 6)

• For risks where there is the potential for positive gains in the standards of service provided – moderate (8 to 12)

• For risks where building collaborative partnerships can create new ways of offering services to patients – moderate (8 to 12)

Context

Healthcare organisations like NLaG are by their very nature risk averse, the intention of this risk appetite statement is to make the Trust more aware of the risks and how they are managed. The purpose of this statement is to give guidance to staff on what the Trust Board considers to be an acceptable level of risk for them to take to ensure the Trust meets its strategic objectives. The risk appetite statement should also be used to drive action in areas where the risk assessment in a particular area is greater than the risk appetite stated below.

NLAG is committed to working to secure the best quality healthcare possible for the population it serves. A fundamental part of this objective is the responsibility to manage risk as effectively as possible in the context of a highly complex and changing operational environment. This environment presents a number of constraints to the scope of NLAG's risk management which the Board, senior management and staff cannot always fully influence or control; these include:

• how many patients need to access our services at any time and the fact our services need to be available 24/7 for them whether we have the capacity available or not
• the number of skilled, qualified and experienced staff we have and can retain, or which we can attract, given the extensive national shortages in many job roles.
• numerous national regulations and statutory requirements we must try to work within and targets we must try to achieve
• the state of our buildings, IT and other equipment
• the amount of money we have and are able to spend
• working in an unpredictable and political environment.

The above constraints can be exacerbated by a number of contingencies that can also limit management action; NLAG operates in a complex national and local system where the decisions and actions of other organisations in the health and care sector can have an impact on the Trust's ability to meet its strategic objectives including its management of risk.

Operating in this context on a daily basis Trust staff make numerous organisational and clinical decisions which impact on the health and care of patients. In fulfilling their functions staff will always seek to balance the risks and benefits of taking any action but the Trust acknowledges some risks can never be eliminated fully and has, therefore, put in place a framework to aide controlled decision taking, which sets clear parameters around the level of risk that staff are empowered to take and risks that must be escalated to senior management, executives and the Board.

Risk Appetite Assessment

Risk Assessment Grading Matrix					
Likelihood of recurrence	Severity / Impact / Consequence				
	None / Near Miss (1)	Low (2)	Moderate (3)	Severe (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Certain (5)	5	10	15	20	25
RISK	Green Risk Score 1 - 3 (Very Low)	Yellow - Risk Score 4 - 6 (Low)	Orange - Risk Score 8 - 12 (Medium)	Red - Risk Score 15 - 25 (High)	

Risk Management

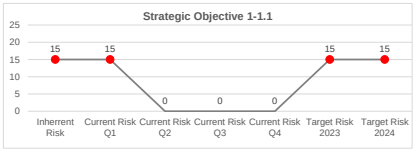
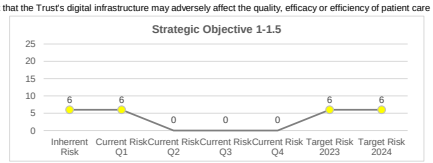
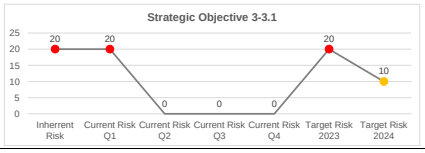
The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using the feedback as an opportunity for learning and improving the quality of our services. The Trust recognises it has a responsibility to manage risks effectively in order to:

• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using their feedback as an opportunity for learning and improving the quality of our services. The Trust recognises it has a responsibility to manage risks effectively in order to:

• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

Board Assurance Framework - 2023 / 24

Strategic Risk	High Level Risk Description and Risk Consequence / Likelihood Assessment	Risk Appetite	Owner	Committee
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard 	Low	Chief Medical Officer and Chief Nurse	Q&SC
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets 	Low	Chief Operating Officer	F&PC
SO1 - 1.3	The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy 	Low	Director of Strategic Development	Trust Board
SO1 - 1.4	The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate 	Low	Director of Estates and Facilities	F&PC
SO1 - 1.5	The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care 	Low	Chief Information Officer	ARG / Trust Board
SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope 	Low	Chief Operating Officer	F&PC
SO2	The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients. 	Low	Director of People	WC
SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities 	Moderate	Chief Financial Officer	F&PC
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital 	Moderate	Director of Strategic Development	Trust Board
SO4	The risk that the Trust is not a good partner and collaborator 	Moderate	Director of Strategic Development	Trust Board
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives 	Moderate	Chief Executive	WC

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.1: To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards nationally.

Risk to Strategic Objective 1 - 1.1: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	3	3				3
Risk Rating Score	15	15				15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 3 July 2023

Lead Committee: Quality and Safety Committee

Risk Owners: Chief Medical Officer and Chief Nurse

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy, Risk Management Strategy, Nursing, Midwifery & Allied Health Care Professionals Strategy, Clinical Strategy, Medical Engagement Strategy

Current Controls

- Quality and Safety Committee (Q&SC)
- Operational Plan 2022/23
- Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems
- Risk Management Group
- Trust Management Board
- Quality Board, NHSE
- Place Quality Meetings - N Lincs, N E Lincs, East Riding
- SI Collaborative Meeting with ICB, with Place Representatives
- Health Scrutiny Committees (Local Authority)
- Chief Medical Information Officer (CMIO)
- Council of Governors
- SafeCare Live
- Serious Incident Panel, Patient Safety Specialist and Patient Safety Champions Group
- Nursing Metric Panel Meeting
- OPEL Nurse staffing levels and short term staffing SOP
- Nursing and Midwifery Board
- NICE Guidance implementation monitoring and reporting processes
- Learning from deaths process
- Mortality Improvement Group
- Vulnerabilities Group
- Incident control group chaired by NHSE to support Paediatric Audiology service.

Assurance (internal & external)

Internal:
- Minutes of Committees and Groups
- Integrated Performance Report
- Annual Safe Staffing Report, Vulnerabilities report, Annual Complaints Report, Quality Improvement Report, Infection Control Annual Report, Maternity and Ockenden Report to Trust Board, Learning from deaths annual and quarterly reports.
- Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board
- NICE Guidance Assurance Report to Q&SC
- IPC - Board Assurance Framework and IPCC
- Inpatient surveys
- Nursing assurance safe staffing framework NHSI
- Audit Outlier Report to Quality Governance Group
- 15 Steps Accreditation Tool
- CQC action planning, monitoring and assurance of action completion processes

External (positive):
- Internal Audit - Serious Incident Management, N2019/16, Significant Assurance
- Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance
- NHSE External Review of Safe Staffing Establishment and Recommendations - February 2022
- Maternity Birth Rate Plus Review - 2022
- Internal Audit - CQC action plan compliance – Significant assurance
- Improved ratings in CQC inspection (Dec 2022 report) with Good for Goole Hospital and Safe domain improved from Inadequate to Requires Improvement
- Maternity CNST standards compliance submission
- Health Scrutiny Committees (Local Authority)

Planned Actions

Action	Quarter / Year	Assurance
Continue to develop metrics as data quality allows	Ongoing	Green
Delivery of deteriorating patient improvement plan	Q4 2023/24	Amber
Implementation of End of Life Strategy (system-wide strategy)	Q4 2025/26	Amber
Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays)	Q2 2023/24	Green
Implementation of the Learning From Patient Safety Events incident reporting requirements (we are in testing phase).	Q2 2023/23	Green
Review and implement changes to Audiology Service	Q2 2023/24	Amber
15 steps Star Accreditation Programme commenced	Ongoing	Green
Delivery of the Quality Priorities for 2023/24 improving patient outcomes in 5 specific areas.	Q4 2023/24	Green
Delivery of the 2023/24 CQUIN schemes to improve quality of care for patients	Q4 2023/24	Green

Future Risks

- Influenza surges and other infections which impact on patient experience
- National policy changes to access and targets
- Reputation as a consequence of recovery
- Additional patients with longer waiting times and additional 52 week breaches, due to COVID-19
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility
- Impact of IPC plans on NLaG clinical and non clinical strategies
- Skill mix of staff
- Student and International placements and capacity to facilitate/supervise/train.
- Transition from SI reporting framework to PSIRF approach.

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.

Gaps in Controls

- Estate and compliance with IPC requirements B12- see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Attracting sufficiently qualified staff - see BAF SO2
- Funded full time Transition post across the Trust
- Paediatric audiology service

Gaps in Assurance

- Delays with results acknowledgement (system live, process not yet embedded)
- Progress with the End of Life Strategy
- Safety and delays on cancer pathways
- Patient safety risks increased due to longer waiting times. (Refer to SO1-1.2)

Links to High Level Risks Register

Divisional / Departmental Risks Scoring >15:
No 2347 Deteriorating patient risk, Surgery = 15
No 2992 Lack of Changing Places facility at SGH = 16
No 3036, Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS = 16
No 3158, Risk of not being able to view scans on Badgernet, patient safety risk to hgh risk pregnancies = 15
No 3161, Risk of patient deterioration not being recognised and escalated on NEWS = 15
No 3162, quality of care and patient safety based on nurse staffing position in Medicine = 20
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20
No 3168, Newborn hearing screening service cross-site (reduced management time / no management cover) = 16

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- International recruitment
- Shared clinical development opportunities
- Development of Integrated Care Provider with Local Authority

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.2: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.2: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	4	4				3
Risk Rating Score	20	20				15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy,Quality Improvement Strategy, Risk Management Strategy, Learning Strategy, Nursing and Midwifery Strategy, Clinical Strategy

Current Controls

- Operational Plan
- Operational Management Group (OMG)
- Performance Review Improvement Meetings (PRIMs)
- Trust Management Board (TMB)
- Waiting List Assurance Meetings
- Cancer Board Meeting
- Winter Planning Group
- A&E Delivery Board
- Policies, procedures, guidelines, pathways supporting documentation & IT systems
- Cancer Improvement Plan
- MDT Business Meetings
- Risk stratification
- Capacity and Demand Plans
- Emergency Care Quality & Safety Group
- Primary and Secondary Care Collaborative Outpatient Transformation Programme
- Divisional Executive Review Meetings
- System-wide Ambulance Handover Improvement Group
- Patient Flow Improvement Group (PFIG)
- Planned Care Improvement and Productivity (PCIP)
- Emergency Department and Medicine Specialties Quality & Safetly Groups

Assurance (internal & external)

Internal:
- Minutes of Finance and Performance Committee, OMG, PRIMS, TMB, Waiting List Assurance Meetings, Cancer Board Meeting, Winter Planning Group, A&E Delivery Board, MDT Business Meetings, System-wide Ambulance Handover Improvement Group, PCIP, PFIG
- Integrated Performance Report to Trust Board and Committees.
- Executive and Non Executive Director Report (bi-monthly) to Trust Board.

Positive:
- Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- Benchmarked diagnostic recovery report outlining demand on services and position compared to peers presented at PRIM, October 2020. No significant differences identified, Trust compares to benchmarked peers.
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022
- Audit Yorkshire internal audit: Waiting List Management (including Clinical Harm): Significant Assurance, Q1 2022
- Completed job plans for relevant clinicians for 2022-23

External:
- Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- NHSE Intensive Support Team
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022

Planned Actions

Action	Quarter / Year	Assurance
Progress with implementation of General Internal Medicine/Frailty Model and the link as a wider integrated frailty model across Northern Lincolnshire	Q2 2023/24	Yellow
Review of clinical pathways linked to HAS programme 1 Humber Clinical Collaborative Programme (HCCP), seven specialties	Q2 2023/24	Amber
Validation of all RTT Clock Stops back to 100%	Q2 2023/24	Amber
Develop divisional dashboards	Q2 2023/24	Yellow
Consultant job plans to be signed off for 2023-24	Q2 2023/24	Red
Completion of theatre refubishment programme	Q2 2023/24	Green
Implementation of 2023/24 Outpatient Clinic Configuration aligned to 2023/24 Activity Plan and NHS Operational Planning Guidance, reducing follow up activity and increasing capacity for new patients	Q2 2023/24	Green
Implementation of Gynaecology Service Review including the support the Integrated Acute Assessment Unit (IAAU) model of care	Q3 2023/24	Green
Expansion of Community Discharge and Admission Alternative Development workstreams (Virtual Ward capacity, Short Term care capacity and OPAT capacity)	Q3 2023/24	Green
Implementation of Criteria to Admit within ED to support reduction in admissions and use of alternative pathways	Q4 2023/24	Green
Review of pathways for High Intensity Service Users	Q4 2023/24	Green
Implementation of Clinical Frailty Score in ED	Q4 2023/24	Green
Review Dementia pathways in ED	Q4 2023/24	Green
Implementation phase 3 of AAU business case	Q4 2023/24	Green

Future Risks

- Further COVID-19 surges and impact on patient experience and bed planning due to IPC guidance (including norovirus).
- National policy changes to emergency access and waiting time targets.
- Funding and fines changes.
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times over 18 weeks, 52 weeks, 64 weeks, 62 days and 104 days breaches.
- Additional patients with longer waiting times across the modalities of the 6 week diagnostic target, due to inability to access scanner and reporting teams externally
- Generational workforce analysis shows significant risk of retirement in workforce.
- Many services single staff / small teams that lack capacity and agility.
- Staff taking statutory leave unallocated due to COVID-19 risk.
- Future requirement of Type 5 SDEC activity to be submitted as part ECDS requires significant system change. Early adopters from July 23, with mandatory submission from July 24
- Inability to staff UCS due to lack of support from Primary Care
- Impact of Mutual Aid work and increase in waiting times - not meeting constitutional standards and impact on diagnostic capacity
- Risk of no contracting for independent sector work
- Funding will not be approved to uplift weekend working for elective activity and support insourcing of theatre staff to backfill vacancy position.
- Replacement of ward A1

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.
Adverse impact of external events (ie. Continued Pandemic) on business continuity and the delivery of core service.

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 64 weeks, over 52 week waits and Diagnostics Constitutional Standards.
- Diagnostic capacity and capital funding to be confirmed.
- Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations.
- High levels of staff sickness
- High levels of staff vacancies across registered nurses, doctors and allied health professionals in all service areas.

Gaps in Assurance

- Quality of reports to board assurance committees
- Quality and timeliness of data
- Recruitment and development of Consultants, specialist nurses

Links to High Level Risks Register

No 1851, Shortfall in capacity with Ophthalmology service = 15
No 2244, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2245, Risk to Overall Performance : Non compliance with RTT incomplete target = 16
No 2562, Failure to meet constitutional targets in ECC = 20
No 2347, Risk to Overall Performance : Overdue Follow-ups = 15
No 2576, Paediatric Medical Support Pathway for ECC - 'Fastrack' = 16
No 2592, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2773, Lack of scanning capacity s leading to a risk of delayed diagnosis = 16
No 2949, Oncology Service = 20
No 3129, Overdue follow-up and new patients waiting lists for paediatric patients at SGH = 15
No 3131, Delay in paediatric assessment being carried out (multi-agency assessmenbt for under five years of age = 16
No 3168, Newborn hearing screening service cross-site (reduced management time / no management cover) = 16
No 3201, Clinical capacity within colposcopy = 15
No 3204, One year wait for new referrals to see a Consultant Paediatrician into the ADHD post diagnostis support service = 15

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- Collaboration with PCNs in NL / NEL to support full implementation of the UCS model

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.3: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

Risk to Strategic Objective 1 - 1.3: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	4	4				4
Likelihood	3	3				2
Risk Rating	12	12				8

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023

Lead Committee: Trust Board

Risk Owner: Director of Strategic Development

Enabling Strategy / Plan: NHS Long Term Plan, Trust Strategy and Strategic Plan, Clinical Strategy, Integrated Care System

Current Controls

- NLaG Clinical Strategy 2021/25.
- Trust Priorities 2023/24
- Humber and North Yorkshire Integrated Care System
- Integrated Care System (ICS) Leadership Group.
- Quality and Safety Committee.
- Acute and Community Care Collaboratives (ACC).
- Humber Cancer Board.
- Humber Acute Services - Executive Oversight Group (HAS)
- Health Overview and Scrutiny Committees (OSC).
- Trust Membership
- Council of Governors.
- Primary Care Networks (PCNs).
- Place Boards
- Clinical and Professional Leaders Board.
- Hospital Consultants Committee (HCC) / MAC
- Joint Development Board (JDB)
- Committees in Common (CIC)
- Patient Safety Champions

Assurance (internal & external)

Positive:
- NHSE Assurance and Gateway Reviews.
- OSC Engagement.
- Clinical Senate formal review
- The Consultation Institute (assurance on the engagement process)

Internal:
- Minutes from Committees and Executive Oversight Group for HAS, JDB, CiC
- Humber and North Yorkshire Integrated Care System
- ICS Leadership Group.
- OSC Feedback.
- Outcome of public, patient and staff engagement exercises.
- Executive Director Report to Trust Board.
- Non-Executive Director Committee Chair Highlight Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel (Humber).
- The Consultation Institute (assurance on the engagement process)

Planned Actions

Action	Quarter / Year	Assurance
CIC / NED / Governor reviews	Q4 2022/23	Blue
Evaluation of the models and options with stakeholders	Q4 2022/23	Blue
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Blue
Citizens Panel reviews	Q2 2023/24	Green
To undertake continuous process of stocktake and assurance reviews NHSE and Clinical Senate review	Q1 2023/24	Blue
Joint OSC - reviews	Q2 2023/24	Green
To undertake continuous engagement process with public and staff	Q2 2023/24	Green
Stakeholder Mapping	Q1 2023/24	Blue
Public Consultation	Q2/Q3 2023/24	Green
NHSE Gateway review	Q4 2023/24	Green
ICB Executive Assurance Board / IC Board Approval	Q4 2023/24	Green
Final report from Clinical Senate review (due Q1)	Q1 2023/24	Blue
HAS Risk Workshop with ICB Executives (30 May 23)	Q1 2023/24	Blue
Decision Making Business Case	Q3/4 2023/24	Green

Future Risks

- Change in national policy
- Delays in legilsation.
- Operational pressures and demand affecting opportunity to engage.
- Uncertainty / apathy from staff.
- Lack of staff engagement if not the option they are in favour of.
- Out of Hospital enablers and interdependencies
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- Government legislative and regulatory changes.
- Change in local leadership meaning priority changes.
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.
- Creation of Placed based partnerships
- Strategic Capital allocation

Gaps in Controls

- A shared vision for the HAS programme is not understood across all staff/patients and partners
- Link to SO3 - 3.2 re: Capital Investment

Gaps in Assurance

- Feedback from public, patients and staff to be wide spread and specific in cases, that is benchmarked against other programmes.
- Partners to demonstrate full involvement and commitment, communications to be consistent and at the same time.
- Alignment of strategic capital
- Alignment to a System wide Out Of Hospital Strategy and ICS Strategic workforce planning

Links to High Level Risks Register

Future Opportunities

- Clinical pathways to support patient care, driven by digital solutions.
- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.
- HAS Programme
- Joint workforce solutions inc. training and development Humber wide

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.4: To offer care in estate and with engineering equipment which meets the highest modern standards.

Risk to Strategic Objective 1 - 1.4: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	4	4				4
Risk Rating	20	20				20

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 7 July 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Director of Estates and Facilities

Enabling Strategy / Plan: Estates and Facilities Strategy, Clinical Strategy, Digital Strategy

Current Controls

- Audit Risk & Governance Committee
- Finance and Performance Committee
- Capital Investment Board
- Six Facet Survey - 5 years
- Annual AE Audits
- Annual Insurance and External Verification Testing
- Estates and Facilities Governance Group
- Trust Management Board (TMB)
- Project Boards for Decarbonisation Funds
- BLM Capital Group Meeting
- PAM (Premises Assurance Model)
- Specialist Technical Groups

Assurance (internal & external)

Positive:
- External Audits on Estates Infrastructure, Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- PAM

Internal:
- Minutes of Finance and Performance Committee, Audit Risk & Governance Committee, Capital Investment Board, Estates and Facilities Governance Group, TMB, Project Board - Decarbonisation
- PAM
- Non Executive Director Committee Chair Highlight Report (bi-monthly) to Trust Board
- Executive Director Report (6 monthly) to Trust Board
- Specialist Technical Groups

External:
- External Audits on Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- ERIC (Estates Return Information Collection)

Planned Actions

Action	Quarter / Year	Assurance
Continue to explore funding bids to upgrade infrastructure and engineering equipment - Action date; ongoing	Ongoing Actions	Green
Secure sufficient Core Capital Funding to ensure the infrastructure, engineering and equipment needs identified in the 6 facet survey can be managed appropriately.	Ongoing Actions	Red
Complete refurbishment of old DPOW ED (prgramme slipped - new completion date Dec 2023)	Q3 2023/24	Red
Complete refurbishment of old SGH ED (completion end of Q4ã)	Q3 2023/24	Red
Complete BLM 23/24 programme	Q4 2023/24	Amber

Future Risks

- COVID-19 future surge and impact on the infrastructure
- National policy changes (HTM / HBN / BS); Ventilation, Building Regulation & Fire Safety Order
- Regulatory action and adverse effect on reputation
- Long term sustainability of the Trust's sites
- Clinical Plan
- Adverse publicity; local/national
- Workforce - sufficient number & adequately trained staff
- Without significant investment future BLM will increase (BLM figures for 2019/20 = £97M circa, and BLM figures for 2020/21 increased to circa £107M, 2022/23 Six Facet = £117m)

Strategic Threats

- Integrated Care System (ICS) Future Funding
- Failure to develop aligned system wide clinical strategies and plans which support long term sustainability and improved patient outcomes. This could prevent changes from being made
- The above prevents changes being made which are aligned to organisational and system priorities
- Government legislative and regulatory changes

The Critical Infrastrucutre Risk (CIR) is 74% of the total BLM. The breakdown of the CIR % per site is detailed below:
•Grimsby 21% CIR of the BLM
•Goole 11% CIR of the BLM
•Scunthorpe 42% CIR of the BLM

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR
- Insufficient Capital funding

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities (development in progress)

Links to High Level Risks Register

No 1620, Medical Gas Pipeline System = 20
No 2038, Fire Compliance = 20
No 2623, Failure of windows - Trustwide = 20
No 2088, Building Management Systems (BMS) Controller failure/upgrade = 20
No 2719, Water Safety Compliance:Oversized water distribution pipes = 20
No 2951, Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide = 20
No 2655, SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers = 20
No 3015 Insufficient estate resources to manage the workload demand - Trustwide = 20
No 1774, Poor condition of Fuel Oil Storage Tanks - SGH = 16
No 2035, Equality Act 2010 compliance - Trustwide = 16
No 2272, EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide = 16
No 2905, Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW = 16
No 2952, Water Safety Compliance: Fire ring main - Trustwide = 16
No 2953, Water Safety Compliance: Sensor taps - Trustwide = 16
No 2959, Replacement/Repairs of flat roof - Trustwide = 16
No 2036, Ventilation and Air Conditioning - HVAC - Trustwide = 15
No 2955, Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide = 15

Future Opportunities

- Closer ICS working.
- Humber Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.
- Expression of Interest submitted for New Hospital Programme (NHP)
- PSDS 4 submission
- Feasibility of District Heating network for DPOW

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.5: To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.

Risk to Strategic Objective 1 - 1.5: The risk that the Trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the Trust vulnerable to data losses or data security breaches.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	3	3				3
Likelihood	2	2				2
Risk Rating	6	6				6

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 July 2023

Lead Committee: Audit, Risk and Governance Committee / Trust Board

Risk Owner: Chief Information Officer

Enabling Strategy / Plan: Digital Strategy

Current Controls

- Finance and Performance Committee
- Up to date Digital / IT policies, procedures and guidelines
- Digital Strategy Board
- Digital Solutions Delivery Group
- Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.
- Audit Risk & Governance Committee (including external Auditor reports)
- Annual Penetration Tests
- Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication
- Trust Management Board (TMB)

Assurance (internal & external)

Internal:

- A Digital Strategy Board reviews progress of the plans to achieve the strategy
- Highlight reports to Trust Board, Audit Risk and Governance Committee, Finance and Performance Committee and TMB
- Digital / IT Policies all current
- CIO/Executive Director Report (6 monthly) to Trust Board
- Digital / IT Policies all current
- Consolidated digital services leadership team (Chief Technology Officer, Deputy CIOs and Chief Medical Information Officer, Chief Nurse Information Officer, Chief AHP and Nursing Info Officer)

External:

- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Risk Moderate, High Assurance, 2023

Positive Assurance:

- The Integrated Performance Report (IPR) has been revised and updated. This was done with NHSE/I who have stated it is now among the leading models for reporting.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Risk Moderate, High Assurance, 2023

Planned Actions

Action	Quarter / Year	Assurance
Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Plus Accreditation. Work is being undertaken to target specific gaps which were undelivered by Q4 2022/23.	Q4 2023/24	Green
IPR - further review of current the IPR to align with how the Group model evolves. (ie. adding digital, finance and estates)	Q4 2023/24	Green
Secure resources to deliver Digital Strategy and annual priorities (PAS; EPR; Data Warehouse; RPA; Document management; Infrastructure upgrades). Depending when NHSE EPR digitisation funding is made available.	Q2 2023/24	Amber
The Data Warehouse with core activity data sets will be completed and running on the new platform by May 2023 due to the rescheduling of the Lorenzo PAS go-live. (Undelivered by Q1 2023-24).	Q2 2023/24	Yellow
Review recently submitted Digital Maturity Assessment when published as part of WGLL framework factor in any revision to strategic plans based on findings.	Q2 2023/24	Green
Reconfiguration of local Digital Services functions commenced to move to group structure increasing resilience and its ability to deliver strategic change.	Q3 2023/24	Green

Future Risks

- National policy changes in some cases in short notice, requiring revisions to work plan
- Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards
- IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG specific agenda
- Ongoing financial pressures across the organisation

Strategic Threats

- Capital funding to deliver IT solutions and establish a 5 yr plan
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve

Gaps in Controls

- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.
- Achieve DSP Toolkit compliance - currently approaching standards.

Gaps in Assurance

- Implementation of PAS and connection to Data Warehouse
- DSP Mandatory Training

Links to High Level Risks Register

- No 2300, Insufficient processes in place to ensure records management /quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards. = 16

Future Opportunities

- Humber and North Yorkshire ICS, system wide collaborative working
- Clinical pathways to support patient care, driven by digital solutions
- Collaborative working with HAS, the Acute Care Collaborative and Integrated Care Partnership

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.6: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	4	4				4
Likelihood	3	3				2
Risk Rating	12	12				8

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan: NLAG Winter Planning and Potential COVID-19 Wave, Business Continuity Policy

Current Controls

- Winter Planning Group.
- Strategic Planning Group.
- A&E Delivery Board.
- Director of People - Senior Responsible Owner for Vaccinations.
- Ethics Committee.
- Clinical Reference Group.
- Influenza vaccination programme.
- Public communications re: norovirus and infectious diseases.
- Chief Operating Officer is the Senior Responsible Officer for Executive Incident Control Group.
- IPC protocols implemented including mask wearing and rapid testing process
- Patient Flow Improvement Group (PFIG)
- Discharge System Improvement Group
- Planned Care Improvement and Productivity (PCIP)
- Industrial action planning (Strategic & Tactical Group)
- Emergency Preparedness, Resilience and Response Steering Group
- Bank Holiday Planing Group
- Executive Led Bed Occupancy and Length of Stay Review

Assurance (internal & external)

Internal:
- National and Regional exercises testing emergency plans, business continuity and planning assumptions (e.g. Artic Willow, Mighty Oak)
- Business continuity management system and business continuity plans
- Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, A&E Delivery Board, Clinical Reference Group, PFIG, Discharge System Improvement Group, PCIP, Strategic & Tactical Group, Emergency Preparedness, Resilience and Response Steering Group, Bank Holiday Planning Group, Executive Led Bed Occupancy and Length of Stay Review

Positive:
- Half yearly tests of the Major incident response cascades
- Annual review of business continutiy plans.
- Internal audit of emergency planning and business continuity compliance 2022/23 rated substantial compliance

External:
- Emergency Planning self-assessment tool and peer review against the NHSE EPRR Core Standards rated substantial compliance
- NHSE review of emergency planning self-assessment 2021/22 rated substantial compliance
- Internal audit of emergency planning and business continuity compliance 2022/23 rated substantial compliance
- EMAS Audit of Trust CBRNe/HAZMAT arrangements with no

Planned Actions

Action	Quarter / Year	Assurance
Relaunch of loggist training and provision	Ongoing	Green
Review of Evacuation Plan	Ongoing	Yellow
Continuous Review of Evacuation Plan	Ongoing	Yellow
Planning for and response to industrial action (multiple unions)	Ongoing	Green
Inclusion of details of BC plans tested/implemented duirng exercises/incidents documented in reports.	Ongoing	Green
Rolling Schedule of annual business continuity plans	Ongoing	Green
Review of Major Incident Plan and Critical Incident Plan	Q2 2023/24	Green
Roll out of new Major Incident Triage Tool (MITT)	Q4 2023/24	Green
Flu / COVID Public Health campaign for Vaccinations	Q3 2023/24	Green

Future Risks

- COVID-19 surge.
- Availability of clinical consumables, equipment and some medications post EU Exit.
- Costs and timeliness of deliveries due to EU Exit.
- Additional patients with longer waiting times RTT, Cancer and Diagnostics.
- Increase in seasonal outbreaks (influenza, norovirus) impacting on bed capacity.
- National industrial action within healthcare and other sectors impacting on workforce levels.
- Increased risk of cyber attacks due to sanctions imposed on Russia.
- Risk of energy supply disruptions over winter period.

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints.

Gaps in Controls

- Capacity to meet demand (workforce).
- Bed Capacity challenges in Northern Lincolnshire, East Riding and Lincolnshire due to ASC workforce challenges being seen and likely to continue into 2023/24.
- Lower than expected uptake of influenza vaccination.

Gaps in Assurance

- BC Plans that are tested or implemented during exercises/incidents are not specifically named or captured within reports to evidence testing.
- Challenge in releasing workforce to attend specialist training (e.g. CBRN/HAZMAT).
- Recruitment pipeline to address medical staffing shortfalls and reduce reliance on agency.
- Recruitment pipeline to address nurse staffing shortfalls and reduce reliance on agency.

Links to High Level Risks Register

- No 2562, Constitutional A&E targets = 20
- No 3164, Nurse staffing = 20
- No 2976, Registered nursing vacancies = 25
- No 3063, Doctor vacancies = 16

Future Opportunities

- Closer Integrated Care System working.
- Provider collaboration.
- Participation in national, regional and ICS/LRF exercising and testing of emergency plans.

Strategic Objective 2 - To be a good employer

Description of Strategic Objective 2: To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations.

Risk to Strategic Objective 2: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	3	4				3
Risk Rating	15	20				15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 12 July 2023

Lead Committee: Workforce Committee

Risk Owner: Director of People

Enabling Strategy / Plan: People Strategy, NHS People Plan, Leadership Development Strategy

Current Controls

Locally
- Workforce Committee
- Audit Risk & Governance Committee
- Trust Management Board (TMB)
- PRIMS
- Nursing,midwifery & AHP recrutiment and retention group
- Remuneration and Terms of Service Committee (RATS)
- Culture Transformation Board (CTB) & Culture Transformation Working Group (CTWG)
- Workforce Systems Group (Finance, HR and Operations)
- People Directorate - People Strategy Annual Delivery Implementation Plan 2023/24
- Annual NHS staff survey and quarterly People Pulse

Regional and ICB
- Humber and North Yorkshire (HNY) – ICB Strategic Workforce Group
- Humber Workforce Group
- ICB People Strategy
- HNY ICB HRD Group
- Yorkshire and North East – HRD Group

National
- National HRD Forum
- NHS People Plan and People Promise
- NHS Employers Forum

Assurance (internal & external)

Internal:
- Minutes of Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, PRIMS, Recruitment and Retention Group, Workforce Development Portfolio Governance Boards, Culture Transformation Board, Workforce Systems Group, Remuneration and Terms of Service Committee.
- NHS People Plan, NLAG People Strategy and Implementation Plan reported to Workforce Committee.
- Workforce Integrated Performance Report
- Annual staff survey and people pulse results
- Medical engagement survey 2019
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board.

Positive:
- IPR decreasing trends
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.

External:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Minutes of Regional and ICB workforce groups
- Minutes of National HRD Forum and NHS Employers Forum

Planned Actions

Action	Quarter / Year	Assurance
Develop and care for our own staff to improve retention (People Plan 23/24)	Q4 2023/24	Green
Develop the attraction and development of new staff (People plan 23/24)	Q4 2023/24	Green
Continue to improve our culture and staff engagement (People Plan 23/24)	Q4 2023/24	Green

Future Risks

- Pockets of low staff morale impacting turnover
- Seasonal illness may impact available workforce numbers
- National policy changes.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Change impact of HASR and Group plans on NLaG clinical and non clinical strategies.
- Reliance on international pipelines to reduced vacancy position. Further local succession planning and future talent identification required.
- Increased demand on people services due to significant volumes of staff recruitment - potential for delays
- Staff retention and ability to recruit and retain HR/OD staff to deliver people agenda
- National strike action driven by pay detracts from local ability to deliver cultural satisfaction.

Strategic Threats

- ICS Future Workforce
- Integrating Care: Next Steps
- Future staffing needs / talent management

Gaps in Controls

- Attract, recruit, retain staff to work in the geographical area.
- Culture and staff engagement.

Gaps in Assurance

- Vacancy postion remain high particulary in medical areas
- Agency spend remains high
- Turnover remains high.

Other Significant Risks & Links to High Level Risks Register

No 1851, Shortfall in Capacity within the Ophthalmology Service - 15
No 2550, Pharmacy Staffing = 15
No 2898, Medical Staff - Mandatory Training Compliance = 16
No 2960, Risk of inability to safely staff maternity unit with Midwives = 16
No 3015, Insufficient estate resources to manage the workload demand = 20
No 3045, Medical Workforce Vacancies in Gastroenterology = 16
No 3048, Challenges to recruitment of acute care physician vacancies in Acute = 16
No 3063, Doctors Vacancies within Medicine Division = 16
No 2976, High registered nursing vacancy levels = 25
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20

Future Opportunities

- Closer ICS working
- Provider collaboration
- International recruitment
- Place based educational collaboratives

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.1: To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber and North Yorkshire Integrated Care System.

Risk to Strategic Objective 3 - 3.1: The risk that either the Trust or the Humber and North Yorkshire Integrated Care System fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	4	4				2
Risk Rating	20	20				10

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 July 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Financial Officer

Enabing Strategy / Plan: Trust Strategy, Clinical Strategy, ICS

Current Controls

- Capital Investment Board, Trust Management Board (TMB), PRIMs, Model Hospital.
- National benchmarking and productivity data constantly reviewed to identify Cost Improvement Programme (CIP) schemes.
- Engagement with Integrated Care System on system wide planning
- Monthly ICS Finance Meetings
- Operational and Finance Plan 2023/24
- Counter Fraud and Internal Audit Plans
- Trustwide Budgetary Control System

Assurance (internal & external)

Internal:
- Minutes of Audit Risk & Governance Committee, Trust Management Board, Finance and Performance Committee, Capital Investment Board, PRIMs, Monthly ICS Finance Meetings
- Non-Executive Director Highlight Report (bi-monthly) to Trust Board

Positive:
- Internal Audit Reports - Internal Control - significant assurance

External:
- Approval received at ICS Level for 2023/24 capital plan
- Internal Audit Reports - Internal Control - significant assurance
- Agreed Financial Plan at ICS Level for 2023/24
- Monthly meetings with NHSE Regional Team as a successor to Financial Special Measures regime.

Planned Actions

Action	Quarter / Year	Assurance
There is specific workforce planning ongoing - linked to Workforce committee (refer to SO2)		Green
Review of nationally specified control actions currently underway with a view to introduction.	Q2	Green
Exercise to identify and complete CIP planning process also underway	Q2	Green
HAS business case planned to go to public consultation	Q3	Green
Develop workforce plans for non-registered nursing and medical staffing	Q2	Red

Future Risks

- COVID-19 further surges and impact on finance and CIP achievement
- Savings Programme not sufficient and deteriorating underlying run rate which is execerbated by the elective recovery programme
- Impact of external factors such as problems with residential and domicilary care, causing hospitals to operate at less than optimum efficiency and cause financial problems
- Vacancy levels in medical and nursing driving an unplanned level of spend
- Inability to transform planned care pathways, including outpatient follow-ups and theatre productivity

Strategic Threats

- ICS Future Funding
- Integrating Care: Next Steps
- System wide control total

Gaps in Controls

- Cost Improvement Programme not fully formed.
- Delivery plan to support activity targets no fully formed.
- Clinical strategy required to inform Finance Strategy
- As we progress, the emerging uncertainty around the financial implications of decisions from the HAS process
- Month on month adverse variants against operational budgets
- Inability to recruit and retain staff to meet financial plannnig assumptions
- Have we systems in place to facilitate level of recruitment
- Systems and processes in place to facilitate reduction in turnover rate
- Uncertainty of existing systems to recruit and retain staff.

Gaps in Assurance

- Trustwide Budgetary Control System, not working to deliver financial balance with current plans
- Recurrent delivery of Cost Improvement Programme Plan
- Management of financial risks arising from the lack of flow
- Individual organisational sustainability plans may not deliver system wide control total
- No assurance recruitment or retention will improve
- Not meeting productivity targets for theatres and outpatients

Links to High Level Risks Register

No 3162, quality of patient cae and patient safety based on nurse staffing position and increase in use of bank and agency nurses and escalation beds = 20
No 3174, Trust doesnot receive SystmOne information to be able to submit costs at a patient level as per mandatory requirements of NHSE = 15

Future Opportunities

- Closer ICS working
- Provider collaboration and formation of the Group
- System wide collaboration to meet control total

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.2: To secure adequate capital investment for the needs of the Trust and its patients.

Risk to Strategic Objective 3 - 3.2: The risk that the Trust fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5				5
Likelihood	3	3				3
Risk Rating	15	15				15

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023

Lead Committee: Trust Board

Risk Owners:
Chief Financial Officer and
Director of Strategic Development

Enabling Strategy / Plan: Trust Strategy, Clinical Strategy, Humber Acute Services Programme/ Capital Investment EOI and potential SOC for NHP

Current Controls

- Capital Investment Board (Internal Capital)
- Trust (Internally) Agreed Capital programme and allocated budget - annual/three yearly
- Trust Board
- Trust Committee(s) in Common
- ICS Strategic Capital Advisory Group
- NHSE - HAS Assurance Reviews

Assurance (internal & external)

Internal:
- Minutes of Internal Trust Meetings

External:
- NHSE attendance at AAU / ED Programme Board
- CiC Minutes
- Place Boards

Planned Actions

Action	Quarter / Year	Assurance
Develop Capital Investment Strategic Outline Case for development of SGH/DPoW	Q3 2022/23	Blue
Review and seek if there are ways of applying for future rounds of PSDS funding	Q2 2023/24	Green
Develop a strategic capital planning framework aligned with joint Board and integrated Place Strategies	Q3 2023/24	Yellow

Future Risks

- National policy changes - implications of three year capital planning
- Lack of investment in infrastructure through Targeted Investment Fund (TIF)
- Inability of Trust to fund capital through internal resource - potential lack of external funding sources
- Inability of Trust to gain Capital Departmental Resource Limit (CDEL) cover for strategic capital investment if not on New Hospital Programme (NHP)
- Not gaining a place on the NHP
- Challenges with existing estate continue and significant issues remain with Backlog Maintenance (BLM), Critical Infrastructure Risk (CIR)

Strategic Threats

- ICS Capital Funding Allocations
- Inability to gain national strategic capital through NHP
- Inability to offset CDEL if non NHS funding sources used for capital investment

Gaps in Controls

- Comprehensive programme of Control and Assurance - potential inherent risk on ability of Trust to afford internal capital for major spend
- Control environment whilst comprehensive may not have ability to influence availability of Strategic Capital - investment funding/affordability
- Control environment may not be able to eliminate or reduce risk of estates condition in the short term

Gaps in Assurance

- Assurance review process does not create a direct link to sources of strategic capital investment
- ICS CDEL may not be sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providers

Links to High Level Risks Register

Future Opportunities

- Provider collaboration and use of Place based funding
- Use of TiF, CDH and Towns Centre funds to support capital spend
- System wide collaboration to major capital development needs.
- Announcement of multi year, multi billion pound capital budgets for NHS
- Gaining a place on the NHP

Strategic Objective 4 - To work more collaboratively

Description of Strategic Objective 4: To work innovatively, flexibly and constructively with partners across health and social care in the Humber and North Yorkshire Integrated Care System (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan (LTP): to make best use of the combined resources available for health care, to work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally, to work with partners to secure major capital and other investment in health and care locally, to have strong relationships with the public and stakeholders, to work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: make best use of the human capabilities and capacities locally; offer excellent local career development opportunities; contribute to reduction in inequalities; contribute to local economic and social development.

Risk to Strategic Objective 4: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	4	4				4
Likelihood	3	3				2
Risk Rating	12	12				8

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023

Lead Committee: Trust Board

Risk Owner: Director of Strategic Development

Enabing Strategy / Plan: NHS Long Term Plan, Trust Strategy, Clinical Strategy, Humber Acute Services Programme, Communications & Engagement Strategy

Current Controls

- Audit Risk & Governance Committee (ARGC).
- Trust Management Board (TMB).
- Finance and Performance Committee (F&PC).
- Capital Investment Board (CIB).
- HAS Executive Oversight Group.
- HNY ICS.
- ICS Leadership Group.
- Wave 4 ICS Capital Committee.
- Executive Director of HAS and HAS Programme Director appointed.
- NHS LTP.
- ICS LTP.
- NLaG Clinical Strategy.
- NLaG Membership of ICP Board NE Lincs.
- Committees in Common
- Acute and Community Collaborative Boards
- Clinical Leaders & Professional Group
- Council of Governors.
- Joint Overview & Scutiny Committees
- MP cabinet and LA senior team briefings
- Primary/Secondary Interface Group (Northbank&Southbank)
- Place Boards

Assurance (internal & external)

Positive:
- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Clinical Senate review approach and process
- Consultation Institute Review
- Place Boards and Place Working Groups established

Internal:
- Minutes of HAS Executive Oversight Group, HNY ICS, ICS Leadership Group, Wave 4 ICS Capital Committee, ARGC, F&PC, TMB, CIB, CoG
- Non Executive Director Committee chair Highlight Report to Trust Board
- Executive Director Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Councillors / MPs / Local Authority CEOs and senior teams
- Place Boards and Place Working Groups established
- Collaborative of Acute Providers Board

Planned Actions

Action	Quarter / Year	Assurance
HAS Programme:		
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Blue
Options appraisal for HAS Capital Investment to be approved	Q4 2022/23	Blue
Joint OSC - reviews	Q1 2023/24	Green
NHSE Gateway review	Q2 2023/24	Green
ICS Board approval	Q2 2023/24	Green
Public Consultation	Q2/Q3 2023/24	Green
Decision Making Business Case	Q3/4 2023/24	
HAS Risk Workshop with ICB Executives (18 April 23)	Q1 2023/24	Blue
Collaborative of Acute Providers:		
Development of H&NY Planned Care Strategy/Framework	Q3 2023/24	Green

Future Risks

- National policy changes
- Delays in legislation
- Long term sustainability of the Trust's sites.
- Change to Royal College Clinical Standards.
- Capital Funding.
- ICS / Integrated Care Partnership (ICP) Structural Change.
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- ICS Future Funding.
- Failure to develop aligned system wide strategies and plans which support long term sustainability and improved patient outcomes.
- Government legislative and regulatory changes.
- Integrated Care: Next Steps and Legislative Changes.
- Strategic capital.

Gaps in Controls

- Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.
- Local Authority, primary care and community service, NED and Governor engagement / feedback (during transition)
- ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Lack of integrated plan and governance structure.
- Alignment with Out of Hospital strategies and programmes

Links to High Level Risks Register

Future Opportunities

- HNY ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Strategic workforce planning system wide and collaborative training and development with Health Education England / Universities etc.
- Acute and community collaborative.

Strategic Objective 5 - To provide good leadership

Description of Strategic Objective 5: To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk to Strategic Objective 5: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	4	4				4
Likelihood	3	3				2
Risk Rating	12	12				8

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 12 July 2023

Lead Committees: Workforce Committee and Trust Board

Risk Owner: Chief Executive

Enabing Strategy / Plan: Trust Strategy, NHS People Plan, People Strategy, Leadership and Development Strategy

Current Controls

- Trust Board, Trust Management Board, Workforce Committee, PRIMS, Leadership and Culture Transformation Committee
- CQC and NHSE Support Teams
- Significant investment in strengthened structures, specifically (a) Organisational structure, (b) Board structure, (c) a number of new senior leadership appointments
- Development programmes for clinical leaders, ward leaders, VB Leadership Development, LIDA
- Communication with the Trust's senior leaders via the monthly senior leadership community event
- NHSE Well Led Framework
- PADR compliance levels via PRIM as part of the Trust's focus on Performance improvement
- Joint posts of Trust Chair, Chief Executive, Chief Financial Officer, Chief Information Officer, Interim Chief People Officer, Interm Director of Strategic Development and Interim Director of Estates and Facilities with HUTH
- Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, Humber and North Yorkshire Integrated Care System.

Assurance (internal & external)

Internal:
- Leadership Strategy
- Minutes of Trust Board, Trust Management Board, Workforce Committee and PRIMS, Leadership and Culture Transformation Committee.
- Trust Priorities report from Chief Executive (quarterly)
- Integrated Performance Report to Trust Board and Committees.
- Board and Committee meeting structures
- Workforce Implementation Plan report (includes development and leadership programmes) to Workforce Committee
- Senior Leadership Community presentation
- Trust Board - Well-Led assessments at Board Development

Positive:

External:
- NHS Staff Survey.
- CQC Report
- ICB Leadership forum

Planned Actions

Action	Quarter / Year	Assurance
Delivery against the Trust Leadership Strategy (2020 - 2024)	Q4 (23/24)	Yellow

Future Risks

- Funding for all leadership programmes is non-recurrent
- National policy changes.
- Impact of HASR and Group plans on NLaG clinical and non clinical strategies.

Strategic Threats

- Non-delivery of the Trust's strategic objectives
- Higher turnover of staff due to poor levels of leadership
- CQC rating and recommendations
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives
- Failure to obtain support for key changes needed to ensure improvement or sustainability
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users

Gaps in Controls

- No ongoing investment specifically for staff training / courses to support leaders work within a different context and to be effective in their roles as leaders within wider systems

Gaps in Assurance

Links to High Level Risks Register

None

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration - particular focus on local education providers
- System wide collaboration to meet control total
- Group model and wider access to leadership development.

Board Assurance Framework - 2023 / 24	
Red	Action rated red means the action is off track, with no mitigation and pose a significant risk to the delivery of the strategic objective
Amber	Action rated amber mean it is in progress, but off track with, no mitigation and could pose a risk to the strategic objective being delivered
Yellow	Action rated yellow - in progress, off track, with mitigation, and could pose a risk to the strategic objective being delivered
Green	Actions rated green mean they are on track to deliver.
Blue	Closed action which supports the progress towards the delivery of the strategic objective

HIGH LEVEL RISK REGISTER AS AT 3 July 2023

No.	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Assessor	Owner	Site	Directorate	Division	Specialty	Department	Risk Rate Score	Review Frequency	Next Review Date	Control Details	Gaps In Controls	Control Assurance
1620	11/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Med Gas: Medical Gas Pipeline System, Mark 4 bedhead terminal outlets - Trustwide	There is a risk of losing bed head medical gases due to Mark 4 medical wall terminals outlets (Oxygen, Vacuum Medical Air, Nitrous Oxide) being obsolete with limited spare parts due to damage caused through clinical activity. The loss of medical gas pipeline behind the bedhead terminal outlets at SGH & GDH, could result in loss of oxygen supply and suction ability to an entire ward for an extended period time.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Med Gas		20	1 Monthly	29/06/2023	Ongoing monitoring of alarms.	Limited spares availability.	Approved ISO9001 contractor and QC pharmacist and access to limited terminal spares through approved spares supplier.
1774	05/06/2014	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Poor condition of Fuel Oil Storage Tanks - SGH	If the Trust lost gas supplies to the SGH site the boilers would have to be fuelled by oil. The material state of the oil storage tanks has resulted in the oil being contaminated and if called upon, could damage the boilers. The strategic risk are the boilers failing to provide heat and hot water due to main hospital site.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Heating/Ventilation		16	1 Monthly	29/06/2023	Emergency generator fitted with own fuel supply.	No replacement plan for SGH.	External condition report.
1851	28/04/2015	30/09/2023	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Shortfall in Capacity within the Ophthalmology Service	The current risk, is the capacity does not meet the demand and the service is unable to meet this. Therefore, this impacts on ability to see patients within the clinical time scales.	Tom Foulds	Jennifer Orton	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Ophthalmology		15	1 Monthly	01/07/2023	Work with the ICB to secure additional capacity in the independent sector.	Recent investment will not mitigate the shortfall in capacity	
2035	22/08/2016	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Equality Act 2010 compliance - Trustwide	The Trust has received numerous claims for slips, trips and falls from the state of the Trust's roads, pathways and corridors. These both damage the Trust's reputation and lead to financial loss. A number of facilities (lifts, toilets) are non-compliant with current regulations which may result in patients and staff being unable to move through the hospital sites safely and with dignity and respect.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Health & Safety		16	1 Monthly	29/06/2023	Estates continually monitor the condition of the roads and pathways, repairing potholes as required. Larger resurfacing scheme are limited to BLM or other capital works funding when available.	Currently none, funding is required to provide adequate assurances. Staff to be made aware of the hazards of parking and moving around this area, as the site is not designated a car park.	The current control measures are not effective, it would need the "car park" to be closed to prevent further incidents.
2036	12/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Ventilation and Air Conditioning - HVAC - Trustwide	There is a risk of failure of the heating and ventilation system due to aged infrastructure resulting in a negative impact on the effective delivery of patient care and pose a risk to the Trusts elective recovery plan in critical areas; theatres, ITU etc...	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Heating/Ventilation		15	1 Monthly	29/06/2023	Planned preventative maintenance (PPM) in place for inspection and maintenance of all ventilation plants.	Limited BLM funding resulting in no long term replacement plan. Capital plan 22-25 capture theatre upgrades	Validation and flow checks carried out by 3rd party accredited contractor.
2038	23/12/2022	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Health & Safety	Fire Compliance	There is a risk failure of the fire alarm resulting in failure to detect fire/smoke leading to fire taking hold and hence possible serious harm and/or loss of life of patients and staff.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Fire Safety		20	1 Monthly	29/06/2023	Compliance Department have dedicated H&S/Fire staff resource.		
2088	28/02/2023	31/03/2024	To provide care which is as safe, effective, accessible and timely as possible	Buildings, Land and Plant	Building Management Systems (BMS) Controller failure/upgrade	There is the risk of failure of elements of the Building Management Systems (BMS). The BMS is the trusts advanced warning system which adjusts and controls the sites ventilation, heating and hot water services, therefore, temperature control of both the hospital environment and water systems could become significantly compromised.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Building Management		20	1 Monthly	29/06/2023	Continued monitoring of the system for operation (by Estates Staff).	Reactive to ongoing BMS failures. Current BMS runs on outdated windows 7 support system. Cyber security risk and patch update	There are limited assurances on controls highlighted by continued BMS failures.
2244	20/06/2017	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	Failure to treat patients within tWT (62 days) will result in poor patient experience and may have the potential for clinical harm in some specialties. The Trust consistently achieves the 14 day and 31 day standards. The likelihood of continuing to not achieve the 62 day standards is high due to some elements of the diagnostic or staging pathway being outside of the control of NLAG and sitting with the tertiary provider. Risk register also relates to Risk ID 2008.	Denise Gale	Abolfazl Abdi	Trustwide - All Sites (DPoW, S	Chief Operating Officer	Chief Operating Officer	Cancer Services		16	1 Monthly	06/10/2021	(1) Weekly Cancer RTT waiting time meeting to challenge and review all cancer PTLs (62 day 1st, screening, consultant upgrade, 31 day 1st, subsequent surgery, subsequent drugs) (2) Automated RAG rated PTL (updated twice daily to reflect current position and available to all Divisional Managers). (3) 62 day Cancer Improvement Plan has translated into the Cancer Transformation Programme (2 year programme commencing 2021) (4) Cancer performance/ backlog is reported weekly to Operational Management Group (5) Improved visibility on all aspects of cancer pathways through the Cancer Power BI Performance report (which is updated daily and available to all Divisional Managers/clinicians. (6) Cancer Trackers attend Divisional Huddles in some specialties (Colorectal/Gynae) as a point of escalation. (7) A trust-wide clinical harm review process is in progress	Failure to treat patients within Cancer Waiting / Performance Target 62 day may result in poor patient experience and potential harm	62 day backlog and 104+ days waits monitored weekly at Operational Management Group
2245	20/06/2017	31/03/2024	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Overall Performance : Non compliance with RTT incomplete target	Given our current operating models, there is a risk that there is insufficient capacity to meet demand in a number of specialities which risks the RTT position and potential for adverse patient impact. Potential for 52 week breaches and potential to not meet current 40 week maximum RTT target This could result in clinical harm	Jennifer Orton	Mathew Thomas	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Surgery (All)		16	1 Monthly	12/07/2023	(1) Capacity & demand plans have been developed for all specialties as part of the business planning 22/23 which highlight our risk specialties and gap between capacity and demand, use of the IST tool working with NHSI and strategy and planning.	Data quality and validation of clock stops.	Currently covering all clinics and wards with the use of agency and locums to mitigate the risk of rota gaps. North East Lincs and N Lincs council of members routinely review the data published.
2272	25/09/2017	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Environmental	EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide	There is a risk that the EHO could instruct that the ward based kitchen is unfit for food preparation and issue a prohibition notice which would prevent food/drink being prepared on ward areas. This would result in a delay to patients receiving food and drink.	Keith Fowler	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Catering		16	1 Monthly	02/07/2023	1) Food preparation boards, minimal ward based food preparation of low risk food. Hazard Analysis of Critical Control Points HACCP. 2) Ward refurbishment programme 3) Quality Matron Environmental Audits 4) Flo-audits	Funding for major ward refurbishments.	Funding for major ward refurbishments. EHO currently assess each site and awards cleanliness standard up to and including 5*, these outcomes are for public communication and awareness.
2300	07/12/2017	31/12/2023	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Information Governance	Insufficient processes in place to ensure records management /quality against national guidance	The Trust has insufficient processes in place to ensure records management / quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards.	Susan Meakin	Christopher Evans	Trustwide - All Sites (DPoW, S	Digital Services	Digital Services	Information Governance		16	1 Monthly	15/06/2023	Oversight by Trust's IG Steering Group and is managed via the Group's Action Log which is reviewed monthly.	None	The IG Steering Group monitor the progress of this actions
2347	24/11/2022	31/03/2023	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Risk to Overall Performance : Overdue Follow-ups	There is a risk that there is insufficient capacity to meet demand in a number of specialities which risks overdue follow up position deteriorating Failure to review patients in clinically specified timescales.	Jennifer Orton	Mathew Thomas	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Surgery (All)		15	1 Monthly	12/07/2023	Specialties have developed recovery plans in all areas	Potential clinical harm due to lack of appointment capacity.	Cap & demand plans for the trust top 8 specialities are reviewed by the Planned Care board. Currently covering all clinics and wards with the use of agency and locums to mitigate the risk of rota gaps. North East Lincs and N Lincs council of members routinely review the data published. Clinical harm review progress report to S&CC Board; Planned Care Board and Trust Board. Fail safe officers in post to ensure Wet AMD patients are on a separate PTL. Risk stratification of outpatient follow up PTL, No harm from risk stratification.

HIGH LEVEL RISK REGISTER AS AT 3 July 2023

No.	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Assessor	Owner	Site	Directorate	Division	Specialty	Department	Risk Rate Score	Review Frequency	Next Review Date	Control Details	Gaps In Controls	Control Assurance
2550	27/01/2023	30/09/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Staffing Levels & HR	Pharmacy staffing	Due to the number of vacancies and maternity leave at this time, the clinical pharmacy service is unable to maintain its current level of service delivery. The impact on service delivery is likely to be in effect for a number of months. The service has been recruiting to posts and continues to do so. Within the pharmacy workforce the applicants have been primarily from pharmacists due to qualify in August therefore resulting in a short term gap as staff have left now and will be replaced in August. With the pharmacy technician workforce multiple attempts have been made to recuruit to fixed term and permanent posts with little success.	James Hargraves	Simon Priestley	Trustwide - All Sites (DPoW, S	Chief Operating Officer	Chief Operating Officer	Pharmacy	Pharmacy - Clinical	15	1 Monthly	16/07/2023	We are trying to source locum cover for both pharmacists and technician posts but have had minimal response from locum agencies. We are working with existing staff to offer bank contracts and additional shifts, again with minimal uptake.	Difficulty recruiting permanent and locum staff. Difficulty retaining staff. Difficulties continue with finding and appointed appropriately experienced locum pharmacists. Situation not helped by current high cost locum rates (£40-£50 per hour) in community making hospital work financially unattractive)	We will have 1x locum pharmacist commencing on the Scunthorpe site in August 2022 for minimum of 3 months.
2562	13/01/2023	01/04/2024	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Failure to meet constitutional targets in ECC	Due to a high level of demand at the front door and challenges with patient flow through the hospital, ED waits are a challenge which has an adverse effect on patient safety. Risk that the Trust's 4 hour A&E performance target may not be achieved and that 12 hour trolley breaches may occur. Due to a high level of demand at the front door and challenges in patient flow through the hospital, ED waits are an ongoing challenge, which has an adverse effect on patient safety.	Nicola Glen	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Emergency Care	Emergency Department	20	1 Monthly	30/06/2023	- Daily Operations Centre Meetings - Establishment for medical staffing in ECC increased to 14 Consultants, 12 Middle Grades, 10 Juniors - Additional consultant coverage up to midnight on shop floor 7 days a week to ensure compliance with RCEM guidance - Additional 3rd middle grade shift overnight 7 days a week to support operational pressures - Daily analysis of challenges and performance Update: 18.06.21 * ECIST support provided and action plan produced * Implemented NHS 111 First Initiative * EMAS direct streaming to SDEC now providing an alternative to going through ED and improving the patient experience * EMAS patient self-handover protocol now in place allowing ambulance crews to leave appropriate patients at ED reception to end the handover and avoid delays * Frailty service at DPOWH went live on 12th May to reduce frail patients within ED and provide an improved pathway for the patients Update: 20.07.2021 * Senior Medicine Management oversight tiers implented to improve support to ED and timely escalation Update: 09.11.2021 * New Urgent Care Service (UCS) model implemented at SGH from 18th October 2021 - phased approach to implementation due to need to build workforce numbers and clinical skills * Newly revised and relaunched IAAU/SDEC SOP to reduce barriers for patient pathway from ED and reduce patient wait times Update: 10.01.2022 * UCS model due to be implemented at DPOWH from 18th January 2022 Update: 10.03.2022 * UCS model implemented at DPOWH and sustaining 100% performance for this cohort of patients, with improved patient care and experience	- Exit block from ED for admission due to lack of patient flow causing long delays for patients in ED - Medical staffing vacancies, sickness, and isolation resulting in over reliance on locum/agency doctors and junior skillmix - Nurse staffing vacancies, sickness and isolation resulting in unfilled nursing shifts and over reliance on agency nurses with less ED experience - Inappropriate attendances to ED due to lack of access to alternative, more appropriate services - Update = 02.03.2021 = COVID 19 has had and is continuing to have a significant impact on the Trust's ability to maintain its constitutional A&E targets, primarily due to maintaining the flow of patients requiring isolation beds, additional PPE and social distancing requirements and delays in diagnostics - Lack of physical capacity within the ED to see patients when exit block occurs resulting in long patient waits in ED and ambulance handover delays	- Emergency Care Quality and Safety Meeting oversight - Medicine Governance Meeting oversight - Agenda item on PRIM - Recruitment plans to recruit to medical staffing vacancies through new ED specific recruitment strategy - Additional medical staff booked by Trust to support covid implications and delayed patient stays within the ED - Additional HCA staff booked by Trust to support covid implications and delayed patient stays within the ED - Implementation of phase 1 of AAU in Nov 2019, followed by phase 2 of integrated AAU in Oct 2020 has improved SDEC provision and patient flow * D2A - audits. Update: 10.01.2022 * 12hr DTA Breach Validation to identify root cause of breach and to check whether patient harm occurred Update: 08.02.2022 * UCS pilots at each site are showing improvements in patient care, exeperience and performance against the 4 hour target
2576	10/03/2022	30/09/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Paediatric Medical Support Pathway for ECC - 'Fastrack'	There is a risk that children and young people are not triaged and assessed within the 15 minute standard as a result of acuity and activity within the Emergency Depratments which may lead to prolonged wait times for nursing and medical assessment within the Emergency Departments which may lead to a sick child not being recognised thus causing a level of harm	Deborah Bray	Preeti Gandhi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Paediatrics		16	1 Monthly	20/07/2023	>Fast track pathway in place across both ED's	Limited paediatric medical workforce on duty out of hours and overnight which could limit ability to respond and pose a risk to care delivery across the paediatric and neonatal areas.	Incidents monitored via Ulysses and RCA's conducted where appropriate.
2592	17/09/2019	31/01/2024	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	Failure to treat patients within the cancer waiting times may result in poor patient experience and potential clinical harm. Risk register also relates to Risk ID 2244.	Jennifer Orton	Jennifer Orton	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Cancer Services		16	1 Monthly	12/07/2023	Weekly Cancer RTT waiting time meeting to challenge and review the PTL.	Failure to treat patients within Cancer Waiting / Performance Target 62 day may result in poor patient experience and potential harm.	104+ waits are reducing week on week, clinical harm review being undertaken on all 104+ patients.
2623	28/02/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Health & Safety	Failure of windows - Trustwide	There is the risk of patient harm due to failing aged windows and window restrictors supported by DoH Alert EFA/2013/002. Many of the windows are the original windows installed (in excess of 40 years) and do not meet HBN 00-10 Part D: Windows & associated hardware requirements, which is retrospectively applied.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Buildings		20	1 Monthly	29/06/2023	Periodic planned maintenance.	Due to the windows been in poor state it is difficult in determining when these could fail.	Labour management system
2655	11/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers	Risk is loss of heating and hot water on site. The steam raising boilers are 31 years old and could fail. Boiler failure would result in SGH closing down all clinical services until temporary boilers could be connected to site.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Heating/Ventilation		20	1 Monthly	29/06/2023	The management of the energy centre (steam boilers) is outsourced to Equans.	Equans contract has expired. Renewing annually.	Adhoc repairs are effective. No significant loss of service.
2719	22/02/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety - Oversized water distribution pipes	There is the risk of micro bacterial water infections from under utilised water services due to legacy oversized water distribution pipework which could result in patient(s) contracting infections whilst in hospital.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Water		20	1 Monthly	19/07/2023	Risk assessments undertaken at two yearly intervals by external competent specialist contractors.	Lack of funding for infrastructure upgrading.	Hydrop defect portal giving real time data on progress of defects.
2773	21/04/2023	31/08/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Clinical Harm	Cause - Lack of scanning capacity is leading to a risk of delayed diagnosis Impact - inability to deliver timely diagnostics for patients on diagnostic pathways, and lack of clinical capacity & agreed pathways is impacting on ability to perform harm reviews. The impact of this is failure to meet waiting times standards, leading to an increased risk of clinical harm.	Ruth Kent	Ruth Kent	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Radiology		16	1 Monthly	22/07/2023	Risk stratification process agreed with groups. Escalation process reiterated to clinical administration staff Monitored via activity meetings and updated via RMT Close working with operational management team, heads of service and clinical leads where appropriate to agree booking priorities Waiting lsits recovering since new scanners opened, CT & MRI not triggering waiting list validation according to national guidance. Non obs ultrasound has become a concern - separate risk has been added for this.	Clinical framework for appointing within current capacity	Monitored and update via COVID-19 management meeting. Added to action plan and risk log of above meeting. Discussed at Trust level Recovery plans and increasing capacity to support reduction of waiting lists

HIGH LEVEL RISK REGISTER AS AT 3 July 2023

No.	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Assessor	Owner	Site	Directorate	Division	Specialty	Department	Risk Rate Score	Review Frequency	Next Review Date	Control Details	Gaps In Controls	Control Assurance
2898	14/03/2023	01/12/2022	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Staffing Levels & HR	Medical Staff - Mandatory Training Compliance	Mandatory Training compliance for medical staff. There is a risk to patient safety if medical staff do not complete their mandatory training before each element has expired. Due to the volume of doctors demonstrating low compliance across all grades, this has impacted upon the divisional CQC improvement plan.	Sarah Smyth	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Medicine (All)		16	1 Monthly	13/04/2023	* Feb Data - Core: 63% Role Specific: 52%. * Rota Coordinators providing more directed support to all level doctors across Medicine to allocate/support training time for them to complete MT * MT raised at SMT, Board Meetings, Workforce SMT and separately at AGM/Speciality/Clinical Lead/Line Manager Level * Workforce Development plans are being developed for each Speciality within Medicine which is being supported by the Medicine Quad, HRBP and AGM down to Clinical Leads. * Reviewed at Divisional Workforce Meeting Updated - 14.03.22 Identification of 2 least compliant staff members in each area each month and target set for compliance to be met HRBP meeting monthly with the rota co-ordinators to identify 10 least compliant doctors and allocate time on the roster to complete Divisional Clinical Leads to work with divisional SMT to develop recovery plans for their specialities Training incorporated at the Quality & Safety meetings Individuals with low compliance being contacted and targets for completion set on-going at ward review meetings Linking in with course leads to look at prioritisation and alternative ways of completing training e.g. targeted cohorts New rotational doctors commenced training prior to starting in post	Potential failure to meet CQC requirements Staff not adequately trained with potential to impact on patient care and staff H&WB	* Report collated by HR Business Partner. * Improvement plan led by AMD / ACOO. * Compliance monitored at Divisional Board / Divisional Governance Meetings. * Reviewed at Divisional Workforce Meeting * Reported via Performance Review Meetings.
2905	07/04/2021	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW	There is a risk that the following areas may not be able to receive essential supply of electricity in the event of a power failure due the age of generator (1979). This will affect clinical procedures and potential persons within the lifts becoming trapped, therefore directly affecting patient safety. - Ramp Plant Room (Med Gas Compressors +) - Theatre Plant Room (All Theatres) - Lifts - I.T and I.T Server - X-RAY - Theatres - Pathology If this risk materialises, the hospital would need to close	James Lewis	Simon Tighe	Diana, Princess Of Wales Hospi	Estates and Facilities	Estates and Facilities	Estates - Electrical		16	1 Monthly	23/06/2023	Monthly test to start and run Diesel Generator for a period of 90mins	Non-compliant with HTM 06-01;17.88 Maintenance programmes should include a longer test run to establish the generator Engine's mechanical performance. A test to prove the generator engine's condition up to 110% full load should be carried out annually. The period of the test should be not less than 3 hours and ideally 4 hours. The Trust is currently only able to conduct an 80% max load test. Tests can currently only be ran for a period of 90 minutes. Potential frailty of equipment was highlighted in the 2019 Load Bank Test as it damaged a Cooling Pump & Radiator on a similar set. Non-compliant with BS7671:2018;414.2.1 Live parts shall be inside enclosures or behind barriers providing at least the degree of protection IP2X	Minor and major equipment services logged in compliance folders.
2949	12/05/2023	31/03/2023	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Oncology Service	As part of the ongoing Oncology HASR work, a joint risk register has been created to capture all potential risks and their mitigating actions. The below are jointly reviewed at the weekly NLaG & HuTH Oncology meeting: 1)NLaG Waiting times for Oncology patients are longer than expected due to absence of Consultant Oncologists at HUTH. Concerns escalated by Surgery Division at NLaG regarding Urology Cancer waiting times and delays to treatment of patients. 2)NLaG Matron has flagged as a serious risk, that inpatient chemotherapy can no longer be delivered on Amethyst due to a shortage of chemotherapy nurses at DPoW and difficulties in training new chemotherapy nurses.	Jill Mill	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Oncology		20	1 Monthly	11/06/2023	1)Currently looking for locum consultants to back fill some of the work, and a locum SpD has been secured, starting week commencing 30/11/2020. Interviewing for a further 5 SpDs. 2)Ongoing work around the management of clinics including clinic redesign, telephone clinic management, practitioner support, adequate time slots etc. Support offered to all staff from management. 3)Covid19 steering group in place, with CSS Health Group and SS Division input into command structure. 7no. Covid19 + beds still in place on C30 and position monitored closely to establish requirements into the future. 4)Liaison between HUTH and NLaG Senior Management Leads to ensure oversight of the waiting times and actions to mitigate avoidable delays. Plan is to develop a single joint activity / waiting times report whc will be produced monthly and reviewed at the joint Oncology meetings. 5)Very small number of patients affected, who could be admitted at HUTH to receive inpatient chemotherapy delivery. 6)Where clinically appropriate, SACT delivery from Lloyds community infusion clinic to reduce demand on SGH dat unit. Consider reducing the number of days SGH day unit opens to consolidate staffing. Continue to access external Level 6 SACT training for RN on Amethyst Unit at DPOW to increase chemo trained workforce.		* Risks reviewed weekly at the joint NLaG & HuTH Oncology meeting and updated accordingly.
2951	23/03/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide	There is the risk of failure of aged (40 years plus) Electrical and/or mechanical LV components which could cause power interruptions to key areas. The impact of such failure is for clinical departments to experience reduced capacity or ability to treat and/or carry out diagnostic investigations on patients, leading to possible harm. This risk became a tangible issue on Dec 22 when a power cable failed causing widespread power interruptions.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Electrical		20	1 Monthly	29/06/2023	Monitoring switch gear regularly to ensure the situation is not deteriorating.	Lack of annual switching.	Periodic inspections carried out annually.
2952	04/08/2021	07/12/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety Compliance: Fire ring main - Trustwide	The fire ring main is legally required to serve only water services for fire fighting, the ring main has a number of building fed from it thus making it non-compliant with regulations and could lead to enforcement action by Humberside Fire and Rescue Service.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Water		16	1 Monthly	29/06/2023	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.		Hydrop defect portal giving real time data on progress of defects.
2953	22/02/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety Compliance: Sensor & Spray taps - Trustwide	Due to the installation of sensor and spray taps and the inability to flush for the required time period, there is the risk of legionella which could impact on the health of the building occupants (patients/staff).	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Water		16	1 Monthly	29/06/2023	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.	Linked to on-going refurbishment works.	Hydrop risk assessment report which identifies location of taps.
2955	24/05/2023	30/06/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - SGH	There is the risk of failure of the oxygen delivery system if the demand exceeds design capacity, which could result in loss of oxygen supply to patients causing the Trust to divert patients to neighbouring hospitals.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Med Gas		15	1 Monthly	29/06/2023	Daily monitoring of the oxygen consumption.		Medical Gas Policy DCP026
2959	12/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Replacement/Repairs of flat roof - Trustwide	There is the risk of failure of flat roofs across the sites. A number of roofs have failed across the site. Roofs of note include the SGH IT roof which houses trustwide servers and a roof over a new £1m MRI unit. A roof failure in either of these areas would result in significant risk to trustwide infrastructure and service delivery impacting elective recovery.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Buildings		16	1 Monthly	29/06/2023	Staff report any roof leaks to the facilities department when they occur.	Limited BLM funding prevents full replacement of flat roofs and only enables patch repairs.	Document will provide targeted spend profile to minimise roof failure.

HIGH LEVEL RISK REGISTER AS AT 3 July 2023

No.	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Assessor	Owner	Site	Directorate	Division	Specialty	Department	Risk Rate Score	Review Frequency	Next Review Date	Control Details	Gaps In Controls	Control Assurance
2960	27/04/2022	30/11/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk of inability to safely staff maternity unit with Midwives	The risk is the potential inability to safely staff the maternity unit in order to provide care and treatment to a defined establishment due to sickness, Covid isolation and vacancies. If the staffing levels are reduced, this will impact on the ability to provide safe care to women and their babies, resulting in increased incidents and potential poor outcomes.	Nicola Foster	Preeti Gandhi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Obstetrics / Maternity		16	1 Monthly	30/07/2023	Daily staffing meetings for oversight of issues Thrice daily Operational meetings to escalate staffing issues SafeCare Live Process to escalate short staffing - request for bank staff / agency staff 24/7 theatre access is managed by surgery division Maternity Services Escalation Policy	Challenges in acquiring midwives via agencies due to limited numbers and trust location Acuity of unit changes requires demand for additional staff and difficult to plan	Any incidents relating to staffing compromise are monitored via weekly incident review meeting and any issues relating to safety being compromised are escalated at time of event.
2976	01/11/2022	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Staffing Levels & HR	Registered Nursing Vacancies	High Registered Nursing vacancy levels - a lower number in the UK market impacting upon the delivery of patient service, travel and accommodation issues causing some difficulties for international recruits.	David Sprawka	David Sprawka	Trustwide - All Sites (DPoW, S	People and Organisational Effe	People & Organisational Effect	Recruitment		25	1 Monthly	21/06/2023	Funding accessed through NHSi to facilitate international recruitment providing additional pipelines.		
2992	18/11/2021	31/03/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Equipment	Changing Places facility at Scunthorpe General Hospital	There is a risk of emotional harm and distress to patients and families who visit the trust and unable to use appropriate toilet facilities. This is due to no adapted Changing Places facility at Scunthorpe General Hospital. This could result in reputational damage from complaints, safeguarding section 42 Care Act enquiries and patient harm due to psychological distress and deterioration in skin integrity,; breaches in the Human Rights Act could lead to reputational and cost implications.	Victoria Thersby	Victoria Thersby	Scunthorpe General Hospital (S	Chief Nurse	Chief Nurse	Safeguarding Adults		16	1 Monthly	29/06/2023	There are disabled toilet facilities within the Trust	Complaints by members of the public and patients attending the outpatient department	
3015	11/04/2023	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Staffing Levels & HR	Insufficient estate resources to manage the workload demand	Failure to recruit technical capital project team members to support current major capital project delivery programme which is impacting on the estates operational teams ability to deliver service level compliance, statutory requirements, and provide an environment that is fit for purpose. Compounding the risk is the limited (11 personnel) number of staff holding the duties of an Authorised Person (AP) for specialist engineering fields. Additionally, there has been an increase in claims being lodged in relation to areas where slips, trips and falls and statutory compliance is not being met. It is anticipated that this risk will be reduced in 24/25 when capital funding reduces. The impact to the Trust if not actioned; inability to meet statutory compliance, leading to potential prosecution for statutory non-compliance, lack of Engineer resource to complete mandatory work and project works, ineffective management of Pre-Planned Maintenance, ineffective management of water systems due to shortage of water APs (SGH), inability to complete emergency testing across main estates disciplines (electrical system emergency testing, ventilation multi-disciplinary emergency testing), ineffective management of the estates leading to reactive maintenance (firefighting), inability to implement proactive management systems (MICAD helpdesk), impact to patient safety, loss of workforce due to on-going work pressure and employee market shortage (supply/demand), reduced staff morale, inability to support wider project delivery, durther degradation and serious incidents within the estates, loss of financial resources due to settlement of claims (majority of claims are under the excess levels so Trust would pay full cost), increase in overall BLM value (6 facet survey) due to limited resourcing levels in FY 21/22 & 22/23	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Health & Safety		20	1 Monthly	29/06/2023	Resources prioritized in a reactive manner	Minimal controls in place, competing priorities for both capital and operational compliance work, resulting in poor ability to manage both within either a safe or responsive realm.	Internal policies and procedures in place
3036	17/03/2022	30/06/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS	There is a risk to patient safety, quality of care and patient experience due to delayed admission to ward beds due to challenges with patient flow throughout the Trust.	Simon Buckley	Anwer Qureshi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Emergency Care	Emergency Department	16	1 Monthly	08/06/2023	LLoS is monitored on an ongoing basis through the following meetings; Medicine Divisional Board Medicine Governance Daily Operation meetings Deprtmental Board rounds and Huddles ED 95% standard compliance		
3045	16/03/2023	/ /	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Medical Workforce Vacancies in Gastroenterology	Following departure of 2 consultants in Gastroenterology there is insufficient workforce to deliver the range of services. Resulting in: - Failure to meet constitutional targets (RTT &Cancer) - Delays in patients being seen both as inpatient & outpatients - Increased waiting times - Increase LOS - Failure to fulfil emergency GI Bleed Rota - Lack of training and supervision - Unable to provide a Barrett's oesophagus service and registry in the Trust for appropriate follow up of these patients. The patients with Barrett's are being managed by gastroenterology, surgery and even some patient's are with primary care.	Simone Woods	Simone Woods	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Gastroenterology		16	1 Monthly	02/06/2023	Staff on the GI bleed rota will travel to the opposite site where needed to attend a patient with a GI bleed or patient will be transferred to the alternate site for treatment if feasible.	When short notice leave applies this puts additional pressure on the current provision for the service	
3048	13/04/2022	30/11/2022	To provide care which is as safe, effective, accessible and timely as possible	Operational	Challenges to recruitment of acute care physician vacancies in Acute	This risk is to highlight the difficulties in workforce recruitment and the increased pressures on staff, which has been exacerbated by the Covid-19 We have vacancies for acute care physicians (ACP) Trust-wide and it is proving very challenging to fill these posts. The cause has been due to a national shortage of ACPs and lack of applicants for the posts when we have advertised them. The impact would result in failure to recruit the required ACPs and this will delay the planned expansion of acute medicine service with extended hours with senior clinician presence on the shop floor and could result in failure to launch phase 3 of the IAAU development plan for 2023. There is a risk that due to the pressures created by having less workforce and increased demands placed on services as a result of not having a balanced workforce, this may result in the current ACPs becoming exhausted, leading to gaps in rotas and therefore not sufficient senior medical staff to ensure quality and safety of patients. In addition, this may also result in doctors withdrawing from our hospitals, exacerbating staffing issues.	Lynsey Chessman	Anwer Qureshi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	General Medicine		16	1 Monthly	21/07/2023	Actively trying to recruit more clinicians through networks		
3063	14/03/2023	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Operational	Doctors Vacancies within Medicine Division	1.lack of substantive practitioners as a result of difficulties recruiting may lead to patient safety issues (lack of continuation of care due to the number of locums who may choose the leave at any time). 2. an increased financial burden for the Trust due to higher costs for locums (circa double the cost of Consultants on Trust contract). 3. There are fluctuating but significant number of vacancy posts required in Medicine.	Sarah Smyth	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Medicine (All)		16	1 Monthly	13/04/2023	weekly workforce panel workforce SMT specialty business meetings review and oversight if data	development of specialty workforce plans	workforce panel workforce SMT Div Board workforce improvement plan

HIGH LEVEL RISK REGISTER AS AT 3 July 2023

No.	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Assessor	Owner	Site	Directorate	Division	Specialty	Department	Risk Rate Score	Review Frequency	Next Review Date	Control Details	Gaps In Controls	Control Assurance
3129	23/02/2023	/ /	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Overdue follow-up and new patients waiting lists for Paediatric patients at SGH	There is a risk of possible delays in diagnosis and treatment for Paediatric patients who have been waiting for a long time, as a result of a backlog from the Covid 19 pandemic (clinics being cancelled and staff shortage/ sickness). This may lead to complications and side effects which can be avoidable if patients are seen on time.	Nicki Chatterton	Umaima Aboushofa	Scunthorpe General Hospital (S	Directorate of Operations	Family Services	Paediatrics		15	1 Monthly	14/07/2023	To risk stratify the cases overdue by 20 weeks and try to priorise these patients.	Ensure patients are seen and safe.	Feeding into weekly performance and activity meetings. This is also being discussed / reviewed within the Teams. Discussed at PRIM.
3131	30/12/2022	/ /	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Delay in assessments being carried out for children with health and educational needs (under 5 years of age)	There is a risk that children are not diagnosed in a timely manner to be able to put the appropriate support package in place due to the delay in assessment being carried out (currently a wait of 2 years).	Deborah Bray	Vijayalaks hmi Hebbar	Diana, Princess Of Wales Hospi	Directorate of Operations	Family Services	Paediatrics	Child Development Centre	16	1 Monthly	20/07/2023	Working collaboratively with the ICB to put a plan in place to ensure the health assessments are carried out as quickly as possible and that parents are sign-posted to healthcare professional, GPs and health visitors.	Unable to proceed with increased capacity due to limited resources across health and education.	Issues are incident reported and specific issues will be addressed depending on the issue raised at the time of the incident. Complaints and PALS management.
3158	02/05/2023	30/06/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	(EPR) Badgernet - ability to view scans	There is a risk that Obstetricians will not have access to electronic scan reports when the new maternity services EPR (Badgernet) is implemented, as a result of the systems incompatibility with the current Viewpoint package, which may lead to an adverse impact on patient safety in terms of potential for high risk pregnancies.	Nicola Foster	Anthony Rosevear	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Obstetrics / Maternity		15	1 Monthly	01/07/2023	MITS Project Board in place MITS Data Migration and Warehousing Strategy in place Digital Midwife and CNIO in place providing oversight EPR project management and digital projects development monitoring systems in place	Current incompatibility of procured IT systems	MITS Project Board
3161	05/04/2023	31/05/2023	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Clinical	There is a risk of patient deterioration not being recognised and escalated appropriately.	There is a risk that patients deterioration is not recognised and the recording and monitoring of NEWS is not consistently completed to guide further actions appropriate to the trust Deteriorating Patient Policy, including the use of risk assessments (Sepsis screening tool) to identify required clinical responses in a timely way.	Joanne Foster	Simon Buckley	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Nursing (All Specialties)		15	1 Monthly	11/06/2023	1.Divisional progress against targets is monitored via the Deteriorating Patient & Sepsis Group.		
3162	08/02/2023	31/05/2023	To provide care which is as safe, effective, accessible and timely as possible	Operational	Quality of Care and Patient Safety based on Nurse Staffing Position	The Registered Nursing vacancy position in Medicine, against current, agreed establishment creates significant issues with producing a robust nursing roster. Reliance upon a pipeline of Newly Registered Nurses and Internationally Educated Nurses creates skill mix issues when set against numbers of leavers. The Nurse vacancy position within Medicine has a direct impact on quality of care and patient safety. There is a finance risk associated with the use of Bank & Agency Nurses in order to fill the gaps in the rosters. Service developments and new build areas (IAAU/SDEC/ED's) and investment in the establishments required have increased demand for Bank/Agency and vacancy in substantively funded posts. Medicine are also staffing escalation beds which adds further risk. Patient harm, increased sickness, staff retention are possible outcomes as a result.	Joanne Foster	Simon Buckley	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Nursing (All Specialties)		20	1 Monthly	11/06/2023	1.Recruitment pipeline for Internationally Educated Nurses Recruitment pipeline and engagement with newly registered nurses	Inability to safely redeploy	
3164	21/02/2023	31/03/2024	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce	Staffing Levels & HR	Nurse Staffing	There is a risk that the Trust will be unable to maintain safe nurse staffing levels as a result of the high number of registered nurse & support worker vacancies and ongoing requirement to support unestablished escalation beds, which may impact on the ability to maintain patient safety and delivery of high quality care, leading to poor patient and carer experience and reputational damage.	Jennifer Hinchliffe	Eleanor Monkhouse	Trustwide - All Sites (DPoW, S	Chief Nurse	Chief Nurse	Nursing (All Specialties)		20	1 Monthly	14/07/2023	SNCT acuity data collected twice a year with formal Chief Nurse establishment reviews undertaken annually	High number of nurse vacancies leading to shortage of nursing staff available to cover required shifts and reliance on bank and agency staff. Increased RN and HCSW turnover rates. Diversity of IEN pipeline and ability of ward to support high numbers of IENs due to impact on skill mix.	Nurse staffing dashboard accessible and contains KPIs re vacancy position, agency usage, nurse sensitive indicators etc.
3168	26/04/2023	28/07/2023	To provide care which is as safe, effective, accessible and timely as possible	Corporate Business	Newborn Hearing Screening Service cross-site (reduced management time / no management cover)	There is a risk that, when the local hearing screening manager is on leave or absent, there is no-one to carry out local hearing screening manager tasks which could result in a lack of service provision as there is no-one within the team who is trained to cover these duties. There is a risk that babies' screening may be missed or escalations may not be followed, if not managed timely, which may result in a late diagnosis of hearing loss. Management tasks for the QA / Public Health England will not be completed which could result in a delay in picking up gaps in the service and screener performance. If there is reduced capacity within the team, this also reduces the amount of time the local screening manager has for managerial tasks. There is also a risk of burnout to the team.	Alison Hilder	Vijayalaks hmi Hebbar	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Newborn Hearing Screening		16	1 Monthly	29/07/2023	Escalating to matrons (including the Antenatal and Newborn Screening Manager).	Escalation to highlight increasingly prominant risk. This has also been highlighted in the QA visit in September 2022.	
3174	22/03/2023	30/06/2023	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Financial	National Cost Collection - patient level community data	Trust doesn't receive system one information to be able to submit costs at a patient level as per the mandatory requirements of NHSE/I.	Damian Kitchen	Lee Bond	Trustwide - All Sites (DPoW, S	Finance	Finance	Finance		15	1 Monthly	16/06/2023	regular contact with information department for progress updates		escalation to internal digital management
3201	28/06/2023	03/09/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Clinical Capacity within Colposcopy	There is a risk we are not meeting the national targets as a result of increase referrals which may led to potential harm.	Claire Shipley	Anthony Rosevear	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Gynaecology	Outpatients - Gynaecology	15	1 Monthly	/ /	All patients are currently being risk stratified	Due to the lack of capacity the national targets are unable to be met	
3204	28/06/2023	30/06/2023		Clinical	Up to 1 year wait for new referrals to be seen by Consultant Paediatrician (single handed service) into the ADHD post diagnosis support service.	There is a risk that patients who are not seen in a timely manner in the post diagnosis support service will be unable to cope with their daily living activities (eg education - concentrating at school; socialising with friends; following routines and boundaries), especially if they require medication. This then impacts on family life.	Umaima Aboushofa	Lesley Harrison	Scunthorpe General Hospital (S	Directorate of Operations	Family Services	Paediatrics	Outpatients - Paediatrics / Childrens	15	1 Monthly	/ /	Ongoing meetings (fortnightly) with Commissioning Manager for Children (NHS Humber & North Yorkshire ICB), Assistance General Manager and Lead Nurse for Paediatrics to discuss current status and ongoing action plan.	Informal meetings / not minuted.	

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 1st August 2023
Director Lead	Jug Johal – Director of Estates & Facilities
Contact Officer/Author	Bill Parkinson – Associate Director of Safety & Statutory Compliance
Title of the Report	**Annual Fire Report**
Purpose of the Report and Executive Summary (to include recommendation	Annual report relating to fire safety for Board Assurance and approval of workplan. Summary points:- Number of system faults for DPOW has dropped significantly due to new alarm installation Cooking is the second largest activation cause due mainly to toasters left unattended Trial to fit alarmed covers to manual call points to prevent accidental activation Fire door inspection – stratification of risk to prioritise repairs/replacement The only recommendation that is considered in this report is to continue to progress the work programme and further development of safety management especially in the areas of fire safety training attendance and expansion of trained fire wardens.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Health, Fire & Safety Group, ARG
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)	Ongoing funding for Scunthorpe General Hospital (SGH) fire alarm replacement scheme

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.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focusing 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

Directorate of Estates & Facilities
Annual Fire Report

1st April 2022 to 31st March 2023

CONTENTS

APPENDICES

1.0 INTRODUCTION

The responsibility for compliance with the Fire Regulatory Reform (Safety Order) referred to as the Fire Safety Officer (FSO) rests with the "responsible person" which in the case of Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) is the Chief Executive Officer or in the event of remote buildings off site buildings this may be the person in control of those premises.

Generally, the Chief Executive Officer (CEO) is responsible for ensuring that, through appropriate delegation, current fire statutory requirements are met. In addition, for areas within the definition of clinical activities, that the requirements of Health Technical Memorandum (HTM) 05-01 (Fire Safety Management within Healthcare) are also complied with (as well as the accompanying HTM's linked to 05-01.

Under Firecode (i.e. HTM 05 suite), the primary responsibility for ensuring that there is an effective policy rests with the board-level director assisted by the Fire Safety Manager.

This report has been developed to provide information to the Trust Board of Directors concerning the management of fire safety for the period **1st April 2022 to 31st March 2023** and to also identify potential issues for the next 12 months.

This report will also assist with the formulation of annual statement within this report and may also assist with demonstrating performance against Regulation 15 of the Care Quality Commission (CQC) Essential Standards of Quality & Safety. This report should therefore be retained along with the workplan as the assurance to external authorities in terms of fire safety management within the Trust.

2.0 EXECUTIVE SUMMARY

Fires within acute Trusts are not common but should they occur then there could be significant risk to life and so the fire safety management strategy should be to:

- Prevent fires occurring
- Detect them at the earliest stage possible
- Ensure appropriate responses are made when a fire is detected
- Contain a fire to the immediate area and reduce the risk of spreading to other areas
- Should a fire spread then ensure that there is the ability to move to a safe place as soon as possible
- Ensure areas of high dependency such as Intensive Care Units (ICU) are constructed with additional measures, so the evacuation of these patients is regarded as the last resort

There has been some significant investment at the Diana Princess of Wales Hospital (DPOW) site with the completion of the new Auto Fire Detection (AFD) alarm system and the removal of the old system in this period. This means that DPOW now has a full digital system which will give detection and protection for the next two decades.

The effectiveness of the new AFD has meant that the number of systems faults for DPOW now only represents 5.2% of all system faults. The breakdown of system faults per site is shown in Figure 1

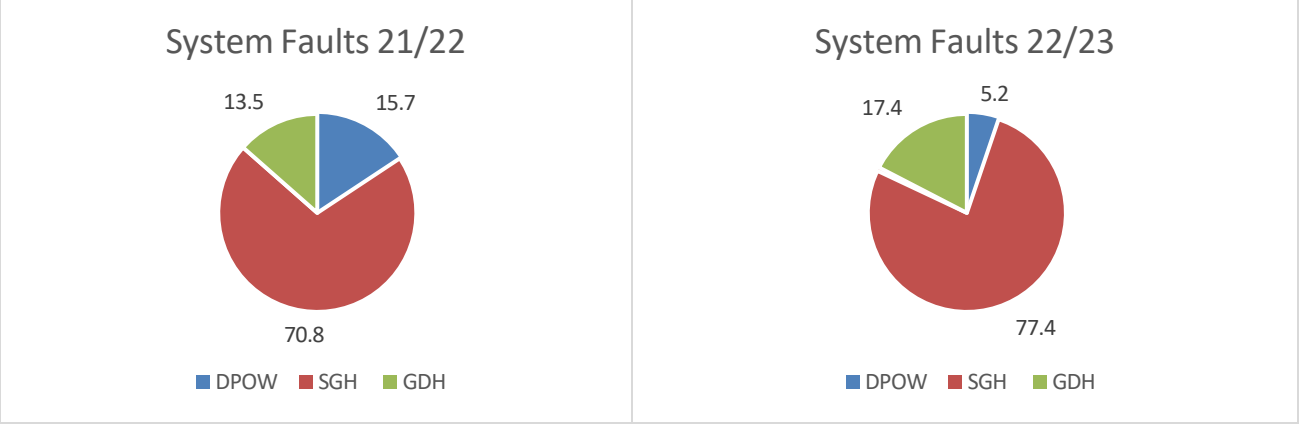


Figure 1 - Comparison of System Faults

As can be seen the change in system faults shows the work on the AFD system at DPOW has resulted in the number of system faults reducing from 15.7% of all system fault activations down to 5.2% after the fire alarm system was replaced. Also figure 1 shows the continuing deterioration in the performance of the fire alarm system at SGH which now accounts for 77.4% of all system fault alarm activations. The alarm system replacement programme will be completed in 24/25 so there will still be a high percentage of system faults attributed to Scunthorpe General Hopsital (SGH) before the work is completed.

The fire alarm system at Goole & District Hospital (GDH) has shown a small increase in the number of system faults and this will continue to be monitored by the Fire Safety Technical Group which is now up and running, meeting on a monthly basis.

Other causes of fire alarm activations are covered below within this report. In addition fire safety related risks which are on the risk register are also covered below.

The Group reports to the Health, Fire & Safety Group (HFSG) which in turn has been aligned to report to the Trust Management Board (TMB) to allow for escalation where appropriate to the Trust Sub Board level and in accordance with HTM 05-01.

3.0 REPORT

3.1 Fire Risks on Risk Register

The Trust Risk Register contains a number of risks relating to fire safety management issues and these are summarised below in Table 1.

Risk Register Number	Site/ Area	Description	Controls in Place/ Actions Underway	Rating
2038	SGH	Risk of failure of SGH fire alarm leading to fire taking hold and hence possible serious harm and/or loss of life of patients and staff (*NB this risk will be removed when installation of new alarm system is completed).* ***This risk is currently estimated as being eliminated by March 2024 when the new system will be fully operational***	• SGH funding allocation now secured and enabling surveys and work underway. • Some old panels replaced until full replacement.	20
2464	Trust-wide	Trust estates alarms not being effectively covered especially within the boiler-house which requires monitoring 24/7. Gaps in switchboard cover and estates staff cover difficulties are raising concerns that cover can be maintained. ***This risk is linked to the digital strategy and upgrades to the Estates and Facilities (E&F) Building Management System (BMS). The latter is estimated to be completed by March 2025 subject to any funding priorities which may change the current timescales***	• Currently gaps are covered but are resources are increasingly strained due to illness and vacancies. • Upgrades to BMS ongoing including notifications of alarms to on call staff	12
2952	Trust-wide	Water Safety Compliance – fire ring main. Currently there are a number of Domestic Water Systems (DWS) connected to the fire ring main making it non-compliant with water	• Upgrades to water systems ongoing to remove DWS connections from fire ring main	16

		safety and fire safety requirements. ***This risk is due to be completed by March 2024 although this could be affected by changes to the BLM/Critical Infrastructure Risk funds which may re-prioritise the programme.***	• Testing of fire hydrants for pressure and flow ongoing • Designers no engaged to take forward removal of DWS connections from ring main at SGH	

Table 1 - Fire risks on Trust Risk Register

Operational risks that sit within the functional responsibilities of the Estates Department are identified through the E&F Operational Risk Register. These risks are separate from the Trust Risk Register and cover specific issues (rather than generalised) and enable appropriate prioritisation to be undertaken so the funding allocation is used to tackle the higher risks as a priority. This operational risk register also includes costed options which will allow any additional allocations received to be quickly utilised avoiding undue delay.

The Coronation Block at SGH still requires further work to comply with the requirements of the FSO but this work will be covered within the fire alarm replacement project in regard to have a fully compliant system based on the revised British Standard.

There is a current agreement with Humberside Fire & Rescue Services (HFRS) to allow the fracture clinic to maintain its current position at present. However, in the long term HFRS do expect this service to be relocated so that no clinical services are undertaken within the Coronation Block. This will then enable the area to comply with statutory requirements as far as is reasonably practicable.

There are also compliance issues within the Ward 2 block and Planned Investigation Unit (PIU) at SGH. These areas are some of the oldest buildings within the SGH footprint and were never designed for the fire requirements as they currently stand. The use of clinical services has to be restricted in these areas and they cannot be used for any overnight stays. This is due to the configuration of the areas and the lack of means of Progressive Horizontal Evacuation (PHE). To bring these areas into compliance would require extensive reconfiguration and significant capital works which is not justified given the current funding available to the Trust.

3.2 Fire Safety Technical Group

The Fire Safety Technical Group (FSTG) is now meeting monthly to review the detailed technical aspects in relation to fire safety management. It also considers and reviews compliance against the statutory provisions within the FSO and also the HTM fire safety documents. The FTSG will also consider requested derogations from HTM based on risk assessments. The group reports to the Health, Fire & Safety

Group and allows the HFSG to oversee fire safety rather than get too detailed which could detract from other agenda items.

The HSFG will remain the body to oversee fire safety management within the Trust in accordance with the requirements of HTM 05-01 and reports to the TMB to enable issues to be escalated when appropriate.

3.3 Fire Safety Management Polices

The Trust has been working towards the appointment of an Authorising Engineer (AE) for fire safety management (as recommended within the HTM) and at the end of 22/23 an appointment has been made .

This appointment will allow independent audits to be undertaken on an annual basis across the organisation to look at compliance against HTM and FSO requirements and give an assurance that requirements are being met. The first audit by the AE(Fire) will be undertaken in June 2023.

In terms of compliance with the requirements of the HTM the last audit undertaken is shown in Table 2 below.

Requirement	Status	Compliance Rating
Clearly defined policy.	The policy has recently been reviewed externally and suggested changes incorporated.	
Board Level Director – accountable to Chief Executive for fire safety.	Director of Estates & Facilities is assigned as the Board Level Director.	
Fire Safety Manager (FSM) – takes lead on all fire safety activities.	Associate Director of Safety & Statutory Compliance is the nominated Fire Safety Manager and trained in HTM 05-01 requirements.	
Fire Safety Officer (FSO) – assists the FSM in fire safety activities.	Fire & Safety Compliance Officer appointed – training to HTM to be completed in 22/23.	
Fire safety policies reviewed and appropriate groups monitoring fire safety issues.	Health, Safety & Fire Group (HSFG) oversees fire safety issues and reports to TMB. Newly formed Fire Safety Technical Group (FSTG) will report to the HFSG and deal with the technical details and recommendations for the HSFG.	
Adequate means for quickly detecting and raising alarm in case of fire.	The fire alarm detection system has been replaced at DPOW and is now being replaced at SGH. The system at GDH will be considered for replacement within the	

	next 3-5 years and currently is not showing any accelerated deterioration	
Means for ensuring emergency evacuation procedures are suitable and sufficient for all areas without reliance on external services.	The emergency evacuation procedures have been reviewed and desktop exercises will be implemented in 2023/24 to further review responses and strategies for specific areas	
Staff to receive fire safety training appropriate to the level of risk and duties they may be required to perform.	Face to face training resuming and fire response for fire warden response being revised and trial of system to maintain fire wardens register.	
Reporting of fires and unwanted fire signals.	All alarm activations are registered via switchboard and notifications sent to the Fire Safety Manager (FSM) and FSO for investigation	
Partnership initiatives with other bodies and agencies involved in the provision of fire safety.	Collaborative working with Hull University Teacher Hospitals (HUTH), ongoing informal discussions with fire authority. No enforcement action undertaken in the last 12 months.	

Table 2 - Compliance with HTM requirements

3.4 Management of Fire Risks

There are currently 155 active fire risk assessments covering the Trust and units which are currently being used by NLaG staff. There are a number of assessments which have been temporarily archived due capital projects where those areas are currently undergoing refurbishment or are new buildings. Once the work have been completed then these areas will be re-assessed.

Previously, there were 17 areas where the review of the fire risk assessment had been delayed due to covid access issues but these have all been reviewed and are now in date.

The current review periods for assessments are:

- In-patient areas - 12 months
- Out-patient areas - 24 months
- Admin areas - 36 months

The assessments are maintained on an electronic system which is cloud based system containing a number of assessment types (service provided by Evotix) and updated by the FSO and FSM. New areas such the new Emergency Department (ED) and Same Day Emergency Care (SDEC) projects are due to have their new fire risk

assessments added during the 22/23 period when they are handed over and the appropriate information transferred across.

3.5 Structural Fire Protection

There have been a number of legislative updates which have come into force in 22/23. Noticeably, changes made to the FSO and the introduction of the Building Safety Act, implementation of the Fire Safety (England) Regulations (2022) have strengthened fire safety requirement particular in relation to residential premises (especially those over 18m in height).

The effect of these changes on healthcare premises is predominately aimed at residential blocks and there are more stringent requirements in relation to “high” residential buildings regarding fire door installation, inspection etc.

Of the current changes made to Building Regulations (arising from the Building Safety Act) the main impact on healthcare is the requirement to retain information relating to fire safety on an electronic format so that it can be easily retrieved by the fire services when called to a fire. This information will help fire services in terms of their fire fighting strategy and also identify entry routes etc.

The Trust is currently undertaking work to make full use of the MiCad electronic system using this as a means of holding relevant fire safety information in a format that satisfies the requirements of the Building Safety Act. This process entails a significant amount of resources to fully achieve and the work required will continue into 24/25 (and beyond) and continues the work in relation to updating drawings so the structural fire protection can be confirmed in respect of the 60 min compartment lines. This work will continue into the 23/24 period.

3.6 Fire Doors Inspection & Maintenance

The maintenance of fire doors is important as they are potentially the weakest element within the strategy of fire compartmentation. Damage to the door or the architrave itself can mean the fire retaining properties of the door set are severely compromised. Fire doors when damaged beyond repair will be required to be replaced as a door set and this can cost the Trust between £3,000 to £6,000 per door set.

During the 22/23 period an accredited door inspection company was contracted to undertake a detailed inspection of every fire door on the three sites. This inspection would result in a real time monitoring of fire doors being available and doors which “failed” their initial inspection would be highlighted on the system. During 22/23 and throughout 23/24 a programme of work to repair fire doors and replacement of those beyond repair will continue with the doors that form part of the 60 min fire compartment being the priority.

Further awareness information regarding damage to fire doors has been undertaken during this period and further information campaigns will be carried out to prevent damage to fire doors. Linking in with capital schemes to ensure appropriate hold-

open devices (or powered doors) are installed where required to reduce resources being used to replace doors that would otherwise last a longer period.

Progress on remedial actions will be reported on a regular basis to the FSTG and where required escalated.

3.7 Fire Response Management

The FSO and HTM requirements in relation to a response to an alarm activation require organisations to deal with the initial stages of fires and alarm activations without relying on the attendance of the fire services. As a result of the Covid pandemic the responses and teams which were in place have now been dispersed over a few areas, have resulted in staff working from home more or less permanently and have also resulted in staff retiring or leaving NLaG.

This has meant that the ability of the Trust to respond to alarms etc. needs to be refreshed and areas identified where more staff are needed to be trained to be able to respond. On a positive note, however, fire response teams are not the only staff members trained in the use of fire extinguishers as all staff receive this as part of their fire lecture refresher training.

However, during the 22/23 period areas where there are insufficient staff to be able to respond effectively, additional staff were identified and trained to give the assurance that suitable and resilient resources are in place to respond within the initial stages of a fire alarm/incident occurring. This work will continue during the 23/24 period to further increase the number of staff who are able to respond to a fire alarm/incident and these responses will be tested through fire drills and desktop exercises.

More details are also included in the sections below and timescales shown within the workplan attached in Appendix 2.

3.8 Fire Training

During the 22/23 period face to face training was recommenced and although the use of e-learning increased the compliance figures, the reliance of e-learning only is not in keeping with the requirements of the fire HTM's. The requirement of face-to-face training at least once in a 4-year period is enforceable by the Fire Authority and some other NHS Trusts have been picked up on this issue.

Prior to the resuming of face-to-face training was implemented the training records of all staff were reviewed to determine the number of training places that would need to be available, and that priority would need to be given to those staff who had not attended these sessions for the longest period.

This does not meet the requirements of the HTM which require staff to undergo a "fire lecture" with a competent fire safety person/trainer at least once in a period of 4 years. The period of validity for this training is two years so staff are required to undertake some form of training at least every two years. If one of the forms of training is via e-learning that this cannot be repeated in consecutive training periods.

This requirement was temporarily suspended (after informal agreement with HFRS) until such time face to face training could be resumed.

The fire training compliance for the 22-23 period is included in Table 3 below.

Period	16/17	17/18	18/19	19/20	20/21	21/22	22/23
% staff trained	80	79	78	84	84	91*	77**

Table 3 - Fire Training Compliance
* - no face to face training
** face to face training reintroduced

As shown in Table 3 there has been a significant reduction in the percentage of staff trained in the 22/23 period. This is due to the reintroduction of face-to-face training meaning that staff now have to be released for 1 ½ hours to attend the training. In addition, for those staff that are out of the 4-year compliance requirement for face to face training the access to e-learning is not available. The rate of non-attendance has been raised to the Trust Management Board (TMB) and is being monitored by the Health, Fire & Safety Group with bi-monthly updates to TMB being submitted. To encourage staff to attend information in the form of attendance reports, posters and discussions with clinical areas is now ongoing and the impact of these steps will be monitored.

3.9 Fire Alarm Activations and Unwanted Fire Signals

Over the years there has been some discussions and different definitions of what an Unwanted Fire Signal is and how it should be reported. In 2014 the Chief Fire Officers Association (CFOA) published guidance as to what the Fire Authorities defined the difference between false alarms Unwanted Fire Signals (UwFS). These definitions are outlined below.

- Fire Alarm Activation (known as false alarms) – where an AFD system is activated either via the sensor head or via a manual call point activation (or system fault)which sends the main fire panel (and local panels) into alarm.
- UwFS – where an alarm activation causes a requirement for the local fire & rescue services to attend the organisation's premises un-necessarily and which impacts on the fire cover for the local population potentially putting lives at risk.

The CFOA is concerned that UwFS can (and do) reduce resources available to tackle actual fires due to Fire & Rescue Services (FRS) attending a UwFS there is no fire. The amount of resources that can be called to attend an UwFS depends on the organisation but in premises where there is a high risk to life should a fire occur, there will be a greater response and the minimum for NLaG is three fire tenders (there is an automatic escalation every five minutes for two more tenders until a stop call is made).

In an effort to reduce the number of UwFS the UK Government introduced legislation that allow FRS services to recover costs of attending organisations where there were persistent UwFS which were not being addressed or reduced. Currently Humberside Fire & Rescue Services (HFRS) has adopted the following charges that will be levied

against organisations that have more then 4 UwFS call outs in a rolling 12 month period.

- One fire tender + 3 Crew + 1 Crew Manager = £311.75 per hour
- Administration costs per call out = £82

The minimum attendance for NLaG would be 3 fire tenders plus crew (including a crew manager per tender).

The number of UwFS each year is shown in Table 4 below. This does not include an actual fire at the DPOW site which would not be classified as an UwFS. Of the 2 recorded for GDH one is regarded as being with “good intent” in that a fire could not be located but HFRS felt that attendance was required (as the alarm activation was indicated to be within a roof void).

The Trust uses a “call filtering” system whereby HFRS are not called for the first 5 mins of an alarm activation so a check can be made to determine if the activation was a false alarm. In the 22/23 there was a total of 282 alarm activations which only resulted in 4 UwFS which shows the effectiveness of the call filtering system (and response by staff and the security team). If there was no such system in place then the cost of charges would be in excess of £250,000. It is hoped that the installation of new fire alarms will reduce the number of UwFS to zero in future years and with call filtering in place HFRS have not attended any fire call for a period of 7 months consecutively.

	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23
SGH	3	7	4	3	10	10	7	7	1
DPOW	4	9	8	9	8	17	3	9	1
GDH	0	0	2	2	0	1	0	0	2*
Total	7	16	14	14	18	28	10	16	4

Table 4 - UwFS for NLaG

* - Classed as “good intent” but HFRS attended despite “stop” call

In relation to the number of alarm activations there were 282 (compared to 234 for the same period last year). The breakdown of the alarm activations is seen in Figure 2 below

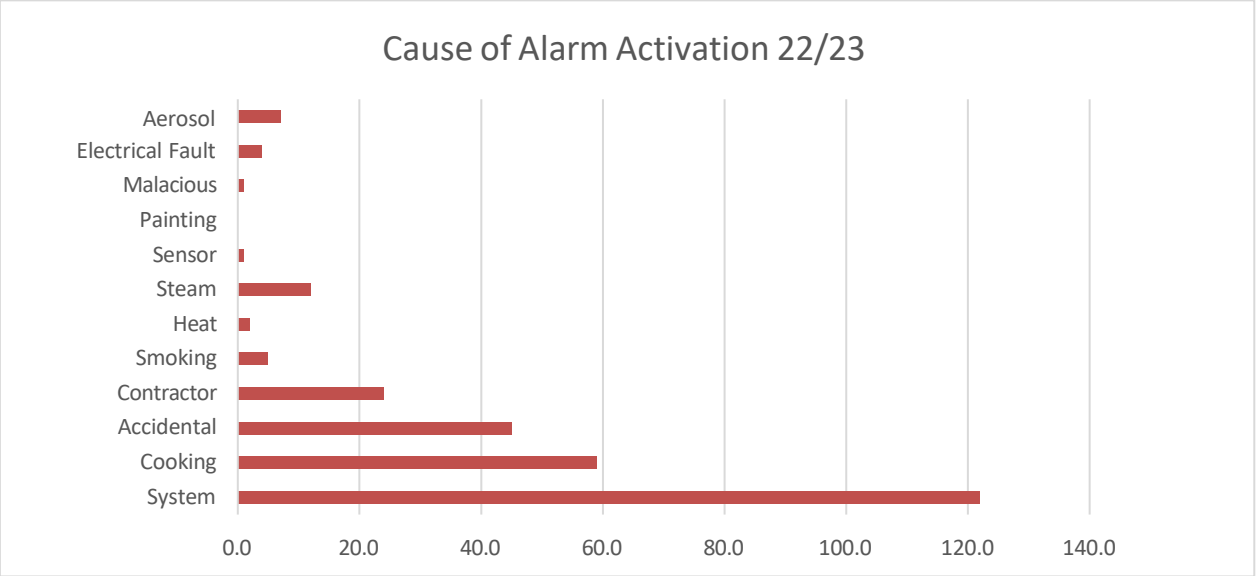


Figure 2 - Breakdown of alarm calls

It can be seen from Figure 4 that that the majority of alarm calls are due to system faults but this is unsurprising given the issues identified with SGH and the number of anticipated system fault calls when replacing the alarm systems. However, the second largest cause is “cooking” and invariably linked to burning toast in ward areas. At DPOW the Roost accommodation accounts for a significant number of calls and these are being further investigated in terms of why the alarm is being activated. The comparison of “cooking” alarm activations compared to 21/22 is shown in Fig 3.

Figure 3 - Activations due to cooking

Nearly 70% of the “cooking” incidents have occurred at DPOW and of those incidents 62% have occurred within the Roost accommodation with the other 38% on the wards. Of the cooking activations at SGH 60% occurred within the accommodation blocks and 40% in ward areas.

A reduction in these types of alarm activation could significantly reduce the number of alarm activations and there are simple ways to do this such as keep the doors closed where cooking activities are undertaken and do not leave anything unattended that is being cooked.

In order to try and reduce the number of alarm activations a pareto chart can quickly identify those categories that cause 80% of all alarm activations. The pareto chart for the 22/23 period is shown below in Figure 4.

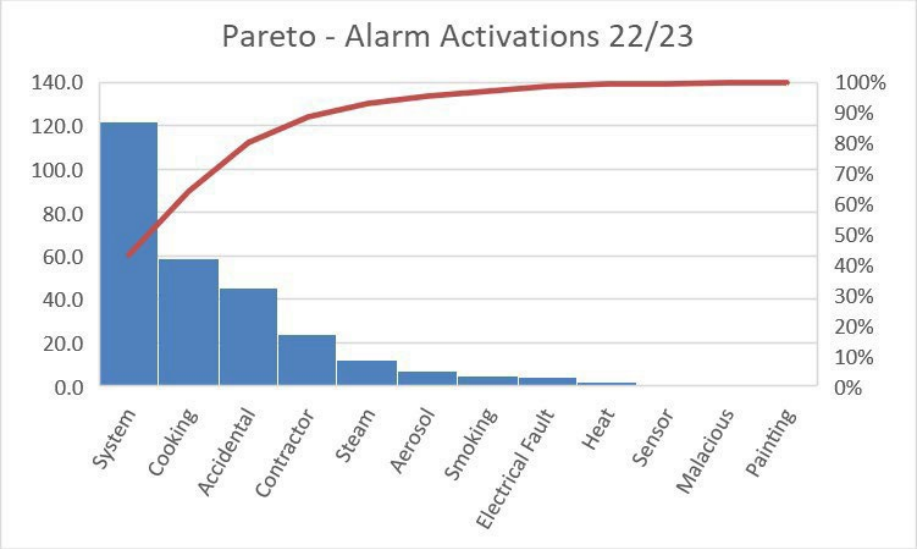


Figure 4 - Pareto Chart of alarm activations

From Figure 4 three causes of alarm activations account for 80% of all activations of which two have already been discussed above. The third highest cause is related to "accidental" activation. This is generally a member of the public pressing the alarm manual call point instead of the door release point in areas where access control is in operation. As part of the new fire alarm system covers are being fitted to fire manual call points which have to be lifted in order to activate an alarm. Currently, it is too soon to determine what impact this has had in attempting to reduce the number of accidental activations, but the issue will continue to be monitored by the FTSG.

Activations due to sensor heads should be minimised by the rolling replacement of sensor heads which have a working life of 10 years before they start to develop faults leading to false detections and alarm activations. The Trust has a rolling programme of replacing 10% of detector heads per year to mitigate the sensor issues.

3.10 Enforcement Activities by Local Fire Authorities

There has been no enforcement action undertaken by HFRS in respect of fire safety within NLaG premises. A physical audit of GDH has been undertaken during the 22/23 period with only minor issues identified. There will be several physical audits taking place over the 23/24 period and these are currently in the planning stage with HFRS.

In relation to surrounding areas their current enforcement/prohibition notices for hospitals. In regard to United Lincolnshire Hospitals there are two Improvement Notices currently still in place in regards to Lincoln County Hospital and Boston Pilgrim Hospital (issued in 2017) and in South Yorkshire there is still a Prohibition Notice in place for a number of clinical areas within Sheffield Teaching Hospitals

(issued in 2018) this means that currently 4 wards are completely closed and not able to be occupied for clinical or non-clinical activities.

In addition a number of Enforcement Notices have been signed off as now being complied with in relation to Hull Royal Infirmary and Doncaster Royal Infirmary

3.11 Capital Investment

The working of a commercial AFD is between 20 – 30 years and does become dependent on the availability of fire panels (when existing ones need to be replaced) etc. The system at DPOW was nearly 40 years old and there had been a number of system failures prompting the decision to replace the system and this has now been completed.

During 21/22 and 22/23 the system at SGH started to increase in system fault activations and it was recognised that this system would need replacing sooner that anticipated. Capital investment to the value of circa £6m has been awarded covering the next 3 years to replace the entire system and this work commenced in 22/23 and will continue until 24/25. This project is considered as a priority over other work addressing some of the risks currently on the risk register. If any further capital investment is secured in 23/24 then this will be used to continue to improve the water systems and the separation of Domestic Water System (DWS) connections from the fire ring main (as required by the HTM).

3.12 Actual Fires Recorded

There are two actual fires which have occurred both of which have happened on the DPOW site. The details of these are

1. 1/8/22– Medical Engineering
   A fan caught fire which was extinguished by staff within the Medical Engineering Department. This fan was purchased through NHS Supplies but was not rated for use on industrial circuits so should not have been purchased via this route.
2. 4/8/22 – Post Graduate Centre
   An activation of the fire alarm within the building occurred at 17:34 and a dishwasher that had overheated and ignited was discovered. Trust staff were able to contain the fire until the Fire Brigade arrived and extinguished the fire (see figure 5 below).

Figure 5 - Fire Damage to Dishwasher

Further investigation identified the dishwasher was rated for domestic premises only and therefore should not have been installed. This highlights the danger of using

equipment that is only designed for use within a home environment and was noted by the Fire Brigade. Industrial rated equipment has additional safety features installed to take into account that industrial circuits can create additional risks of overheating etc. The Trust does have a policy where anyone wishing to purchase “white goods” electrical equipment can contact purchasing staff who have a list of commercial/industrial rated equipment that can be installed on the sites.

As a result of this fire all sites were checked and several items that staff had purchased or brought in from home were removed or isolated until they could be replaced. The approval of these white goods will also be overseen by the Electrical Safety Group within E&F in the future and regular checks made of work areas and any unauthorised equipment identified will be removed or isolated.

4.0 Work Plan for 23/24

The workplan for the next period (23/24) is attached in Appendix 2. It should be noted that this workplan may be further developed and added to after the initial AE(Fire) audit depending on the findings and action plan developed. The action plan will be incorporated into the workplan as appropriate.

5.0 Conclusions & Recommendations

Management of fire safety within NLaG is an ongoing development and the workplan shown in appendix 2 gives more detail on the various elements that need to be further developed. The level of capital investment over the last 24 months (and over the next 24 months) will mean circa £10m has been invested in bringing the systems up to date with more modern and flexible systems. The Trust should be recognised for this level of investment and demonstrates how important fire safety is considered within NLaG.

The appointment of an AE(Fire) also further demonstrates the Trust’s approach to fire safety as currently this is not a legal requirement but is seen as a positive benefit to the Trust having an independent expert available to further develop fire safety management with the Trust.

The only recommendation that is considered in this report is to continue to progress the work programme and further development of safety management especially in the areas of fire safety training attendance and expansion of trained fire wardens.

Appendix 1 – Annual Fire Safety Statement

ANNUAL FIRE STATEMENT FOR PERIOD – April 2022 – March 2023		
I confirm that for the period 1st April 2022 to 31st March 2023, all premises which the organisation owns, occupies, or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order and (*appropriate boxes below ticked*)		
1	There are no significant risk arising from the risk assessments	N/A
OR 2	The organisation has developed a programme of work to eliminate or reduce as low as is reasonably practicable, the significant fire risks identified by the fire risk assessment (see appendix 2)	✓
OR 3	The organisation has identified significant fire risks, but does NOT have a programme of work to mitigate those significant fire risks*	N/A
* Where a programme to mitigate significant risks HAS NOT been developed, please insert date by which such a programme will be available, taking account of the degree of risk Date:		
4	During the period covered by this statement, has the organisation been subject to any enforcement action by Humberside Fire & Rescue Authority? If yes, then details should be included in Part 1 below	No
5	Does the organisation have any unresolved enforcement action pre-dating this statement? If yes, then please give details in Part 2 below	No
AND 6	The organisation achieves compliance with the HTM 05-01, by the application of Firecode or some other suitable method.	✓

Fire Safety Manager	Name: Bill Parkinson Signature:	
	Contact e-mail: bill.parkinson@nhs.net	Date:
Chief Executive	Name: Signature:	
	Contact e-mail	Date:

Part 1 – Outline details of any enforcement action during the period and the action taken or intended by the organisation. Include where possible cost implications required to comply.
None
Part 2 – Outline details of any enforcement action unresolved from previous years, including original date and the action the organisation has taken so far. Include any proposed further actions need to comply, costs incurred and additional costs required to comply.
None
NB Statement to be retained for external fire authority audits.

As a Foundation Trust annual fire safety statements are not required to be submitted to the Department of Health & Social Care. However, the completion of an annual statement signed off by the Trust Board is seen as good practice and allows the Board to gain assurance in relation to fire safety that adequate systems and controls are in place to reduce the risk of fire within the Trust premises.

Appendix 2 2023/24 Work Plan for Fire Safety Management

Item	Area	Task / Objective	Target Dates	Completed Date
Review of Policies				
1.1	Review fire safety management policies and guidance with external review and report to appropriate groups actions identified.	• Newly appointed AE(Fire) initial audit • AE Action plan arising from audit • Update fire safety management policies and evacuation guidance and re-issue post AE audit • Present annual report & workplan to appropriate groups prior to submitting to Trust Board • Submit annual report and workplan to Trust Board	June 2023 July 2023 September 2023 May 2023 August 2023	
1.2	Humberside fire & rescue services need to keep their operational plans for each site up to date	• Arrange operational plan review visit (annual). • Fire audits with HFRS • Complete any actions arising from HFRS audits	May 2023 March 2024 March 2024	
1.3	Review Technical Fire Safety Terms of Reference after 12 months of operational meetings	• Ensure FSTG continues to develop and review technical fire safety issues • Schedule meetings for 23/24 period	July 2023 April 2023	**Completed**
1.4	Review annual report to Trust Board and requirements of HTM that need to be within the report.	• Review annual reporting requirements within HTM • Complete draft annual report for consultation	April 2023. April 2023 June 2023 August 2023	**Completed**

		• Finalise annual report and send to TMB for recommendation for Board Approval • Approval by Trust Board		
Fire Training				
2.1	Review annually face to face training content for delivery of fire lecture	• Revise training presentation and content • Highlight reports on fire training attendance to TMB	April 2023 Ongoing to March 2024	
2.2	Review fire wardens training and methods of maintaining register of fire wardens to ensure appropriate cover	• Increase number of fire wardens per area • Work with HUTH regarding register of fire wardens • Review and revise fire warden training content • Implement recruitment campaign for fire wardens	March 2024 October 2023 April 2023 September 2023	**Completed**
Fire Drills and Exercises				
3.1	Fire drills or desktop exercises need to be undertaken (where fire drills cannot be held due to potential risk to patient)	• Identify areas where no fire drills or desktop exercises have been undertaken in last 24 months • Engage with fire wardens training scenarios for clinical areas requiring desktop exercises • Implement series of desktop exercises	June 2023 September 2023	
Fire Alarm Tests				

4.1	Regular fire alarm tests are required to be undertaken and testing of manual call points (MCP)	• Review fire alarm testing capabilities on new advanced system • Consider digital communications strategy and fire alarm communications integration • Review with AE (Fire) alarm testing strategy and notification processes	May 2023 December 2023 March 2024	
4.2	Communication regarding alarm testing schedule will need to be sent on regular basis to all areas	• Liaise with communications when schedule finalised • Monthly publication of date & time of testing to be drawn up	January 2024 February 2024	
Fire Action Plans				
5.1	Localised fire action plans are required to assist with emergency responses in the event of a fire	• Audit areas to ensure fire action plans are in place and updated • Fire action cards to be located in each area	May 2023 June 2023	
5.2	Fire safety response kits should be developed and rolled out to each area	• Review with AE (Fire) regarding use of fire safety response kits and locations • Roll out response kits to all areas identified where required	August 2023 March 2024	
Fire Strategy Development				
6.1	Development of fire strategy to improve fire safety across the Trust	• Work with AE (Fire) to ensure fire safety strategy appropriate for all areas • Fire strategy drawings to be drawn up on MiCad • Undertake fire stopping surveys and ensure appropriate fire stopping in place	December 2023 July 2023 December 2023	

		• Use MiCad to develop appropriate “layers” of information to enable fire strategy drawings to be available to all areas/ • Update and maintain fire risk assessments in-line with the fire safety policy • Continue and further develop working relationship with HFRS to avoid any enforcement action	March 2024 Ongoing Ongoing	

NLG(23)148

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	01/08/2023
Director Lead	Jug Johal, Joint Director of Estates and Facilities/Health Inequalities (NLaG)
Contact Officer/Author	Philip Young, Security and Safety Compliance Officer Compliance
Title of the Report	**Annual Report for Security Management 2022/23**
Purpose of the Report and Executive Summary (to include recommendations)	This report covers all aspects of Security Management at a local level and provides an update on the work streams that have been completed between the 1st of April 2022 and the 31st of March 2023. The NHS Constitution states you have the right to be cared for in a safe, secure, and suitable environment, in addition to legal obligation to protect our staff, patients have a right to be cared for in a safe and secure environment. The security and safety of staff, patients, visitors, and property are a priority to enable the effective delivery of healthcare services. Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) has continued to develop its security management arrangements as part of a structured work programme.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ✓ Divisional SMT ☐ Other: Audit, Risk & Governance Committee - July 2023
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: To Note

***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

Directorate of Estates and Facilities

Annual Report for Security Management 2022/23

Report Date:	August 2023
Number of Pages:	31
Report Author:	Philip Young, Security (LSMS) & Safety Compliance Officer
Director Sign-Off:	Jug Johal, Director of Estates and Facilities (Security Management Director (SMD)

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Executive Foreword

The NHS Constitution states you have the right to be cared for in a safe, secure and suitable environment, in addition to legal obligation to protect our staff, patients have a right to be cared for in a safe and secure environment. The security and safety of staff, patients, visitors, and property are a priority to enable the effective delivery of healthcare services. Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) has continued to develop its security management arrangements as part of a structured work programme identified in last year's Annual Report. This has included:

- A proactive approach to the issuing of informal warning letters to aggressors of violence and abuse against staff, which links into compliance with the NHS Violence Prevention and Reduction Standards.
- Review of Trust wide Close Circuit Television (CCTV) system, a new system has been installed at Grimsby, Scunthorpe and Goole with new cameras which provide enhanced footage, the CCTV system is now fit for purpose.
- The organisation continues to develop and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property, and assets; the Local Security Management Specialist (LSMS) is working closely with Humberside Police, Local Authorities and Safeguarding teams. There is also Improved sharing and analysis of crime data between NLAG, Humberside Police and North East Lincolnshire Community Safety Partnership.
- The organisation ensures that security is a key criterion in any new build projects, or in the modification and alteration (e.g. refurbishment or refitting) of existing premises, this has taken place with the upgrading of the CCTV system and the new Emergency Departments buildings that are now fully operational.

There have been several successful criminal sanctions and Trust policy sanctions applied during 2022/23.

The criminal sanctions include convictions against offenders for verbal and physical assaults. The Trust has issued 29 informal warning letters which were sent to patients and visitors warning them of inappropriate behaviour towards staff. The Trust issued 2 formal warning letters to patients due to the severity of their behaviour towards staff, no exclusions have been issues to any patients or visitors during 2022/23.

The 6 Point Promise for victims of intentional physical assaults whilst at work was implemented late 2021, we continue to work within the Joint Working Agreement (JWA) between the Trust, the Yorkshire and Humberside Crown Prosecution Service, and Humberside Police.

The Trust continues to work within the NHS Violence Prevention and Reduction Standards which were published in December 2020.

Jug Johal
Director of Estates and Facilities (Nominated Security Management Director)

1.0 Background and Introduction

This report covers all aspects of Security Management at a local level and provides an update on the work streams that have been completed between the 1st April 2022 and the 31st March 2023.

The Trust is committed to improving the provision of a secure environment for staff, patients and visitors and the security and protection of its premises and assets, whilst recognising the need for accessible clinical services and the desirability of a welcoming non-threatening environment. The Trust aims to achieve this objective through the implementation of appropriate systems and arrangements which meet national, legislative and code of practice requirements issued from various bodies.

The **NHS Standard Contract** no longer exists as it finally came to an end in 2021/2022, however in respect of services provided to NHS Commissioners and the Standards that were previously set by NHS Protect, the four priority areas for the Trust to continue to develop a secure environment are:

- **Strategic Governance**
- **Inform and Involve**
- **Prevent and Deter**
- **Hold to Account**

The Trusts Security Strategy, which is coordinated at a local level by the Local Security Management Specialist (LSMS), focuses on seven generic areas for action:

- **Creating a pro-security culture** – to promote a culture in which the responsibility for security, including timely reporting of security incidents, is accepted by all
- **Deterrence/Reduction** – Identifying and implementing ways to deter and reduce security incidents and breaches
- **Prevention** – Identifying and implementing ways to prevent security incidents and breaches
- **Detection** – Ensuring security breaches are detected and appropriate reporting systems are in place
- **Investigation** – Initiating post incident reviews and criminal investigations
- **Sanctions** – Providing advice on relevant sanctions and utilising Trust policies
- **Redress** – Support the Trust to seek redress in all appropriate circumstances and assessing the true cost of security incidents to the NHS

2.0 Security Management Structure

The Trust's security management structure sits within the Directorate of Estates and Facilities and consists of the nominated roles of Security Management Director (SMD), held by the Director of Estates and Facilities, and the Local Security Management Specialist (LSMS) role held by the Local Security Management Specialist (figure 1). These roles work closely with the operational security functions that are managed by the Associate Director Facilities & Sustainability and delivered through the Bidvest Noonan security contract.

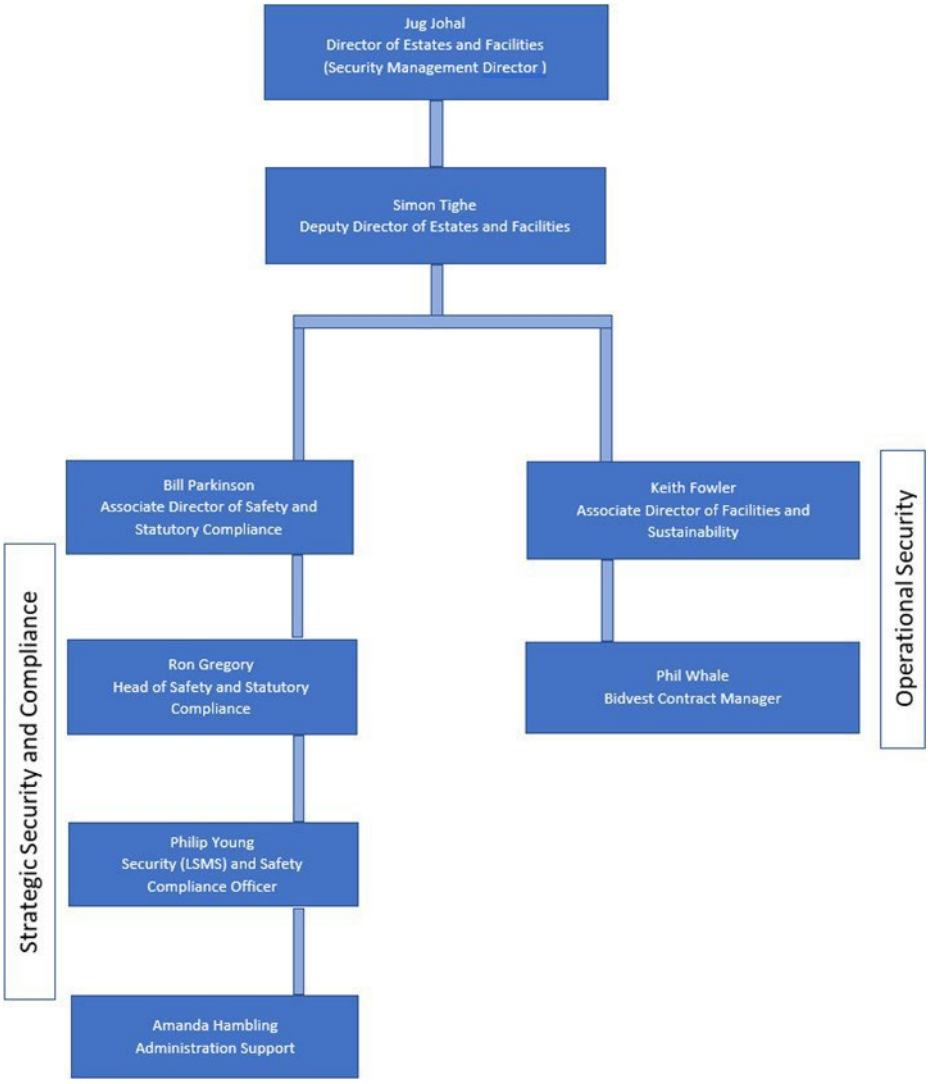
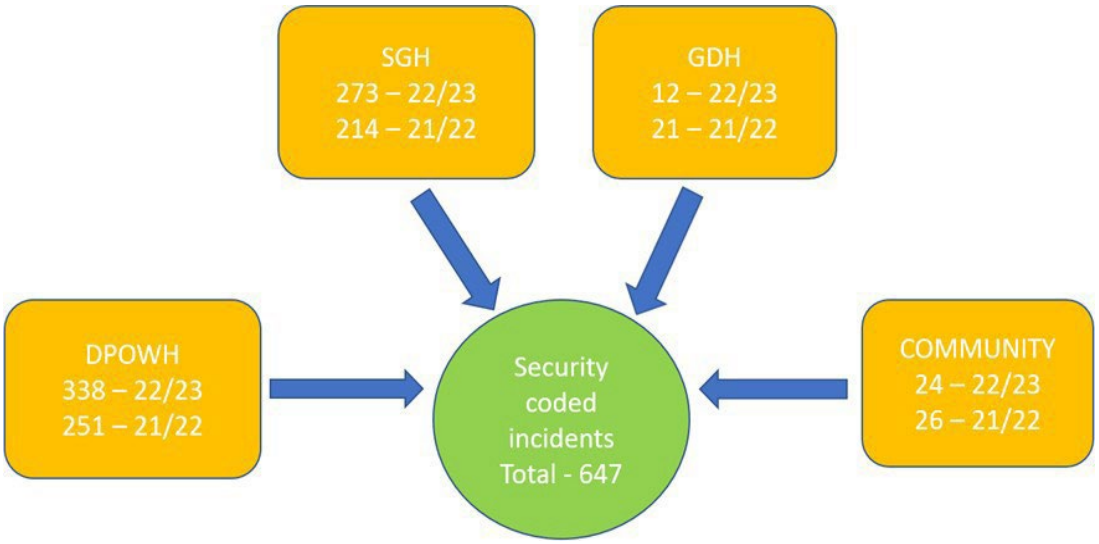


Figure 1 – Security Management Structure

2.1 Violence and Aggression against Staff

The number of reported security coded incidents during 2022/23 was a total of **647** incidents Trust wide, this is up from **512** in 2021/2022.



This includes all incidents that are coded as security incidents including behaviour that is related to medical condition, absconding from wards, and is not just coded to violence and aggressive behaviour. There appears to of been an increase on the figures that was reported during 2021/22, over the last 12 months the LSMS has been actively promoting the reporting of Ulysses throughout the Trust, making staff aware of the benefits of reporting incidents which include through investigations taking place, joint working with the Police and other partner agencies, positive action being taken against offenders and the Trust identifying trends and acting upon them to make the Trust a safety place to work and visit.

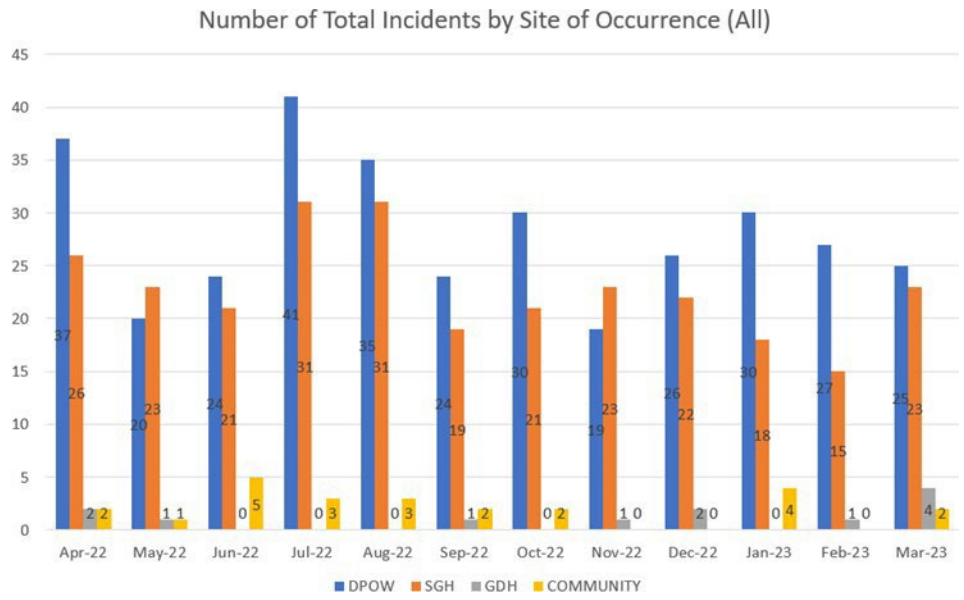
Staff have been made aware that they will be supported if they are a victim and violence and aggression and the LSMS will contact them, it was considered throughout 2022/2023 that there would be an increase in the incident figures due to the under reporting that had previously occurred as staff didn't see the benefit is recording incidents on Ulysses.

It also may be that the figures have also increased due to footfall overt he last 12 months as the Trust has been extremely busy with patient demand.

The chart below (figure 2) shows the number of incidents per month by site. The reported numbers show that there has been a steady number of incidents reported at both Diana Princess of Wales Hospital (DPOW) and Scunthorpe General Hospital (SGH) throughout the year, with July 2022 seeing the largest number of incidents reported at both DPOW and SGH, this is potentially due to it being the summer months and the peak period for holiday season.

DPOW had a drop in numbers in November 2022 and SGH had a drop in numbers in January and February 2023, Community figures sit in single figures each month with the highest in a month being 5 in June 2022.

Goole General Hospital (GDH) average 1 to 2 incidents a month.



Calendar Month	Community	DPOWH	GDH	SGH	Total
Apr-22	2	37	2	26	67
May-22	1	20	1	23	45
Jun-22	5	24	0	21	50
Jul-22	3	41	0	31	75
Aug-22	3	35	0	31	69
Sep-22	2	24	1	19	46
Oct-22	2	30	0	21	53
Nov-22	0	19	1	23	43
Dec-22	0	26	2	22	50
Jan-23	4	30	0	18	52
Feb-23	0	27	1	15	43
Mar-23	2	25	4	23	54
Total	24	338	12	273	647

Figure 2 – Number of incidents per month by site

It should be noted that of the total 647 behaviour incidents reported during 2022/23, 26% related to behaviour that included violence and assault and 49% in relation to aggressive behaviour.

The remaining 25% was relating to absconders, Self-harm, drug use and Harassment.

The next chart (figure 3) shows the percentage of incidents per category for the year.

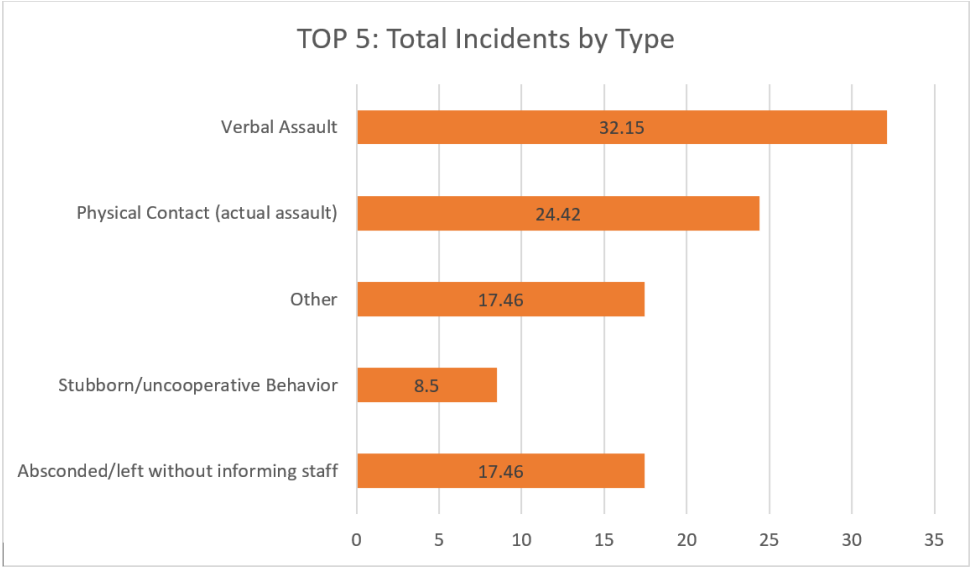


Figure 3

The percentage of reported physical assaults is 24.24 which is up from 23% on 2021/2022. The type of physical violence ranges from pushing and lashing out to punching and kicking, this also includes sexual assault incidents. A number of these incidents will relate to patients that are suffering from a medical episode so lack capacity to understand their behaviour so no action is taken by the LSMS but should be reviewed by the medical team in charge of their care to ensure correct care package has been provided to support the patient and staff, the LSMS provides advise and support to the medical teams to unsure that both the staff and the patient are safeguarded appropriately.

Most incidents that are reported relate to both Emergency Care Centres this could be due to the patient and visitors they have within their departments and the acute treatment and care been delivered. The incidents that don't include clinical factors, the LSMS and Police will endeavour to take strong action to try to prevent these incidents reoccurring.

Work is undertaken to support victims of these incidents and to put relevant actions in place against the aggressors in the hope of positive outcomes, and to try and prevent any further reoccurrence. Details of some of the work in progress are included in other sections of this report and the 2023/2024 LSMS workplan.

The LSMS is keen to promote to staff that they are supported if they are a victim of Violence and aggression and that the LSMS can be a point of contact for them throughout the investigation, every report will be taken seriously by the Trust and reviewed and acted upon by the LSMS.

2.2 Joint Working Agreement

The Joint Working Agreement (JWA) between the Trust, Yorkshire and Humberside Crown Prosecution Service and Humberside Police is currently undergoing a full review and once reviewed, amended, and published the new JWA will be promoted by the LSMS within Humberside Police Crown Prosecution Service and the Trust. The LSMS will work closely with Inspector Richard Mirfin and Inspector Thomas Stevens from Humberside Police to implement and raise awareness of the JWA and its principles to ensure it makes an impact at frontline services. A 6-Point Promise was approved in 2021 between Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Humberside Police that details the six key points that NLAG staff will receive should they become a victim of an intentional physical assault whilst at work. These include the support that will be made available to them and that NLAG and Humberside Police will work together to achieve a positive outcome for the victim wherever possible.

2.3 Warning Letters for Unacceptable Behaviour

The Trust does not tolerate any acts of criminal violence or aggression towards our staff and in support of this the Trust has a Policy for the management of Violent, Aggressive and Intimidating Behaviour which contains an exclusion procedure. The exclusion procedure consists of four stages, verbal warning, informal warning letter, formal warning letter and then an exclusion letter.

The LSMS has taken a proactive approach to challenging unacceptable behaviour as an early intervention to try and prevent the escalation of behaviour and reoccurrence of incidents. This proactive approach has led to 29 informal warning letters being sent to patients and visitors warning them of inappropriate behaviour towards staff during 2022/23, which is an increase of 24 from 2021/2022

The Trust also issued 2 formal warning letters to patients due to the severity of their behaviour towards staff, no formal warnings were issued in 2021/2022.

The Trust has not issued any exclusions to patients or visitors during 2022/23. The types of behaviour that can lead to the informal and formal warning letters being issued include being verbally aggressive, threatening staff, physically assaulting staff, and racial abuse.

This year's figures are up from 2021/22, this was to be expected as the LSMS has actively promoting the reporting of Ulysses Incidents for inappropriate behaviour throughout 2022/2023 and providing more support to staff when they become victims, also footfall has also increase as we have come out of Covid-19 restrictions.

Monitoring of the number of incidents that occurred prior to the warning letter and after the warning letter, provides evidence that in most cases there has been no reoccurrence of incidents involving the individuals after the letter has been issued, When there is opportunity arising through the individual making contact with the LSMS, the LSMS promotes constructive discussion in order to positively educate the individual to deter inappropriate behaviour in the future.

The LSMS reviews Body Camera footage and CCTV footage on a weekly basis which provides valuable evidence and Information for the purpose of the exclusion procedure and its four stages, the footage is also valuable if reported to the Police.

2.4 Community Lone Working

The Peoplesafe Lone Worker devices currently in use contain the latest lone working technology, are linked to a 24/7 specialist alarm receiving centre and feature GPS locating technology that can be directly linked to the Police Command Centre Dispatchers during an emergency to ensure the quickest response possible for staff requiring help. The feedback received from staff has been positive regarding training, service provided by Peoplesafe and the device functionality.

There are approximately **608** staff that have received face-to-face or on-line training and have been issued or have access to a device, this figure is up from **599** in 2021/2022. Currently there is **61** active devices assigned to staff with a mixture of individuals and pooled units, this is down from **346** in 2021/2022.

A root to branch gap analysis commenced on the 15th March 2022 by the LSMS, this took place due to evidence of units not being used or being allocated to staff that have either left the Trust or moved to alternative posts, no recent audit had taken place due to the Covid-19 Pandemic, the gap analysis identified a number of users which no longer needed a device and the devices were retrieved and the users removed from the Peoplesafe database.

In May 2022 an exchange programme was also commenced alongside the gap analysis, this was due to the Trust receiving new upgraded devices for every user, with the support of the Safety and Statutory Compliance Team Administrator, the Divisions and Peoplesafe Management the exchange programme ended in January 2023, the end date was set by Peoplesafe as the old devices had to be returned to avoid additional charges.

Both the gap analysis and the device exchange programme running alongside each

other provided an excellent opportunity to update the trust database and obtain devices that could then be redeployed to new users.

Despite carrying out the gap analysis and the exchange programme the usage of the devices fell sharply during the year, notwithstanding support from Peoplesafe and the divisions, promotion of the usage of the devices via Communications on the Trust Intranet and Social Media pages, Violence against staff awareness workshops and the issue being escalated to Trust Management Board the amount of active users and the usage has not increased over the last 12 months, the LSMS continues to promote the use of the devices with users so that the devices are being used to their full potential, the promotion is supported by Peoplesafe who provide weekly workshops, case studies of incidents involving the use of the device to show the positive benefits of using the device, Peoplesafe are providing weekly usage reports which will show who has not used their device, this will then be escalated to the Line Manager of the users and the users themselves. Peoplesafe are also planning to attend the Trust in September 2023 with a Peoplesafe Roadshow which will be available for all users.

2.5 Surveillance Systems

The Trust currently operates 3 Security Surveillance Systems, CCTV, Body Worn Video (BWV) devices and non-recording patient cameras and monitors. The Trust also has Automatic Number Plate Recognition (ANPR) in use on our car park barriers which, although not a security system, is still classed as a surveillance system.

The current CCTV system is Digital at DPOW and GDH, and SGH, we are also using Digital Cameras. The systems at DPOW and GDH used to regularly fail with issues associated with the hardware, including the recording units, the cameras, and the controller units prior to the upgrade that occurred during 2022/2023. The system at DPOW, SGH and GDH has now been fully upgraded with new software and cameras, new cameras have been replaced within the buildings and outside, camara positions have also been rationalised to provide better coverage both in and outside the Hospital, the new cameras provide a much better-quality picture and can also take still shots. The rationalisation also provides assurance that the Trust has taken all reasonable measures to reduce unnecessary surveillance, which is in line with the Surveillance Camera Commissioner (SCC) Code of Practice.

Fisheye Camaras have also been installed throughout the Hospital sites which give a full 360-degree view, and they can also be broken down into zones so more than one view can be monitored at any one time, the 1 camera can put up to 6 different screen zones up for the controller to view.

The fisheye cameras can give a 360-degree view and the image quality is good. Cameras including fisheye cameras are being installed in the new Emergency Departments and they will also be linked to the Security Office that is constantly monitored, we can now retain CCTV images for a period of 30 days, however images are deleted once their purpose has been discharged and they are no longer required for the stated purpose of a Surveillance system.

Work is ongoing to identify how we can use the capabilities of the new CCTV system to our advantage due to the extra functions and capabilities of the new system.

No covert cameras were deployed during this year financial year.

2.6 National NHS Security Management and NHSE Standards

In December 2020 NHSE released a new set of standards for security management, in the form of the Violence Prevention and Reduction Standard to support a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression, and violence. which has replaced the previous standards and guidance issued by NHS Protect before they were disbanded in 2018. The Trust continues to work to these standards to ensure compliance and the work plan for Security Management for the 2023/2024 reflects the standard, the work plan is attached as Annex A.

During 2023/2024 the LSMS will create a Violence Prevention and Reduction Strategy and Workplan for the Trust.

The LSMS will be attending and completing a recognised Violence Prevention and Reduction and Public Health qualification when one becomes available.
The LSMS has completed the NEBOSH Investigation course to support his role as LSMS and will attend and complete a regulated (generalist) Security Management Course during 2023/2024. The Accredited LSMS course ceased some years ago.

2.7 Counter Terrorism

The many terrorist incidents that have occurred in the UK over the past few years reminds us of the continued need to ensure our sites and staff are prepared to respond to an incident and to be aware of the warning signs leading to an event. The Trust continues to work closely with the National Counter Terrorism Policing: North East Counter Terrorism Unit in providing up to date advise and appropriate training sessions for Trust staff. The Trust is in the process of arranging new counter terrorism training for all staff using the new Action Counter Terrorism training (ACT Training) which incorporates SCaN (See, Check and Notify) which is provided online, Work is currently ongoing by the LSMS and the Training Department with a view to having the ACT Training available on the Electronic Staff Record (ESR) as a E- Learning package. This is likely to become law once the Terrorism (Protection of premises) draft bill is passed.

Trust staff have been made aware of the available ACT Training via a communication release on the Hub and sign posted to the Counter Terrorism Policing website whilst work is carried out to make the training available via ESR is progressed.

2.8 Terrorism (Protection of premises) (Draft Bill) (**Martyn's Law / Protect Duty)**

The government have published the Terrorism (Protection of premises) Draft Bill, is commonly referred to as 'Martyn's Law' and is a response to the Manchester Arena Bombing. A publicly accessible location is defined as any place to which the public or any section of the public has access, on payment or otherwise, as of right or by virtue of express or implied permission. Publicly accessible locations include a wide variety of everyday locations such as: sports stadiums; festivals and music venues; hotels; pubs; clubs; bars and casinos; high streets; retail stores; shopping centres and markets; schools and universities; medical centres and hospitals; places of worship; Government offices; job centres; transport hubs; parks; beaches; public squares and other open spaces. This list is by no means exhaustive, but it does demonstrate the diverse nature of publicly accessible locations.

Martyn's Law is a new legislation that is currently going through Parliament that will

require many businesses to formally assess terrorism risk for the first time. The Home Office estimates that 650,000 UK businesses could be affected by Martyn's Law.

This legislation, and the changes it brings, will enhance the protection of the United Kingdom's publicly accessible places from terrorist attacks and ensure that businesses and organisations are prepared to deal with incidents.

The Legislation will require the Trust to:

- Engage with freely available counter-terrorism advise and training.
- To conduct an enhanced terrorism risk assessments of operating places and spaces.
- To mitigate the risks created by these vulnerabilities.
- To put in place a counter-terrorism plan.
- Work with local authorities to plan accordingly for the threat of terrorism.

The LSMS will continue attend online briefings and conferences delivered by the Home Office and Homeland Security.

2.9 Joint Working

During the last 12 months the LSMS has prioritised the building of working relationships within the Trust and with external partners, this has been successfully achieved with positive outcomes now being seen across trust and with its partners.

Trust/Police working relationship
The working relationship we have built with both the Grimsby and Scunthorpe Neighbourhood Policing Teams is really reassuring and has progressing well, we have implemented a number of better working practices to support each other, we have bi-monthly Police surgeries at both DPOW and SGH where we display a joint presence to the public and staff.

There has been good evidence of the benefit of the working relationship we now have which has shown very positive outcomes on Police Investigations where convictions have been secured.

Comments from PC Khan at Humberside Police –

"I am thankful for all the hard work and the joint working you are doing; we have not had this much joint working with the hospital before!"

Unison/Trust
Carried out violence at work events on all 3 sites during October 2022, whereby Unison representative Alex Hutchinson, Julian Corlett and the LSMS attended the restaurants and café areas with information to provide support and advise in relation to violence at work, this also supported the Violence prevention and Reduction Strategy that is currently being written.

Safeguarding
Close positive working relationship has been built with the Safeguarding Teams and the Mental Health teams.

The LSMS is invited to strategy meetings and members of the team contact LSMS regarding patients that pose a risk to other to plan their visit/inpatient stay and obtain advise.

The LSMS now writes a management plan when required to support and protect Safeguarding, ward staff, ward management, the patient, visitors and the Security team, the management plan is security focused and details the risk the patient presents and how it can be managed within the Trust and with support of partner agencies when required, the plan also details routes of escalation when required. The joint working has been positively acknowledged by Head of Safeguarding who has commended the LSMS during minuted meetings.

The LSMS supplies written reports and attends the Safeguarding and Vulnerabilities Operational Forum and the Vulnerabilities Oversight Board.

Ward Councillor visit

The LSMS had impromptu visit on Friday 5th August 2022 by Councillor Daniel Westcott (Park Ward), Councillor Marian Boyd (Park Ward) and PC Khan and PCSO Barry Clark, they stayed for over an hour and the Councillors were very impressed with the relationship we now have with Humberside Police and the positive outcomes in the last 6 months, they were also impressed with what we are doing in relation to security and Violence prevention and reduction, they were unaware what work is being carried out with regard to Security, staff safety and violence prevention and reduction.

The LSMS received the following comments from Councillor Westcott –

"Really pleased Barrie and Nuha brought us over.

We were very impressed, and I think anybody visiting, staying, or working at Diana Princess of Wales should feel very reassured.

As mentioned, I have the Park ward community Forum on Facebook, along with a wider NEL page.

It would be great to share any positive work at the site, as our hospitals are so integral to any community."

Community Safety Partnership

The LSMS is an active member of the North East Lincolnshire Community Safety Partnership (NEL CSP), and chairs the Violence Against Women and Girls (VAWG) Subgroup, the LSMS also sits on the serious Violent Crime working group and serious Youth Violence working group.

There has been a delay in joining the North Lincolnshire Community Safety Partnership (NL CSP) due to changes in management and restructuring, however the LSMS is now attending the Safer North Lincolnshire meeting.

3.0 2022/23 Work Plan for Security Management

The 2023/24 Work Plan for Security Management, which outlines the key actions against each security management objective, has been attached at Appendix A.

4.0 Summary and Next Steps

In summary, there continues to be a considerable amount of work in developing the Trust's security management arrangements to improve the safety of our services for staff, patients, and visitors, and to protect NHS property and assets. The focus

areas incorporated into the 2023/24 Work Plan for Security Management are continuing the close collaborative working with partner agencies to increase incident reporting and investigation outcomes, support for staff who become victims of crime, and progressing new technology and improvements to surveillance systems. The renewed national focus on reducing violence against NHS staff in relation to the Violence Prevention and Reduction Standards is likely to see a new set of security management standards and improved sharing of incident data and analysis across NHS organisations.

There is also focus on the Martyn's Law Legislation and how the Trust will ensure compliance, The LSMS will prioritise Marty's Law within the workplan as its anticipated that the responsibility put on the Trust will impact on the Trust, as part of the preparation process for the new Legislation effort is being made to provide Trust staff with up-to-date training on Counter Terrorism via the approved ACT Training, continued work will take place with partner agencies to promote positive community involvement with regard to the rehabilitation and the diversion from committing further crime of people that commit offences on trust property, when this is suitable via the Restorative Justice process.

5.0 Trust Board Action Required

The Trust Board is asked to:

- Note the contents of the report
- Note the 2023/24 Work Plan for Security Management at Appendix A

Appendix A

2023/24 Work Plan for Security Management

Standard	Area	Task / Objective	Target Dates	Completed Date
Strategic Governance				
1.1	A member of the Executive Board or equivalent body is responsible for overseeing and providing strategic management and support for all security management work within the organisation. This person is nominated to NHS England	• LSMS to meet at least quarterly with SMD or as required • Quarterly Security Group Meeting • Investigation or management reports to be provided as required • Security Management Annual Report to the Trust Board	Quarterly Quarterly As required April each year	
1.2	The organisation employs or contracts a qualified, accredited and nominated security specialist to oversee and undertake the delivery of the full range of security management work	• LSMS to attend relevant conferences and CPD events • LSMS to attend and complete a recognised Security Management Course • LSMS to attend and complete a recognised Violence Prevention and	As required March 2024 December 2024	

		Reduction and public health qualification when one becomes available. • LSMS to attend Regional LSMS Forum • LSMS to become an approved and accredited Trainer for VAWG – CPS responsibility and enable training to be delivered within the Trust.	Quarterly March 2024	
1.3	The organisation employs or contracts a qualified, accredited and nominated Health & Safety Specialist to oversee and undertake the delivery of the full range of Health & Safety work	• LSMS to attend and completed the NEBOSH Investigation Course • LSMS to attend and completed the NEBOSH General Certificate Course	March 2024 March 2024	
1.4	The organisation allocates resources and investment to security management in line with its identified risks	• Funding is allocated to security issues as identified through security risk assessments and incident reporting • LSMS to support the Trust wide CCTV review and upgrade.	Ongoing In progress	
1.5	The organisation reports annually to its Executive Board, or equivalent body, on	• works within the NHS Violence Prevention and Reduction Standards	Ongoing	

	how it has met the standards set by NHS England in relation to security management, and its local priorities as identified in its work plan	published in December 2020 and using the guidance notes which were published in June 2022, reporting compliance to the Security Group. • Results of compliance in relation to the NHS Violence Prevention and Reduction Standards published in December 2020 and using the guidance notes which were published in June 2022 to be included in Security Management Annual Report to the Trust Board.	April 2024	
1.6	The organisation has a security management strategy aligned to NHS England Violence Prevention and Reduction Standards. The strategy has been approved by the executive body or equivalent body and is reviewed, evaluated, and updated as required	• Review Policy and Strategy for Security in line with review schedule • Create and publish a Trust Violence Prevention and Reduction Strategy • Create and Publish a Trust Violence Prevention and Reduction Workplan • Security Management Annual Report to the Trust	28/02/2024 September 2024 September 2024 April 2024	

		Board		
1.7	LSMS to monitor Trust Policies and Terms of Reference (TOR'S) – • DCP203 Policy for the Security and Management of Assets. • DCT077 Security Group – membership and terms of reference. • DCP154 Policy for the Management of Violent, Aggressive, and Intimidating Behaviour. • DCP197 Security Policy & Strategy. • DCP148 Internal & External Surveillance systems policy. • DCP149 Policy & Procedure for bomb threats and suspect packages. • DCP150 Policy & Procedure for deployment of armed Police officers. • DCP162 Policy & Procedure for the use of directed Surveillance. • DCP195 Policy & Procedure for Lockdown. • DCP140 Lone Working Policy and Procedure	• LSMS to review policies and TORS when made aware of any legislation, change to guidance or changes to Trust sites that will require the document to be updated. • To action required changes to the document. • To review Documents periodically before the review date in case of any required changes.	DCP203 – April 25 DCT077 – Jan 24 DCP154 – Feb 24 DCP197 – Feb 24 DCP148 – May 24 DCP149 – July 24 DCP150 – July 24 DCP162 – Oct 24 DCP162 – Oct 24 DCP195 – March 25 DCP140 – Jan 26	

1.8	Martyn's Law formally Protect Duty is a new legislation under Government consultation that will require many businesses to formally assess terrorism risk for the first time. The Home Office estimates that 650,000 UK businesses could be affected by Protect Duty.	• LSMS to monitor the progress of the legislation going through parliament and attend seminars and meetings in relation to the legislation.	Ongoing	

Standard	Area	Task / Objective	Target Dates	Completed Date
Inform and Involve				
2.1	The organisation develops and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property, and assets	• Joint Working Agreement in place with Humberside Police and CPS which is being reviewed and updated by all partners • Promote the Joint Working Agreement once reviewed, updated, and published within Humberside Police, CPS and the Trust	August 2023 July 2024	

		• LSMS meets with senior Police representative to progress collaborative working • LSMS attends relevant Community Safety Partnership work groups	Quarterly Bi-Monthly	
2.2	The organisation has an ongoing programme of work to raise awareness of security measures and security management in order to create a pro-security culture among all staff. As part of this, the organisation participates in all national and local publicity initiatives, as required by NHS England Violence Prevention and Reduction Standard, to improve security awareness. This programme of work will be reviewed, evaluated, and updated as appropriate to ensure that it is effective	• LSMS to update all security related posters throughout the Trust with latest contact details • Security bulletins and alerts to be published in the weekly all-staff team brief newsletter • LSMS to provide security stands on each site promoting Violence Prevention and Reduction • Security bulletins published on the Trust Intranet Hub • Staff to be made aware of crime trends including County Lines and anti-terrorism training and sign posted to relevant training and information.	September 2023 Ongoing July 23 Feb 24 As required Ongoing	

2.3	The organisation ensures that security is a key criterion in any new build projects, or in the modification and alteration (e.g. refurbishment or refitting) of existing premises. The organisation demonstrates effective communication between risk management, capital projects management, estates, security management and external stakeholders to discuss security weaknesses and to agree a response	• LSMS to liaise with project teams of new builds and refurbishments • LSMS to liaise with Humberside Police Safer by Design Officer • LSMS to conduct security assessments on existing buildings as required and place on Evotix	As required As required As required	
2.4	All staff know how to report a violent incident, theft, criminal damage, or security breach. Their knowledge and understanding in this area are regularly checked and improvements in staff training are made where necessary	• LSMS reviews all security incidents reported through the Ulysses reporting system, coding and grading where appropriate • Feedback provided to incident reporters • LSMS to support relevant incidents reported on Ulysses and if required be lead investigator • Awareness campaign to be launched to provide guidance to all staff on which incidents should be reported to the Police	Ongoing Ongoing Ongoing June 23	

2.5	All staff who has been a victim of a violent incident have access to support services if required	• Victims of physical assault while at work to be sent a letter from CEO that contains the contact details of the LSMS and support on offer • LSMS proactively contacts those identified as victims through Ulysses reporting	Ongoing Ongoing	
2.6	The organisation uses the Security Incident Reporting System (SIRS) to record details of physical assaults against staff in a systematic and comprehensive manner. This process is reviewed, evaluated and improvements are made when necessary	• LSMS to review all reports of physical assaults • LSMS reports physical assault data to the Trust Security Group	Ongoing Quarterly	

Prevent and Deter				
3.1	The organisation risk assesses job roles and undertakes training needs analyses for all employees, contractors and volunteers whose work brings them into contact with NHS patients and members of the public. As a result, the level of training on prevention of violence and aggression is delivered to them in	• Training compliance to be monitored through the Trust Security Group • ACT Counter Terrorism Training to be placed on ESR and available for delivery to all trust Staff • Counter Terrorism training to be published on the Hub and all staff signposted to available	Quarterly December 2023 August 2023	

	accordance with NHS guidance on conflict resolution training. The training is monitored, reviewed, and evaluated for effectiveness	information and e-learning training, work with Training to design and create a training package that can be available on ESR • County Lines training package to be created and training/awareness sessions to be arranged with support from Humberside Police for Trust staff	December 2023	
3.2	The organisation ensures that staff whose work brings them into contact with NHS patients are trained in the prevention and management of clinically related challenging behaviour, in accordance with NHS England Violence Prevention and Reduction Standard. Training is monitored, reviewed, and evaluated for their effectiveness	• Training compliance to be monitored through the Trust Security Group • LSMS to link in with clinically challenging behaviour restraint training project • New project launched to develop to risk assess patients on admission for risk of violent/aggressive behaviour and security incidents – Violence, Aggression and Security. (VAS) Score	Quarterly In progress November 2023	

3.3	The organisation assesses the risks to its lone workers including the risk of violence. It takes steps to avoid or control the risks and these measures are regularly and soundly monitored, reviewed, and evaluated for their effectiveness	• Issuing and training staff in the lone working devices • Promote the usage of Peoplesafe Lone Working devices with support from, Divisions, Staff Unions and Peoplesafe • Community lone working device usage to be monitored through the Trust Security Group	Ongoing Ongoing Quarterly	
3.4	The organisation distributes national and regional NHS alerts to relevant staff and action is taken to raise awareness of security risks and incidents. The process is controlled, monitored reviewed and evaluated	• LSMS to review alerts received from other NHS organisations and partner agencies and disseminate within the Trust as appropriate • LSMS to receive alerts from the Cross-sector Safety and Security Communications (CSSC) and disseminate as appropriate	Ongoing Ongoing	
3.5	The organisation has arrangements in place to manage access and control the movement of people within its premises, buildings, and any associated grounds	• LSMS to advise on access control as areas are refurbished or risks identified • LSMS to complete annual audit of CCTV releases	As required In Progress	

3.6	The organisation has systems in place to protect its assets from the point of procurement to the point of decommissioning or disposal	• Review of DCP203 Policy for the Security and Management of Assets	April 2025	
3.7	The organisation operates a corporate asset register for assets worth £5,000 or more	• Review of DCP203 Policy for the Security and Management of Assets	April 2025	
3.8	The organisation has departmental asset registers and records for business-critical assets worth less than £5,000	• Service leads to review their business continuity plans as part of the annual review schedule	Ongoing	
3.9	The organisation has clear policies and procedures in place for the security of medicines and controlled drugs	• Any breaches of medicines security are notified to the LSMS	Ongoing	
3.10	The organisation has policies and procedures in place to ensure prescription forms are protected against theft and misuse. These policies and procedures are reviewed, evaluated, and updated as required	• The Medicines Code and associated policies are in place	Ongoing	
3.11	Staff and patients have access to safe and secure facilities for the storage of their personal property Patient lockers / Self Administration Patients Own Drug (SAMPOD) digital lock upgrades installed at DPOW	• Monitor the use of the access-controlled door systems and escalate when faults are identified. • Work with specialities when there is incidents of theft occurring from the	Ongoing As required	

	Staff to have access to access-controlled staff only changing/locker rooms in their work areas where there is a risk of public having access and there being a high footfall.	changing/locker rooms		
3.12	The organisation records all security related incidents affecting staff, property, and assets in a comprehensive and systematic manner. Records made inform security management priorities and the development of security policies	• The Trust uses the Ulysses incident reporting system for all incidents and security related incidents are reviewed by the LSMS	Ongoing	
3.13	The organisation takes a risk-based approach to identifying and protecting its critical assets and infrastructure. This is included in the organisation's policies and procedures	• Service leads to review their business continuity plans as part of the annual review schedule	Ongoing	
3.14	In the event of an increased security threat level, the organisation is able to increase its security resources and responses	• Bidvest Noonan Contract Review meetings • Review of DCP149 Policy for Bomb Threats and Suspect Packages	Quarterly July 2024	
3.15	The organisation has suitable lockdown arrangements for each of its sites, or for other	• Review the Policy and Procedure for Lockdown	March 2025	

	specific buildings or areas			
3.16	Where applicable, the organisation has clear policies and procedures to prevent a potential child or infant abduction, and these are regularly tested, monitored, and reviewed	• A test of the child abduction procedures to be completed at DPOWH and SGH • LSMS to work closely with Safeguarding when risks are identified	Ongoing Ongoing	
3.17	Security scenarios to be conducted to test resilience and provide feedback	• Night-time suspicious person on site scenario to be carried out by LSMS with debrief. • Night-time in building suspicious person in building scenario to be carried out by LSMS with debrief.	November 2023 December 2023	
3.18	LSMS to work with Youth Offending team and create a working partnership for the rehabilitation of first-time offenders who are eligible to take part in the diversion programme as it is their first offence, work on victim awareness and consequences of their behaviour. As part of this, explain to them the real impact of his behaviour on staff, other patients and visitors and the impact it has on services we provide for care and treatment of other	• Build a working relationship with the Youth Offending Team • Create a working agreement with the Youth Offending Team. • Once the programme is operational with the Trust and Youth Offending team with the assistance of the Trust Communication team promote it to the Trust staff.	Sept 2023	

	patients, the programme can be carried out via a face-to-face meeting or letter from persons involved to the offender. The Trust will be supporting the Community in the rehabilitation of Offenders of Crime which occur on Trust Sites and will positively work with offenders to actively deter reoffending.			

Standard	Area	Task / Objective	Target Dates	Completed Date
Hold to Account				
4.1	The organisation has arrangements in place to ensure that allegations of security related incidents are investigated in a timely and proportionate manner and these arrangements are monitored, reviewed, and evaluated	• LSMS reviews all security incidents reported through the Ulysses reporting system, coding and grading where appropriate	Ongoing	
4.2	The organisation is committed to applying all appropriate sanctions against those responsible for security related incidents	• LSMS to assist Police with investigations and be primary police liaison for the Trust • LSMS to attend court, case conferences and other sanction hearings	Ongoing As required	

		• LSMS to manage the warning letter system for unacceptable behaviour as part of the Trust's exclusion process • LSMS to send informal / formal warning letters on behalf of the Trust and support managers in sending informal warning letters	Ongoing Ongoing	
4.3	Where appropriate, the organisation publicises sanctions successfully applied following security related incidents	• Criminal sanctions to be published internally and externally as appropriate •	As required	
4.4	The organisation has a clear policy on the recovery of financial losses incurred due to security related incidents, and can demonstrate its effectiveness	• Standing Financial Instructions are due review by the Finance Directorate	Ongoing	
4.5	Collaborative working with Safeguarding team for – • Post incident reviewing • Planning for potential incidents • Advise and guidance with safeguarding team when supporting at risk/vulnerable patients are visiting a Trust site.	• Communication with Safeguarding team when a risk is identified. • Write an operational plan with safeguarding and Security when required. • Attending Vulnerabilities Oversight Board meetings • Being a member of the NEL/NL Community Safety Partnership Board.	Ongoing	

		• Become a board member with North Lincolnshire Community Safety Partnership		

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	1 August 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	**Health Tree Foundation Trustees' Committee (HTF) - Terms of Reference (ToR)**
Purpose of the Report and Executive Summary (to include recommendations)	The attached HTF Terms of Reference with minor changes made and approved by the Committee at the July 2023 meeting.
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)	Only on Health Tree Foundation Charitable Funds
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:	1 August 2023
Report From:	Health Tree Foundation Trustees' Committee held on 6 July 2023

Highlight Report:

Community Diagnostic Centre's (CDC)

- The Director of Estates and Facilities gave a short brief on the planned new build CDCs in Grimsby and Scunthorpe. He emphasized the partnership nature of the programme and highlighted the likely much wider footfall in such facilities compared with the hospital sites. This included passers by as well as patients attending diagnostic appointments. Discussion ensued and it was agreed by Trustees that this presented an opportunity to spread the Health Tree Foundation message ever further, including the potential to launch a fundraising appeal for the two new centres, like those recently held for the new EDs at each site. The HTF Charity Manager was asked to examine this idea and report back to Trustees.

Communications

- Trustees yet again emphasized the need to ensure that the work of The Health Tree Foundation was publicised effectively across the Trust, including patients, their families and friends and staff. The HTF Charity Manager and Communications Assistant agreed to re-examine their current plans with the aim of introducing new ideas to enhance such awareness across the Trust and wider community.

Annual Self-Assessment

- The Committee discussed their Annual Self-Assessment results and agreed that a more tailor-made assessment should be used in future. This, it was felt, would provide a set of questions that would be more relevant to the business of the HTF Trustees' Committee. It was agreed that these would be developed and reviewed at the next Committee meeting.

Confirm or Challenge of the Board Assurance Framework:

Action Required by the Trust Board:

The Trust Board is asked to note the decisions made by Trustees.

Neil Gammon
Independent Chair of Health Tree Foundation Trustees' Committee

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Finance

HEALTH TREE FOUNDATION TRUSTEES COMMITTEE

Kindness · Courage · Respect

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:	06/07/23
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

Membership and Terms of Reference

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 by the Corporate Trustees, 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 Corporate Trustees.

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
- 2 Non-Executive Directors;
- Executive Directors:
  - Chief Executive
  - Chief Medical Officer
  - 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
- A representative from the Trust Communications Team'
- 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 Chief Medical Officer 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. Any Trustee may request an Extraordinary Trustees' Meeting through the Independent Chair.

6.2 Independent Chair and Trustees

The Independent Chair and Trustees shall be appointed by the Corporate Trustees.

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 Trustees' 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 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)

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	01 August 2023	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Georgina Birley, Personal Executive Assistant to COO	
Title of the Report	**Finance and Performance Committee Minutes – April and May 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	The Finance and Performance Committee Minutes from the meetings held in April and May 2023 and subsequently approved at the following months meetings.	
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: **Wednesday 19 April 2023, Boardroom, SGH and Teams**

Present:	Gill Ponder	Non Executive Director (Chair)
	Fiona Osborne	Non Executive Director (NED)
	Jug Johal	Director of Estates & Facilities
	Shaun Stacey	Chief Operating Officer (COO)
	Simon Parkes	Non Executive Director
	Brian Shipley	Deputy Director of Finance
In Attendance:	Ian Reekie	Lead Governor
	Annabelle Baron-Medlam	Compliance & Assurance (item 6.1)
	Richard Peasgood	Executive Assistant to COO
	Ab Abdi	Deputy Chief Operating Officer (item 8.3)
	Simon Priestley	Head of Pharmacy (item 7.2)
	Janet Mellor	Exec Assistant (for the notes)

ITEM

1. Apologies

Apologies were received from: Lee Bond (Brian Shipley deputised)

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 22 March 2023

It was agreed that the minutes of the previous meeting were an accurate reflection of the meeting held on Wednesday 22nd March 2023.

5. Matters Arising / Action Log

5.1 Action Log

The action log was discussed and amended accordingly:

9.1 from meeting held on 21-12-22 was carried forward as the dashboard had not been included

9.3 from the meeting held on 21-12-22 was closed, as a quarterly update was provided to the Committee on progress with elective recovery and the annual update to the voluntary self-certification process would be added to the Workplan in December.

Action: Richard Peasgood

9.1 from the meeting held on 26-1-23 was closed, as a brief summary was provided of the reasons for additional spend on Clinical Supplies

6.1 from the meeting held on 22-2-23 was closed as Gill Ponder had arranged to meet with the Chair of the Workforce Committee.

5.2 from the meeting held on 22-3-23 carried forward, as the new Terms of Reference (TOR) were on the agenda for agreement prior to submission to the Trust Board for approval. Once the TOR were agreed, the Workplan would be updated and brought to the May meeting.

5.3 from the meeting held on 22-3-23 was closed, as Gill Ponder had clarified the constitution with the Director of Corporate Governance and the Director of Estates and Facilities had been added as a Lead Director for the Finance and Performance Committee.

5.2 Terms of Reference

The ToR were agreed by the group. The comments within the ToR should be removed prior to the ToR going to Trust Board in June for approval.

Action: Richard Peasgood

5.3 Finance & Performance Committee Workplan

Item not discussed at this meeting, as it was due to be amended to reflect the changes to the TOR agreed at this meeting

5.4 Action Plan and Self-Assessment Tool

The results of the Committee self-assessment exercise were discussed. Gill Ponder stated that there were some actions from the results that could form the basis of an action plan.

The following issues had been raised:

The Highlight Reports were still a concern, Gill Ponder stated that she was still getting feedback that the highlight reports were too long.
Discussions took place around how many highlight reports are produced and how making the reports shorter could also be an issue. Gill Ponder suggested that it would make more sense to put Estates with Finance and not Performance, as that would bring the reports in line with the way that the Trust Board meeting agenda was structured.
Fiona Osborne suggested that the Finance and Performance reports were not a problem. The report should be more around any items of concern where the Board was requested to take action or be aware of. That was happening within the highlight reports from this Committee. The emphasis should be around the escalation of items to the Board for a higher-level review, rather than the length of the report.
Further discussions took place around how to present the reports in an alternate format which was less lengthy.
Gill Ponder proposed the following:

- Where there were two Committee meetings reported to a Board meeting which followed, merge the two months' report in a single summary paragraph to alleviate duplication.
- Try bullet point format as opposed to paragraphs
- Produce 3 separate highlight reports every 6 months when the Director of Estates and Facilities was due to present his report at the Board meeting

Gill Ponder continued that on 2D actions were required on productivity intervention linked to the operating plan.

Shaun Stacey responded that the information from GIRFT was not being brought forward in the reporting matrix to the Board. Shaun Stacey requested that some time was given within the plan to work on the productivity data and advised that by the second half of the financial year the reporting should be available on BI and could then be pulled through into the IPR for regular reporting.
Gill Ponder enquired as to when the deep dive into productivity could be conducted. Shaun Stacey indicated that due to the data reporting requiring correction, the middle of the financial year should be the right time.

Action: Richard Peasgood to schedule Deep Dive into Productivity on the Work Plan.

Shaun Stacey also advised that Theatre reporting was due to be delivered at the end of May, which could be included in the Planned Care quarterly report from July onwards.

Action: Shaun Stacey to arrange for Theatre data to be included in the quarterly Planned Care report from July.

Item 5a stated that there was little time for discussions at the meetings due to having packed agendas. Gill Ponder asked the group what was needed in the Action Plan to address this, as she had been under the impression that some good quality discussions were being held.
Fiona Osborne stated that the last meeting had good discussion and was very productive. Previous meetings may have been too hectic. A discussion may be necessary at Board level in respect of the purpose and expectations from the Committees.
Simon Parkes suggested that the Committee was making steps in the right direction and suggested that some of the items may not need to be addressed every month. Simon Parkes further suggested that some items could be discussed every other month or even every quarter.
Gill Ponder stated that that may have been due to the Trust being in Special Measures where more scrutiny was required and agreed to look at the Workplan to see what could be done as there may be an opportunity to review some items less frequently.
Fiona Osborne flagged that some papers were seen quarterly with them being exactly the same report with extra sentences tagged on. It would be preferrable if the report was the extra sentences with the previous report being excluded. Gill Ponder stated that there was still work to do on the papers and that should be reflected in the Action Plan for that to continue.
Shaun Stacey agreed and suggested alternating things so that every three months a topic was discussed in depth.

In terms of admin support Gill Ponder advised that there was a plan to include admin support which could be articulated in the action plan.
Gill suggested that all the information above was pulled together for a draft action plan in readiness for the next meeting.

Action: Gill Ponder and Richard Peasgood

6. Presentations for Assurance

6.1 Care Quality Commission (CQC) Progress Report

Annabelle Baron-Medlam advised the Committee that the report had not changed too greatly, however the pace had increased which was positive. The number of actions rated full or significant assurance had increased from 25 to 32. None of the actions were awaiting rating, all divisions were working on the actions.
Some actions had been moved from divisional action plans. This was due to findings related to outpatients being a Trust wide action which was a quick action to achieve.
Five assurance papers had been uploaded to the CQC.
An appendix at the end of the report went into more detail for the actions which related to cancer and other performance types had been updated.

The internal assurance process for CQC had received significant assurance from the Internal Auditors and good feedback had been received from the CQC as part of the recent audit.
Gill Ponder stated that the report and assurance had given confidence that the process was robust.
Shaun Stacey requested details of the Outpatient Matron mentioned in the report to follow through to ensure ownership of the action.

Action: Annabelle Baron-Medlam to send details of the Outpatient Matron mentioned in the report to Shaun Stacey
Post meeting note: information received by Shaun Stacey on 19th April 2023.

Fiona Osborne stated that appendix one was good for this report, however she struggled with Med18 due to it having quite a few actions. That could be due to it having limited assurance and work being on-going but she would be curious as to the changes next month and what was being put in place.
Annabelle Baron-Medlam advised that the divisions guide the assurance level and feel that they can only give limited assurance. The action will be achieved within the current timescales. Annabelle Baron-Medlam would ask the team to bear that in mind and give context around it.

Action: Annabelle Baron-Medlam to ask the Medicine Division to provide context on Med18

Fiona continued that the medical oncology stated it was dependant on medical workforce via the SLA with HUTH and was not clear on what that meant.
Shaun Stacey raised concerns that that could be reported in the wrong way stating that in terms of the services mentioned the group had a clear workforce challenge that was contributing to the lack of ability to deliver in time. Shaun continued that the division needed to describe the risk in the report rather than produce statistics.
Gill Ponder thanked Annabelle Baron-Medlam for the report.

7. Estates & Facilities (SO1.4)

7.1 Ventilation

Jug Johal asked for the report to be taken as read. The risk for ventilation was monitored through the HVaC Group for regular oversight. The average life span of the units was usually around 20 years, however 86 of the units were 30 years old. The Trust was running the systems to complete failure due to not having sufficient capital funding to replace the units, as each new unit cost approximately £25k. The Trust was now incurring revenue costs at £6k per month for the hire of one unit when units failed. Jug Johal advised that some of the dates had slipped within the action plans due to the amount of work on the capital programme, but the team would catch up with that during the year.
Simon Parkes advised that he supported the Director of Estates and Facilities and stated that it was pushing beyond what was sensible. A discussion around costs took place.
Fiona Osborne raised concerns around there being no back log maintenance funding allocated to this issue for the coming year, but it had one of the highest levels of risk on the risk register and enquired how the discussions went through the planning process for this year. Fiona also noted that the report stated that Coldstar and Dixon's had provided exceptional support and asked if the risk would have been higher if that had not been in place.
Jug Johal advised that the risk would have been the same. The units were over serviced due to the age of the systems to try to keep them running. There had been a need to allocate the limited available funding to even higher risk items such as replacing fire alarm system.
A discussion around equipment, funding and the impact of failure to invest in infrastructure took place.
Gill Ponder picked up that the timeline within the report required amending.
Gill Ponder also questioned comments within the report around inadequate business continuity plans to mitigate risks of equipment failure. Jug Johal responded that the team were looking at PAT assessments which came to this Committee annually. An action plan for self-assessment

would have been completed, but he agreed to check when it happened or how far it had progressed.

Action: Jug Johal to provide additional information on the business continuity plans to mitigate risk of equipment failure.

Gill Ponder enquired if ventilation systems were brought fully up to required standards when theatres were refurbished. Jug Johal confirmed that would happen.
Gill Ponder noted that within the 2019 and 2021 audit actions it stated that this was not high risk. If this was the case, should the funding go to higher risk areas? Jug Johal explained that the risk register in terms of planning and the Authorised Engineer audit actions were two separate things. That did not mean that plans had not been made for structural upgrades.
Fiona Osborne flagged that the core report was the important part for this Committee. All from page 16 onwards would be too granular for this Committee. The first pages up to 16 were good examples of what this Committee required.

7.2 Entonox

Simon Priestley asked for the paper to be taken as read and gave the highlights from the paper stating that this was a risk control activity following NHSE guidance in March. The actions that were required due to the new guidance would be monitored as part of the Medical Gas meetings. All areas of Entonox had been checked, including ventilation. Further assessments on cylinders would be carried out. The Trust were looking at ventilation. The Trust would not stop using Entonox as it was beneficial to patients.
Staff administering Nitrous Oxide would wear monitoring devices and once monitoring commenced that would establish the level of occupational exposure, which would enable any risks to be managed. Updates in training would be required. It would also provide an opportunity to look at the green agenda which suggested that Entonox stocks may not need to be maintained in the pipes.
Gill Ponder asked the cost of the personal devices. Jug Johal stated that costs were being looked at and a proposal was in development now. The funding was most likely to be capital rather than revenue.
Gill Ponder asked Jug Johal to bring an update to a further meeting due to the guidance only coming out in March 2023.
Shaun Stacey suggested that the paper was brought back to the Committee at the same time as the Ventilation paper. Fiona Osborne, Jug Johal and Simon Priestley agreed to bring Ventilation and Entonox papers back to a future meeting for assurance.

Action: Simon Priestley and Jug Johal to bring an update on Entonox back to the Committee at the same time as the Ventilation paper.

7.3 Assurance Confirmation & Board Highlights

Gill Ponder summarised the risks of ventilation due to age and lack of capital to replace equipment in danger of failing should be highlighted. Jug Johal asked that running to failure be included in the highlight report. It was agreed that monitoring the operational impact of failures, including productivity and costs, should be recommended to the Board. In terms of Entonox, it should be reported that the Trust had responded to NHSE guidance and actions to measure exposure were in place to ensure that staff were not at risk from the use of Entonox.

8. Review of NLaG Monthly Performance and Activity Delivery (IPR) (SO1.2/SO1.6)

8.1 Unplanned Care

- Urgent Care Performance
- Ambulance Handovers
- Patient Flow in Discharge to Assess Performance

Shaun Stacey asked that the report was taken as read and highlighted that emergency care continued to be a challenge due to the volume of admitted patients and flow through the hospital. This had resulted in continued poor performance in ambulance handovers and delays in the Emergency Department, contributing to wait to be seen times exceeding 4 hours.
Staffing concerns remained and workforce gaps were a problem. Recruitment was being addressed but further work was required. It had been agreed that UCS would be run 24/7. However, all approval of additional investments was suspended whilst the financial position was balanced. SDEC continued to be a challenge with the main challenge being activity being streamed through SDEC and the workforce not being able to deliver the volume of care for patients needed.
The average length of stay was in a good position, however 7/14/21 days had gone up. Some of that related to workforce and discharge decisions and some related to Greater Lincs and Northern Lincs being unable to mobilise patients within 4 days of discharge decisions.
Fiona Osborne stated that she was encouraged by the contrast of the A&E attendances in March compared to the performance, this had not deteriorated in line with the number of patients coming through the door. Fiona enquired about the business case submitted around the rapid assessment and treatment model and asked if there had been any progress. Shaun Stacey advised that there were considerable changes for next year for consideration in terms of funding. There was no change with the business case, the team were doing as much as they could, any further development would depend on finance.
Fiona Osborne raised that within the IPR the reference to sub-committees needed to be removed from the report.

Action – Richard Peasgood to liaise with the Digital Team for the removal of 'Sub-Committees' in the report

Gill Ponder enquired about the percentage of patients being re-admitted in 30 days.
Shaun Stacey explained that the report was taken straight from data. All patients who were admitted into SDEC were seen as a re-admission when they came back for an emergency appointment. It was taking some time for the informatics team to correct the analysis.

Discussions took place around the system finance plan and how long this would take to agree the finances and mobilise 24/7 availability of the UCS. Shaun Stacey advised that it may take some time as it was not a quick fix and they would need to recruit to deliver it.

8.2 Planned Care

- H2 Recovery Position Update
- RTT 52 Weeks and above, Overdue Follow-ups
- Cancer Waiting Times
- Levelling up of Waiting Lists with ICS

Shaun asked that the paper be taken as read and that any questions should be directed to him for follow up.

8.3 Planned Care Improvement Program

Gill Ponder asked that the paper was taken as read. Ab Abdi gave highlights of the paper which included theatre utilisation, ambulance handovers and work with the GIRFT National Team. The theatre session utlisation had been increasing and had now reached 93%.

The GIRFT national team had been completing some work with the anaesthetic assessment teams internally and this had led to some positive results.
In terms of RTT, there were no patients waiting more than 78 weeks at the end of March apart from 9 mutual aid Gynaecology patients received in March. There were a few positives and some challenges in terms of GIRFT.

Cancer had been positive since the end of 2022. Five indicators from nine had been met for the first time. The 28-day faster diagnosis had been met and the 62-day backlog had improved. MRI capacity continued to be a challenge affecting the DM01 standard. Improvements had been seen in Clinic Utilisation. The ERF activity level achieved 96% year to date but if the 7.5% adjustment was incorporated due to the lack of sessions because of refurbishments, then the Trust would have reached 103.5%. Risk stratification was positive. Lung health checks went live in January.
Fiona Osborne commented on the construction of the report stating that the report received in January had exactly the same content as the current report with only three pages being different. Fiona stated that she was struggling to find the changes within the reports and would like to see what more has been done and the impact of any actions since the last report was presented. It was a struggle to understand what the biggest challenges, risks and achievements were. This was possibly something that could be amended for the next report focusing on commitments on delivery met, what had stopped delivery where commitments had not been met and the actions in place to overcome those barriers . The report needed to be more concise.

Shaun Stacey interjected that the detail was in there, but the presentation needed amending. The summary given had been good but that needed to be in the presentation.
Fiona Osborne agreed that the Executive Summary would be a good place to state what had changed, the delivery being committed to, what didn't get done and why.
Fiona Osborne flagged that some statistics on RTT differed in January and December to what they were now and asked if that is a timing issue and if so, if it could be caveated in the future that it needed further validation. Shaun Stacey confirmed that the difference was down to validation. Some treatments could take up to six weeks to be validated. Validation was a real key to the information, the reporting of validated and unvalidated data should be indicated.

Gill Ponder enquired why were there 100% late starts on theatres. Ab Abdi explained that it usually took time for the patient to be prepared and assured that this was part of the actions which GIRFT was picking up. Ab Abdi also assured the Committee that sessions were being fully utilised. Shaun Stacey further explained that the Trust did not have theatre operating holding bays, so porters had to collect patients who were next to be operated on and a discussion around the theatre utilisation lists followed. Harrogate are using a different system (Bluesphere) to WebV in theatres which assists in turning round data and information quicker than WebV.
Gill Ponder enquired why the separate reports pre and post Covid were relevant. Ab Abdi advised that that linked into elective recovery and that it would demonstrate efficiency. Ab Abdi suggested that it could be removed from the document.
Further to attending a webinar with NHS Providers where suggestions were made that deep dives into waiting lists using socio economic factors should be carried out to identify if there were health inequalities arising from patient waiting lists, Gill Ponder enquired if the Trust was doing this. Shaun Stacey confirmed that the Trust was following guidance from NHSE/I to ensure that health inequalities were considered during waiting list management. A report would be brought to the next meeting.

Action: Shaun Stacey to bring a report to the next meeting explaining how health inequalities were considered for patients on waiting lists

8.4 Assurance Confirmation & Board Highlights

Gill Ponder stated that the highlights from this section to be included should be: The Trust was working with GIRFT on the anaesthetic pre-assessments. The decrease to nine 78 week breaches at the end of March. Cancer met five of the nine standards and the 62 day backlog had improved. The continued challenges around UEC and ambulance handovers.

9. Review of NLaG Monthly Financial Position (Finance Report) (SO3.1/SO3.2b)

9.1 Finance Report – M12

Brian Shipley gave an update on Month12 which was reporting a balanced over-all position for the year end. The Income & Expenditure position reported as a Trust was a £14m deficit which

differed from the M12 report. That was due to excluded items from the NHSI control total process, which were £13.5m for impairments and donated assets of £0.5m.
Key points within the report were over delivery in CIP due to the non-recurrent technical reviews. The core programme was slightly behind where it needed to be. There had been slippage on workforce over-compensated by back office delivery. There had been technical adjustments for pension contributions which would be accrued to the Agenda for Change.
The run rates held no surprises with the exception of medical staffing and the impact of strikes being the main contributors. There were still some potential back-pay claims within medical job planning, these were still being processed. There were further adverse variance with additional ED and UCS doctors in March. Clinical supplies showed a very high month due to increased day case activity. Pathlinks had increased significantly in the final quarter, with March showing 10% higher than previous years. There was still a significant growth in excluded devices.
All other areas were in line with the plan.
Capital expenditure was in line with plan, as some equipment spend had been brought forward.
The end of year elective recovery performance showed 96% with the system position at M11 showing a £5.4m deficit. Agency spend was the biggest driver for the adverse position at £3.6m higher than the same position last year.
Shaun Stacey raised that the 96% RTT delivery was irrelevant as the system was looking for 104%. Mitigation would be put in place and work was being carried out to deliver the increased requirement from 104% to 107% next year.
Fiona Osborne asked after if after looking at all the elements of the overall position, there was assurance that all cost pressures had been tackled through the planning process for the coming year. Brian Shipley explained that the predominant adverse variances were understaffing, lack of recruitment and retention. There were also issues within clinical supplies plus issues with escalation beds open all year. There were pipeline plans for staffing included within the plan.
Fiona Osborne asked if other Trusts were in the same situation with non-recurrent balance sheet releases. Brian Shipley responded that all providers had recorded deficits all year with a forecast of a balanced position.
A discussion was held around up to date information being available in a timely manner and how the Trust would operate more efficiently if this was the case.
Further to Gill Ponder raising the question of equipment being brought forward, Brian Shipley assured the Committee that the equipment brought forward was from next year's plan, which would enable items planned in 2022/23 to be completed in 2023/24.

9.2 Operational and Finance Plan Update

Brian Shipley advised that the plan submitted showed a planned deficit of £20m through to March 2024. The Trust was now in a position to submit a planned deficit of £16m at ICB level. There was no change requirement for NLaG to improve on £20m, as the Trust had committed to a Cost Improvement Programme of £35.7 million which was already exceptionally challenging, as the Trust was still working on a £10m gap in plans to underpin those savings. A further submission was due in May. Improvement on the ICB position was £28m. There was a requirement that other providers within the ICB improved their position by £27m which would leave a £60m deficit. Other options for support would be discussed further.

9.3 Recovery Support Program Update

Brian Shipley advised that there was nothing to report from the last meeting with the exception of the Trust not being recommended for financial special measures exit yet. There was a plan for exit and a review was anticipated in May.

9.4 Business Case Assurance

There were no further business cases to discuss at this month's meeting.

9.5 Reference Costs Update

In terms of the first two papers to outline the approach to reference costs, there was a delay in the process nationally. The team were expecting to get this ready early Autumn. Brian Shipley advised that the workplan would need to be amended and he would advise the timescale prior to the next meeting.

Action – Brian Shipley to advise a date for the Reference Costs review

9.6 Assurance Confirmation & Board Highlights

Gill Ponder advised highlights to report to the Board in terms of Finance as being end of year including non-recurrent support and continued concerns of high level spend on temporary staffing. The 2023/24 plan to highlight reliance on divisions delivering their plans including workforce CIP. The system position for the current financial year. Fiona Osborne suggested that the reliance on the need for the delivery of workforce plans should be highlighted. Shaun Stacey asked that the risk to quality of care delivery set against available budget should be highlighted to the Board.

10 Finance & Performance Committee Governance

10.1 SO1-1.2 BAF Review

Gill Ponder asked that the Committee take the paper as read.
Fiona Osborne raised that the format of the report made it difficult to see concerns.
Gill Ponder felt that mitigations were missing from the report. Gill gave an example where no mitigations were shown against a risk.
Jug Johal agreed with Gill Ponder and agreed that mitigations would be included in future reports.

Items for Information

11.1 Performance Letters to Divisions – PRIMS

PRIM meetings were stood down in March and therefore there were no letters to review.

12 Any Other Urgent Business

- Emerging Issues

No items of Any Other Business or Emerging Issues were raised

12.1 **Matters to Highlight to other Trust Board Assurance Committees**

A meeting had been requested with the Chair of the Workforce Committee to discuss the impact of staffing issues on Trust Performance and Finances.

13 Matters for Escalation to the Trust Board

Items to be highlighted to the Trust Board were discussed at the end of each section of the agenda.

13.1 Review of Meeting

Gill Ponder summarised that the quarterly face to face meeting had worked well. Jug Johal agreed that the depth of conversations was good due to the format of the meeting. Gill Ponder agreed to keep the quarterly face to face meetings in place, with the next one being in July.
Post meeting note – Janet Mellor had booked the Executive Meeting Room at SGH for the July and October meetings. Diary invitations had been amended accordingly.

14 DATE & TIME OF NEXT MEETING:

WEDNESDAY 24 May 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	√	√	√	x								
Jug Johal	√	√	√	√								
Shaun Stacey	√	√	√	√								
Ian Reekie	x	√	√	√								
Richard Peasgood	√	√	√	√								
Simon Parkes	x	x	√	√								
Brian Shipley	√	√	x	√								
Annabelle Baron	√	√	√	√								
Abdi Abolfazl	√	x	x	√								
Ashy Shanker	x	√	√	x								
Shiv Nand	√	x	x	x								
Dr Peter Reading	x	√	x	x								

MINUTES

FINANCE & PERFORMANCE COMMITTEE

Meeting: **Wednesday 24th May 2023, via MS Teams**

Present:	Gill Ponder	Non Executive Director (Chair)
	Fiona Osborne	Non Executive Director (NED)
	Jug Johal	Director of Estates & Facilities
	Shaun Stacey	Chief Operating Officer (COO)
	Simon Parkes	Non Executive Director
	Lee Bond	Director of Finance
	Ian Reckie	Governor
In Attendance:		
	Annabelle Baron-Medlam	Compliance & Assurance (section 6.1)
	Richard Peasgood	Executive Assistant to COO
	John Awuah	Interim Deputy Chief Operating Officer (section 7.1)
	Georgina Birley	Personal Executive Assistant to COO
	Jodie Hamilton	Personal Executive Assistant (for the notes)

ITEM

1. Apologies

Apologies noted from the Chief Executive, Peter Reading.

2. Quoracy

It was confirmed the Committee was fully quorate.

3. Declarations of Interest

No declarations of interest to note.

4. To Approve the Minutes of the Meeting held on 19th April 2023

Fiona Osborne requested the following changes:

- Page 2, item 5.4 to read – Fiona Osborne stated that she had been given advise as a new Chair for another Committee. This advised that if a report is presented to the Committee it does not need to state that this is a highlight report unless it was delegated by the Board. The report should focus on any items of concern where the Board was requested to take action or be aware of.
- Page 3, item 5.4 – to say - It would be preferrable if the report reflected movement from the last report without repeating information previously presented.
- Page 4, item 6.1 – to read - Fiona Osborne stated that appendix one was good for this report, however she struggled with MED18 due to some of the services having no actions including endocrinology and geriatric services.

Lee Bond made an observation in regard to the requirement of the committee meeting minutes and if the committee requires verbatim minutes. Gill Ponder acknowledged the observation and it was agreed verbatim minutes are not required.

Shaun Stacey informed the committee the previous minutes have been annotated prior to this meeting with the changes Fiona Osborne stated.

In reference to the action on page 4, reference Outpatient Matron Report, Shaun Stacey confirmed liaising with Matron's regarding the CQC outside of the meeting today. Agreed this action to be removed from the minutes on page 4 and remove from the action log.

Subject to the agreed amendments, the committee approved the minutes of the previous meeting.

5. Matters Arising / Action Log

No matters arising to note.

5.1 Action Log

Action reference 9.1 unplanned care – no update available to the committee due to the ongoing planning cycle, suggestion to amended the date to June 2023. IPR amendments are co-ordinated centrally, therefore nervousness around a June deadline. Shaun Stacey suggested to close the action as there is no confirmed date as yet for the new IPR and to update the committee once the new IPR has been completed. This was accepted by the committee.

Action reference 5.2 Work plan – ToR's updated and added the extra item from the April minutes and work plan updated. Agreed action to be closed, noting the ToR's and work plan are on the agenda for approval today.

Action reference 5.4 – confirmed included, action to be closed

Action reference 5.4 carry forward (theatre data) confirmed on track.

Action reference 5.4 – draft action plan to be developed, confirmed complete and for discussion in the meeting today.

Action reference 6.1 – confirmed action complete. Med18 detail is now incorporated as part of the progress report. Agreed action to be closed.

Action reference 7.1 – in reference to committee updates, it was agreed, business continuity plans and Ventilation report to be presented in April and the Entonox report presented in September.

Action reference 8.1 – confirmed requested action to be closed

Action reference 8.3 – to provide an update to the committee in June 2023.

Action reference 9.5 – confirmed action complete.

5.2 Terms of Reference

ToR's agreed at the last meeting, one additional amendment made since to the Estates and Facilities Section, paragraph 5.2.4 the word like to read life. With this amendment, the committee approved the ToR's which will be sent to the Trust Board in August.

5.3 Finance & Performance Committee Workplan

In response to a self-assessment comment noting the committee agenda is very full, suggestions made to the work plan to reduce the frequency of reports. The committee noted the following comments and action:

- Sustainability update duplicated in August and September, confirmed to be remove from the August papers.
- Financial element – agreed to report on the underlying deficit quarterly therefore removing row 20. The Committee agreed this would be sufficient.
- Financial element - Row 24 reference capital, agreed to incorporate business cases and provide a report summary to include the previous CIB meeting minutes. It was acknowledged there potentially will not be an update every month however the committee agreed to keep the item as monthly to form part of the agenda set meeting and ensure business cases are presented when relevant.
- Fiona Osborne said assurance is required as a whole, not just from a financial perspective. The Committee agreed, however appreciated there would not be adequate time within the Finance and Performance Committee meeting to present and discuss benefits realisation in such depth. Fiona Osborne requested a presentation to be shared of the benefits realisation monitoring process to provide assurance to the committee. **Action – Benefits realisation process to be shared with the committee – Shaun Stacey, Ashy Shanker, Lee Bond**

5.4 Action Plan and Self-Assessment Tool

The committee agreed the action plan.

6. Presentations for Assurance

6.1 Care Quality Commission (CQC) Progress Report

Showing pace with an increase in the number of actions completed that are rated high or significant from 34 to 35. The number of actions rated limited assurance has decreased from 45 to 42. The team continues to submit papers to the CQC.

Following the internal audit, the recommendation to ensure all actions have a due date and nominated lead has now been completed and closed. Some actions are now breaching the original due date, the report highlighted these actions in red and provides reasoning. There is only one action relating to the Finance and Performance Committee which is Trust wide, the delay is due to the sign off process rather than any actual delays.

Fiona Osborne highlighted MED18 has improved significantly however still require actions for endocrinology and geriatric services. **Action - Annabelle Baron Medlam confirmed requested clarification from division and to provide an update report and assurance to the Finance and Performance Committee at the June Meeting**.

Gill Ponder highlighted discrepancy in the numbers to the narrative in the appendix on page 30. **Annabelle Baron Medlam confirmed to inform the divisions and request the reports are updated to ensure the narrative and the numbers are correct and very clear in terms of the explanation.**

7. Review of NLaG Monthly Performance and Activity Delivery (IPR) (SO1.2/ SO1.6)

7.1 Unplanned care

The Committee agreed to discuss agenda item 7.1 and 7.3 Deep Dive into A&E Performance & Ambulance Handovers at this point (time 14:12)

Shaun Stacey highlighted the significant improvement in the 60 minutes ambulance handover period with evidence to support and also 12-hour waits. UTC, SDEC continues to be in a good position. Important to note the average length of stay is currently in a good position however this will change for general internal medicine once SDEC is removed from the data. The Trusts general internal medicine length of stay is 5.6 days, the national benchmark is 4.4 days. The team are working to achieve this benchmark however SDEC is supporting the average length of stay significantly.

Shaun Stacey welcomed John Awuah to provide a further update reference agenda item 7.3 Deep Dive into A&E Performance & Ambulance Handovers. The shared presentation was taken as read. In terms of ambulance handover rates, significant improvement, down to 9% from 36%. As of May the rate is 7%, similar improvement is seen in the 30 minute handovers, previously at 44% now achieve 80% .

Both UTC's are achieving 99% performance and maintaining. There is Improvement in ED performance. By next year the Trust need to ensure reaching 76% ED performance trajectory. Currently on average 62% and on occasions more recently achieving 70% performance. SDEC achieving targets set. Frailty virtual wards are now live at both SGH and DPOW with average length of stay 4 to 5 days. In terms of the long length of stay, to note the Trust is the 2nd best performing for 21 days and the 3rd best in the region for 14 days.

Lots of improvement regarding standing D2A's Circa 25% per day. The team are working closely with partner organisation. Emma Owens, system wide discharge lead supporting.

Overall positive picture regarding discharges, the teams have very high moral, seeing their hard work showing in terms of statistics.

Fiona Osborne referenced the trend data, the report captures two data points providing the statistic's, generally a trend requires 5 data points. The committee acknowledged this and agreed important to note the improvement. **It was agreed to present the data and trend in graph form referring to the overall trend from March 2022 against a trajectory/SPC chart. John Awuah confirmed to work with Ashy Shanker to update the report going forward.**

A number of items referenced in the previous report noted as high risk require a further update, items as follows:

- ED QI programme - requires progress update
- Risk regarding inability to staff extra shift to support the current amount of acuity
- IAAU SDEC system wide discharge lead role interview taken place but no appointment made. John Awuah confirmed Emma Owen has been appointed.

Action – John Awuah to provide an update for outstanding risk items stated in update reports to ensure continuity.

Lee Bond referred to the slide regarding discharge to assess patients and where the patients are from as the report shows in the figures a trend referencing Lincolnshire. It has been noted previously Lincolnshire potentially being problematic and requested further understanding on this. Shaun Stacey confirmed there is a worrying trend in reference to Lincolnshire and currently in negotiations in regards to contracts as cost of activity is not being covered. John Awuah is working

with the ICS clinical and Operational lead for discharges to improve the flow in Lincolnshire however continue to see a large number of patients from the Lincolnshire area effecting Grimsby's functionality. Lincolnshire lost bed days are double that of North Lincolnshire. Lee Bond noted the importance to recognise the particular challenges Lincolnshire pose to the Organisation.

Gill Ponder referenced slide 7, discharges, there is a statement noting short stay ward in IAAU wards ineffective. John Awuah exampled this is in reference to short stay wards, patients are staying longer and the teams are working with the medical teams to trying and ensure the ward remains a short stay ward.

Gill Ponder summarised the report, noting the committee would like to see continuity in future reports and reference back on statements of concern, in addition provide further data points providing a chart and a trajectory or SPC chart. Overall there are some very positive improvements made.

John Awuah left the meeting at 14.30

7.2 Planned Care

The report was taken as read, there is a sustained approach to planned care with limited assurance, particularly in cancer. The DMO1 decrease in month, overall due to the size of the waiting list and the ability to report in a timely way.

The number of streams asked of diagnostics set against equipment failure and workforce capacity is seeing some challenges. The team are working on opportunity to increase temporary mobile diagnostics units whilst the community diagnostics centres come on stream.

Cancer shows an unvalidated position and continues to show concern regarding the 104 day waiting position and some issues remain in terms of oncology and tertiary diagnostics. Difficult to manage due to workforce challenges although there are some plans to improve which should show by half year.

Challenge regarding pathology, agreement to increase histopathology access to 7 days, waiting approval to authorise the business case and then the recruitment process to start. A breast pathologist is returning, scheduled to start in 3 month's time which will provide some additional capacity.

Elective Anaesthetics pre assessments remains a challenge particularly, theatre 7, 8 and A in terms of capacity. Work is due to finish in June/July 2023 and it is hopeful to put back the capacity short falls. Some extended operating days were put in place to compensate on a volunteer basis, however staff uptake was not as expected due to a number of factors, such as pension, tax, and workforce stretch supporting other additional work.

Fiona Osborne asked in reference, cancer request test, originally asked to change from 14 days to 7 days. Looking at the April figure, it has got better for 7 days but worse for 14 days. What does this mean in terms of patient impact and why. Shaun Stacey noted there will be some variability, It will also depend on the urgency and type of request. It was noted the data is not validated. Lessons learnt have come from this in terms of timing from a capacity point of view, staff leaving, retirement and also trying to run the service from only SGH and DPOW and consider sharing this across the team. Also tax and pension being a contributing factor.

Lee Bond highlighted, from a financial perspective the changes made to real time reporting and annual allowance, very few consultants will receive a tax charge. The potential issue is the rate the Trust pay which needs to be considered and at what point does it become unaffordable. Starting to

see some organisations providing additional capacity in house. A full package from an affordability perspective is to be consider, more financial modelling to take place however the industrial unrest is not supporting.

Cancer concerns continue, however pending CDC's hopeful to see an improvement. Issue currently as the new scanners are much heavier than the site can take, this is currently an engineering exercise.

Jug Johal noted, when the new SGH ED scanner comes online there was always a plan to keep the old scanner. Shaun Stacey noted there is a workforce capacity issue, and the scanner is very old and needs to be replaced.

7.3 Deep Dive into A&E Performance & Ambulance Handovers

Discussed at agenda item 7.1

7.4 Business Continuity Updates

The shared monthly report was taken as read, Matthew Overton noted the business continuity policy has guidance and supporting documents at both Directorate and Service level. There are 137 service level plans reviewed, at a minimum annually. A national tool kit released last month and with the tool kit new service guidance, templates and case studies to support implementation. The team are currently refreshing arrangements aligning to the new guidance. The team frequently review and update policies therefore there is not much change required. It was noted the annual compliance of the NHSE core standards NHS EPRR was completed which received substantial compliance.

The internal Yorkshire audit report on arrangements also received substantial compliance with minor recommendations which have been incorporated in the business continuity plans.

Key risks to note:

- Industrial action
- Potential for cyber attacks internal and external
- Global and international goods and services
- Residual risk from infectious diseases

In reference to the risk register – BAF objective 1.6 the score was 16 through the last 12 months however this has now been reduced to 12, a medium rating. further mitigations and action plans in place to reduce further by the end of the year.

Fiona Osborne noted the risks have not changed and the overall risk types are the same as last year, the arrangements are sufficient and the testing and implementation. One area that would be beneficial to see some expansion on would be the framework, how different is that to what was in place. Matthew confirmed the arrangements as a strategy have not changed, the new guidance and tool kit may see some changes and the structure change. The risks remain very similar, but the rating may change. Confirmed regular learning exercises take place.

Gill Ponder asked, regarding communications how do we keep business continuity fresh and communicate this to staff on the ground due to high turn over. Matthew confirmed each section within the service plan has a service lead, they must demonstrate how they cascade to the staff and update the detail and this is one areas through the re-launch of the business continuity plan to

strengthen and go further to understand what the service leads do to test the plan and staff understanding, communication and role.

Gill Ponder asked, when an update would be available following the recent electrical failure. Matthew Overton confirmed to update and provide assurance to the Committee in September. It was noted the action plan is being monitored by the EPRR group.

7.5 Assurance Confirmation & Board Highlight report

It was noted, committees have been asked to significantly reduce highlight reports. The Committee agreed the following key points to highlight:

- Improvement to note in urgent care
- Extra mobile capacity noting the units are to heavy and not sure if able to accommodate them. Shaun Stacey noted this was a national specification, NLaG is not the only organisation having this issue.

8. Review of NLaG Monthly Financial Position (SO3.1 / SO3.2b)

8.1 Finance Report Month 1

The team have produced month one reportable results. Against planned deficit of £2.6m reporting £600k to the good in month. Slightly behind on CIP however, the underlying Income and Expenditure (I&)E position is ok. the underlying position is still £41m.

Lee Bond referred to page 4 of the report, showing where the Trust is by category of expenditure noting the biggest issue is pay, circa £700k medical staffing over spend, circa £300k of which is the net cost relating to strikes which will also hit the activity numbers. There is also continued reliance on agency.

Appendix C shows the temporary staffing summary, £5.8m spent in month against this month last year which saw a spend of £5.4m. The two biggest contributing factors continue to be medical and nursing staffing. The concern is, if £2.9m is spent on medical staffing on bank and agency, that works out at circa £98k a day over 30 days. Lee Bond confirmed looking at spend in medical staffing and nursing to triangulate.

Appendix B shows elective recovery, the strike presents some degree of mitigation, however April 2022 vs April 2023, more elective work completed than last year, more day cases than last year, however outpatient has dropped by a 3rd which is problematic, unsure as to the reason, potentially due to the strike or Easter. Whilst the Trust is doing more work than last year, still some way behind 2019/20 activity, potentially operational issues effecting this.

Regarding I&E, showing a positive variance against plan in month. The phasing of the plan will be included in the report going forward which will see some significant steps throughout the year and targets will be greater. The phasing of the plan will be included as an appendix and also a number relating to the opportunity cost regarding outpatient follow ups in excess of 75% for which funded to put a quantifiable costs against the work.

Fiona Osborne referred to appendix A, agency and bank breakdown between staffing levels. medical staff have been successful in reducing agency spend but increasing bank spend whereas nursing is spending more on agency and less on bank, what are the drivers. Lee Bond noted, the bank is on NLaG premiums, the move from bank to agency is an issue as increase in cost. In terms of medical, locum contracts are offered and individually negotiated therefore a range of rates. Lee noted, requested a forecast model of nurse vacancies for the rest of the year, there will

be a marked improvement mid-year when new starters join and potential to see improvement when over seas nurses are in post. Also, to note, there has been 40 escalation beds opened which will have seen some increase in costs from a nursing perspective, B4 now closed which will have a few weeks of impact in May, however if the bed base can remain stable it should support cost in terms of bank and agency spend.

Fiona Osborne asked, in reference to nursing, the bank is paid on Agenda for Change (AfC) however £200k less spend against this time last year, is this due to demand, in which case less bank volume take up than there was before, and why is that and what is driving the Trust to go to agency. **Action - Lee Bond confirmed looking into increase of agency use in nursing and confirmed to provide further detail including fill rate and to circulate a response post meeting.**

Fiona Osborne referred to page 8 of the report, CIP Performance, noting month 1 is reporting a significant non-delivery . Lee Bond noted the concern is 2.8% core cash releasing efficiency savings which is yet to be fully agreed. There is also the £10m stretch and a further £9m principally through fixability sourced non-recurrently. Of most concern is the £10m which a plan is yet to be set.

Additional to this, considering income recovery in terms of assets. From a waiting list perspective in a good position. The plan is to get to 107% of 19/20. The Trust has some way to go yet to reach 107% and then anything over that goes towards to the £10m saving. Lee confirmed reviewing this with Shaun Stacey.

Gill Ponder also shared concern regarding to the £10m stretch and capital in reference to the ED/IAAU potential £1m overspend which is not included in the plan.

Simon Parkes noted, going into a period of interim leadership and the challenge of moving to a group model, would this make the £10m saving more difficult to achieve? Lee Bond noted having recent conversations with the ICS and the Region they have noted, the change is seen as an avenue in reducing cost therefore there is a level of expectation outside of the organisation in development of the group structure to reduce costs. It was noted, potential to reduce cost in terms of duplication.

8.2 Recovery Support Programme Update

Lee Bond confirmed meeting tomorrow with the ICS. Confirmed the Trust has excited from soft 4

8.3 Business Case Assurance

SGH CDC revenue consequences to be developed into a short form business case. Lee Bond noted hopeful to present to the Committee next month.

8.4 Assurance Confirmation & Board Highlights

The committee agreed to highlight the spend on temporary staffing, exceeding spend in month 1 in comparison to last year. Also, to note the shift from bank to agency use in terms of cost and implications on patient care.

Helen Harris Joined the meeting 15.10

Shaun Stacey noted, the system should be able to provide data from a nursing perspective to articulate why there is an increase/shift in bank to agency use. Shaun confirmed to request this data. More understanding is required in terms of overall medical spend, unfortunately the rostering system is unbale to demonstrate.

In reference to nurse staffing, Lee Bond noted, Ward Managers are not authorised to roster nurses in excess of the area establishment under the scheme of delegation. Shaun noted, every ward has a base line, the rostering tool rosters against acuity. The system will then be able to give detail of agency and bank spend which should be specifically attributed to sickness/absences with some expectations for example B4.

9. Estates and Facilities (SO1.4)

9.1 BLM and Premises Assurance Model (PAM)

Reports taken as read. 2023/24 allocated BLM of £3m, highlighting some schemes from last year agreed to carry over to 2023/24, these are fire alarm replacement works ,disabled access and theatre UPs.

Fiona Osborne noted, the programme for the coming year is 50% of the spend from last year, the committee have previously noted nervousness regarding back log maintenance that needs to be scheduled. Jug Johal note the funding is not sufficient however the annual allocation for capital is circa £12m a year which is split between, equipment, digital, major projects and BLM.

Jug Johal noted the biggest risk is fire replacement and this is the focus. DPOW complete and SGH Ongoing. Seeing the benefits of this following a recent inspection from the fire brigade, no infringement notices. Water will always remain a top risk due to very old pipework as with HV and LV lots of electrical cables which continue to be replaced. The team continue to maintain an aging infrastructure/Estate.

In reference to PAM, page 11 captures the detail of the workshops conducted to gather the required data. PAM is part of the NHS national contract to be completed annually across 6 domains. Noticeable improvements made in comparison to last year with an overall good outcome.

Additional this year, the new national standards of health care cleanliness and nutrition and hydration, with no concerns to note.

The Committee were asked to approve the report. It was agreed to note approval of the report to the Trust Board as part of the Finance and Performance Committee report.

Gill Ponder noted, it would be helpful to include short detail/action to take for items that are requiring improvement. Jug Johal confirmed to include within the report going forward.

9.2 Assurance Confirmation & Board Highlights

It was agreed to append the PAM report and recommend to the board.

10. BAF

10.1 Review of the current BAF risk ratings

Helen Harris shared the BAF report on screen updating on the current and targeted risks.

Strategic objective 1.2 – Significant amount of work taken place, seeing a number of actions completed. risk for Q4 is 20 against a target risk of 15. The committee support the risk rating of 20. Target risk by the end of March 2024 of 15 was also agreed by the committee.

Strategic objective 1.4 – Deep dive completed last month. Confirmed risk rating agreed.

Strategic Object 1.6 - Target score met for this year, noting major incident tabletop training to be completed and a review of the action plan remains outstanding. Target risk rating by next year to reduce down to 4. The committee were asked if in agreement, Fiona Osborne noted, received the annual EPRR report today informing no significant change in the report, no change to risk or

framework and asked are the risks essentially the same. Shaun Stacey advised, reduced the risk as by next year there will be more familiarity regarding outbreaks. The committee approved a score of 8

Strategic Objective 3.1 – The committee agreed the risk rating of 20

11. Items for Information

11.1 Performance Letters to Divisions – PRIMS

Item for information only.

12 Any Other Urgent Business

The Annual safe staff report received; financial consequences to be confirmed pending bed base review. Operational and financial plans approved by the ICS and the Board, however there is an ongoing exercise for nursing establishment this year, therefore a referral has come across and asked how any changes to nursing establishment will be considered and why it was not aligned as part of the business planning process. **Action - Lee Bond to bring an update on the bed base and how this effects nursing establishment financial risks.**

Action - Delivering plan for recovering emergency and urgent care, paper submitted by NHSE, Shaun Stacey confirmed to present a comprehensive paper on the Trust position in terms of standards to provide assurance in July.

Action - Elective Care prioritising for 23/24 and tool kit received from NHSE , Shaun Stacey confirmed to complete and provide an update to the committee in elective update in June.

Reference agenda item 7.1 Fiona Osborne asked, regarding the supporting NHSE document the report does not refer to the document. Shaun Stacey noted the paper is for any other business however important to note the context. Shaun Stacey confirmed to provide an update summary to the Committee, date to be confirmed. The Committee requested this item be noted under any other business.

13 Matters for Escalation to the Trust Board

To note risk in terms of workforce.

13.1 Review of Meeting

In summary, very good conversation and agreed good quality of discussion. The committee agreed require further detail in relation to workforce expenditure and further understanding as to the spend in bank and agency and to be clear on benefits from investments.

14 DATE & TIME OF NEXT MEETING:

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	√	√	√	**x**	√							
Jug Johal	√	√	√	√	√							
Shaun Stacey	√	√	√	√	√							
Ian Reekie	**x**	√	√	√	**x**							
Richard Peasgood	√	√	√	√	√							
Simon Parkes	**x**	**x**	√	√	√							
Brian Shipley	√	√	**x**	√	**x**							
Annabelle Baron	√	√	√	√	√							
Abdi Abolfazl	√	**x**	**x**	√	**x**							
Ashy Shanker	**x**	√	√	**x**	**x**							
Shiv Nand	√	**x**	**x**	**x**	**x**							
Dr Peter Reading	**x**	√	**x**	**x**	**x**							

NLG(23)151

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	1 August 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 17 May 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Health Tree Foundation Trustees' Committee held on 17 May 2023 and approved at its meeting on 6 July 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.

MINUTES

MEETING:	Northern Lincolnshire & Goole NHS Foundation Trust **Health Tree Foundation Trustees' Committee**	
Date:	**17 May 2023 – Via Teams Meeting**	
Present:	Neil Gammon	Independent Chair of HTF Trustees
	Susan Liburd	Non-Executive Director
	Tony Burndred	Governor
	Peter Reading	Chief Executive
	Lee Bond	Chief Financial Officer
	Jug Johal	Director of Estates and Facilities
	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
	Elaine Wier	HTF Representative
	Michelle Soar	HTF Representative
	Lauren Short	Finance Admin (For the Minutes)

Item 1 05/23 **Apologies for Absence**

Apologies for absence were received from: Kate Wood, Ellie Monkhouse and Gill Ponder.

Item 2 05/23 **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 05/23 **Minutes of Meeting held on 9 March 2023**

The minutes from the meeting held on 9 March 2023 were approved.

Item 4 05/23 **Matters Arising**

All matters arising were covered within the action log.

Item 5 05/23 **Review of Action Log**

The action log was updated accordingly.

Item 6 05/23 **Items for Discussion / Approval**

6.1 Staff Room Improvements – Proposed Plan

Lucy Skipton explained that a priority list had been drawn up with the help from Melanie Sharp, Rachael Greenbeck and Simon Buckley who advised which staff

rooms needed to be looked at first. The list included 10 wards at DPOW, 10 wards at SGH and 3 wards in GDH. An electronic selector was then used to randomly select one ward from each of the sites to be the first projects. The results of this random selector were the Theatre Ward staff room at SGH, Ward 3 staff room at GDH and the Stroke Unit staff area at DPOW.

Neil Gammon thanked Lucy Skipworth for the update and opened up the item to questions.

Lee Bond queried how the priority list was presented and asked if the list was in priority order. It was confirmed that it was not in any particular order, however the various staff rooms were all deemed to be a priority. With the staff rooms averaging £2,500 each needing to be spent, Lee Bond asked in what time period this would be completed. Lucy Skipworth confirmed that it would take around 2 to 3 months to complete each room and then the random selector would be used again to choose the next staff rooms to complete. It would thus be a rolling programme, taking some time, commensurate with available funds, to complete in total.

Jug Johal advised Lucy Skipworth to make contact with Kerry Carroll to ensure there were no clashes with regards to the HASR project and the ward refurbishments at DPOW.

Action: Lucy Skipworth

Neil Gammon commented that there was a deliberate vagueness with regards to the timeframe to ensure expectations are managed. Sue Liburd asked how the expectations were being managed. Neil Gammon asked Lucy Skipworth to run through the communications which may answer this question and any further questions the Trustees may have.

HTF have been working closely with Simon Leonard in the communications team to come up with a list of FAQs to share with staff when the communications for the staff rooms are published via Trust wide email.

Peter Reading again expressed his passion for this project, as it should bring significant patient benefit due to increased staff morale and wellbeing. Although the nursing staff rooms are the first to be considered, he did not want other staff to feel excluded. Therefore, the communications about this project need to make clear that other staff rest areas and staff rooms will be examined.

Melanie Sharp added that she had shared this news with a few members of staff, and it was well received with positive thoughts, however expectations do need to be made clear within the all staff communications as to what improvements will and can be made.

Sue Liburd queried whether where would be a contingency plan, however it was confirmed that all staff rooms will be taken on, on a case-by-case basis, however there are no plans to undertake any extensive and thus significantly expensive improvement work.

Neil Gammon asked all Trustees if they were content to approve the staff room proposed plan whereby all in attendance agreed to approve.

Item 7 05/23 **Updates from Health Tree Foundation**

7.1 HTF Manager Update Report

Lucy Skipworth spoke to the report and highlighted the following key updates expanding the discussion where necessary:

- NHS Charities Together: Development Grant – The money will be used to build a new circle of wishes system and to fund the digital fundraiser position which will soon be advertised.

- Fairchild Legacy Update – work has been delayed until June 2023 due to contractor availability.

- Pennies from Heaven – HTF have been looking into this scheme which many other NHS organisations use successfully. Staff sign up directly with Pennies from Heaven who would (if approved) have links with ESR to withdraw pennies from staff wages of up to a maximum of £1.
  Jug Johal asked whether the HTF would receive the full amount of the donations or whether Pennies from Heaven take a percentage. Lucy Skipworth would double check this information but from her knowledge, the HTF would receive the full donation. Clare Woodard noted the great success of other NHS organisations using this scheme with some having an income of around £700 per month. All staff have the choice to opt in which would be reviewed annually. Trustees approved the proposal, with the decision to implement and review progress at the next Committee meeting.

  Action: Lucy Skipworth

- Fundraising Strategy Update – The team have been working hard by positively engaging with the strategy with a recent increase in fundraising targets. “Scan to donate” posters have been put up around wards, whereby if donations are received, the funds go directly to that ward. This data is all trackable.

- Newsletters - Displayed in local GP practices and community groups to promote the charity and share any news and projects.

- Training – A number of HTF employees attended a training course to help with completing Grant applications which will hopefully have a positive impact when applying for future grants.

Neil thanked Lucy Skipworth for the updates and highlighted a few extra points:

- Impact Report – Trustees confirmed that this information was what was required with Neil Gammon highlighting how useful the report is for Trustees.

- Wish 16/23 – Lucy Skipworth confirmed the figure of this was £7,991

Neil Gammon thanked Peter Reading on behalf of the Health Tree Foundation for his support of the charity and professional input throughout his time as NLAG's Chief Executive.

7.2 Risk Register

Lucy Skipworth noted that the Risk Rating for the cost of living has been increased following on from Gill Ponder's advice given at the previous Committee meeting.

Neil Gammon referred to Risk Number 2 and felt a formal induction process for the new executives was required with the action taken by Lucy Skipworth.

Action: Lucy Skipworth

Lee Bond highlighted Risk Number 4 and queried whether the risk and impact are both high and challenged the scoring of 16. After discussions took place, it was explained that 16 was the initial risk score, however due to mitigations put in place the current risk score is 8.

Neil Gammon asked for the last column on the table to read 'Last Reviewed at HTF TC' and for the 'additional comments' column to be updated to reflect the risk being reviewed.

Lucy Skipworth informed the Trustees of no one yet having taken over the Scunthorpe Hospital League of Friends but as soon as any information is known, this will be communicated to the Committee.

Action: Lucy Skipworth

Item 8 05/23 Sparkle Programme

8.1 Sparkle Update

Lucy Skipworth spoke to the report and thanked Lauren Henry for all the progress made so far on the various projects being undertaken.

Neil Gammon acknowledged the high standard of the report provided with no further questions asked by the Trustees.

Item 9 05/23 Finance Update

9.1 Finance Report – Year 22/23

Paul Marchant presented the Finance report for the 22/23 year and highlighted the key points, including;

- Income for the year was £888k which was £62k less than the annual budget of £950k. Income includes £501k of NHS Charities Together (NHSCT) grant income.

- Expenditure for the year was £1,411k which was £129k more than the annual budget of £1,282k. Expenditure includes £471k of NHSCT grant payments.
- Key expenditure included; DPOW & SGH A&E Departments £112k, Funding of staff £149k, Mammography Licences £61k, Hamilton MRI Ventilator £27k, MotoMed Exercisers £23k and ECGs £24k.

- The CCLA investment fund was revalued on 31st March resulting in a gain of £46k, resulting in a total loss of £90k for the year. Investments will be revalued again on 30th June.

- Investments to the value of £300k were sold during the year to meet expenditure commitments.

- Fund balances after commitments are 882k

KPIs for every £1 spent;

	22/23 Actual	**22/23 Plan**
• Charitable Activities	£0.84	£0.80
• Fundraising costs	£0.08	£0.11
• Non fund raising admin	£0.04	£0.06
• Governance	£0.04	£0.03
Total	**£1.00**	**£1.00**

9.2 Finance Report – April 2023

Paul Marchant presented the Finance report for the first month of the new financial year and highlighted the key points, including;

- Income for the month was £18k, which is £7k less than budget of £25k.

- Expenditure for the month was £35k, which is £7k less than budget of £43k.

- Fund balances after commitments are £730k.

- The Bank balance at the end of April was £84k

KPIs for every £1 spent;

	23/24 Actual	**23/24 Plan**
• Charitable Activities	£0.60	£0.75
• Fundraising costs	£0.12	£0.14
• Non fundraising admin	£0.19	£0.06
• Governance	£0.09	£0.05
Total	**£1.00**	**£1.00**

Item 10 05/23 **HTF Trustee's Committee Annual Effectiveness Review 2023**

Neil Gammon expressed his disappointment with the lack of responses received for the HTF Trustee's Committee Annual Effectiveness Review for 2023, however noted that the five responses received looked to be content with how everything is working. Focus turned to the 'Action Required' column whereby Lucy Skipworth and Clare Woodard took these actions.

Action: Lucy Skipworth / Clare Woodard

Neil Gammon referred to a comment relating to extraordinary meetings and clarified that where necessary meetings will be called if and when any extra-ordinary requests need to be discussed or agreed by Trustees. He emphasised that any Trustee could seek an extraordinary meeting.

Item 11 05/23 **Any Other Business**

Terms of Reference
Paul Marchant presented the Terms of Reference on screen which were agreed by Trustees.

Item 12 05/23 **Matters for Escalation to the Trust Board**

It was agreed that Neil Gammon would highlight the following to the Trust Board:

- Trust Staff Room Enhancements
- Pennies from Heaven – NHS
- Quoracy

Action: Neil Gammon

Item 13 05/23 **Date and Time of the next meeting:**

Thursday 6 July 2023
9.30am – 12.00pm
Via MS Teams

Attendance Record:

Name	July 2022	Sept 2022	Nov 2022	March 2023	May 2023
Neil Gammon	✓	✓	✓	✓	✓
Peter Reading	✓	✓	✓	✓	✓
Terry Moran					
Linda Jackson					
Gill Ponder	✓	✓	✓	✓	Apols
Mike Proctor	Apols	Apols			
Maneesh Singh	✓				
Lee Bond	✓	Apols	Apols	✓	✓
Jug Johal	✓	✓	✓	✓	✓
Kate Wood	Apols	✓	Apols	Apols	Apols
Ellie Monkhouse	Apols	Apols (Rep)	Apols (Rep)	Apols (Rep)	Apols (Rep)
Christine Brereton	-	-	-		
Paul Marchant	✓	✓	✓	✓	✓
Andy Barber	-	-	-	-	
Victoria Winterton	✓	-			
Clare Woodard	✓	✓	✓	✓	✓
Adrian Beddow	-	-	-		
Ian Reekie (Governor)					
Tony Burndred	-	-	-	✓	✓
Susan Liburd			✓	Apols	✓
Simon Leonard			✓	✓	✓
Lucy Skipworth			✓	✓	✓
Total	**9**	**7**	**8**	**10**	**10**

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	1 August 2023	
Director Lead	Kate Wood, Chief Medical Officer 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 – May and June 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 May and June 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
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 23 May 2023 from 1.30pm to 4pm
Via MS Teams

Present:

Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Kate Truscott	Non-Executive Director
Sue Liburd	Non-Executive Director

In attendance:

Dr Kate Wood	Chief Medical officer
Jenny Hinchliffe	Deputy Chief Nurse
John Awuah	Deputy Chief Operating officer
Richard Dickinson	Associate Director of Quality Governance
Rachel Greenbeck (item 138/23)	Deputy Head of Nursing, Community & Therapies
Belle Baron-Medlam (item 144/23)	Interim Inspection Compliance & Assurance Manager
Kay Fillingham (item 147/23)	Lead Mental Health Nurse
Fiona Moore (item 148/23)	Head of Quality Assurance
Diana Barnes	Governor (observing)
Laura Coo	PA to the Chief Medical Officer **(minute taker)**

131/23 Welcome and Apologies for Absence

Apologies for absence were received from: *Shaun Stacey (John Awuah to rep), Ellie Monkhouse (Jenny Hinchliffe to rep), Lydia Golby, Ian Reekie, Nicky Foster, Dr Peter Reading*

132/23 Opening remarks

Fiona Osborne welcomed members to the meeting and advised that the Quality Priorities paper had been deferred to the June meeting to allow the team sufficient time to generate the first paper in a new monthly presentation.

Attendees would still be asked for a two minute introduction of their papers emphasising any key points before moving on to questions.

133/23 Declaration of Interests

There were no declarations of interest related to any agenda item.

134/23 To Approve the Minutes of the Previous Meeting held on 25 April 2023

The minutes were accepted as an accurate reflection of the previous meeting.

135/23 Matters Arising

There were not any matters arising

136/23 Review of action log

113/23 Renaming of Board sub committees – Kate Wood had had a discussion about this with Helen Harris and the action could now be closed. **Action closed.**

119/23 QSC Workplan, Mortality updates - A mortality update had been added to the Committee's workplan and the first update would be provided in June therefore the action could be closed. **Action closed.**

119/23 BAF - Fiona Osborne had raised this with Helen Harris and it was thought that once the new Chief Executive Jonathan Lofthouse started in post in September the BAF would be reviewed as part of his starting document review. **Action closed.**

120/23 QSC Terms of Reference (ToR) – Laura Coo had been unable to set up a meeting with core QSC members due to availability therefore a conversation was had off line and a paper was generated. It was escalated to Peter Reading and Sean Lyons and would be included in the highlight report for the Board. **Action closed.**

Regular Reports

137/23 Maternity Safety Oversight Update (including Ockendon & metrics)

Fiona Osborne advised that Jenny was presenting the paper on behalf of Nicky Foster and that this was a new paper being presented for the first time bringing together all aspects of Maternity. Fiona advised that the report was extremely thorough but as is the case with new regular reports, it would go through further refinement as part of a natural development. Fiona advised there was some overlap with other reports presented and that as a result, any queries linked to the maternity services in both the Nursing Assurance Report and SI Report would be discussed under this agenda item for completeness.

Jenny Hinchliffe referred to the report distributed which was taken as read

Jenny Hinchcliffe advised there had been a slight improvement in the maternity vacancy rate in April, seven international Midwives would be joining NLaG, four had already started in March and they were in the process of interviewing over 20 newly qualified Midwives so Jenny was hopeful the rates would steadily improve although they were slightly lower at SGH.

DPoW Neonates fill rate had gone down as a result of including establishment which affected the previous month and was why the vacancies had increased. They

had successfully recruited but people had then gone on to get promotions so were currently being managed as per escalation plans

Maternity triage second phase had experienced some delays in implementation, but a staff meeting was planned for the following week and plans were progressing.

The number of PALS and complaints was improving.

CNST - The Trust had reported compliance with all 10 safety actions within the Maternity Incentive Scheme for the second successive year and awaited publication of Year five and risk would be monitored.

Maternity safety champions continued to do monthly walk abouts and weekly 'shout outs'.

There had been one new SI for May which was a maternal cardiac arrest and was currently being investigated.

Sue Liburd referred to the Serious Incident and asked how mum and baby were doing. Richard Dickinson advised that mum spent a period of time in critical care and was subsequently discharged. As the patient required critical care escalation it was decided it was appropriate for an investigation.

Fiona Osborne requested that Nicky Foster meet with Richard Dickinson with regards to the SI section as the SI report due to be presented later in the meeting contained additional information that gave more context to the Maternity SI. Fiona requested that an agreement on how and where a complete report on Maternity SIs are reported. Richard Dickinson clarified that the SI report covered all SI's and how they were dealt with but would meet with Nicky to discuss how to proceed.

Action: Nicky Foster to meet with Richard Dickinson to agree how a complete picture of Maternity SIs are reported.

Sue referred to the sustainability and delivery plan for Neonatal services included in the report, the sustainability plan was 47 pages and whilst Sue knew there was a requirement for the Board to be kept up to date asked if the plan was to bring it only to this Committee or to then take it to the board as well. Jenny understood this report would go to the Board and Fiona confirmed her understanding was it needed to be received by the Board.

Sue referred to the three year delivery plan and asked what had been done in preparation to this arriving in March 2023. Jenny knew the team had started looking at this but could request for the team to provide an update in readiness for next month.

Action: Jenny Hinchliffe to request for an update from the team on the three year delivery plan.

The safety mail box and the 'shout outs' had caught Kate Truscott's attention and wondered if this Committee could assist at all as some of the actions seemed to be going on for a long time. i.e. emergency buzzers had been an issue since 2021. There seemed to be clearly some very practical things that would be effective to

support women delivering but for whatever reason had not come up the list of priorities. Jenny knew there was a robust mitigating in place for the emergency buzzers but appreciated it was not included in the report.

Action: Jenny Hinchliffe to request the safety mailbox section in the Maternity Report to include the Mitigations for unresolved actions next month.

Fiona Osborne asked about the risks and learning from themes at the base pf page 17. She felt these were high priority but noted that these had not been highlighted in the Conclusion or the Executive Summary. Jenny agreed that they needed noting in the Executive Summary.

Fiona asked about the risk associated with not recruiting a Maternity Voice Partnership Lead. Jenny advised there was a potential risk for CNST next year but hopefully that post would be filled by that time.

138/23 End of Life (whole cycle including C&T)

Rachel Greenbeck referred to the report distributed which was taken as read and highlighted the key points.

Rachel apologised that she might not know all the answers as Donna Smith had written the report before she left the Trust. Fiona Osborne thanked Rachel for presenting the report and advised the Committee were aware that Rachel may need to come back to the Committee with answers.

Rachel referred to page four, that stated about the increase in the number of patients with a Respect form in place, however they had seen a deteriorating picture. Rachel explained that the respect form data came from the audit tool and needed to be recorded on WebV, there was a lot of work going on with Comms , EoL training sessions to advise this change in recording. Comms was being put on the hub and the EoL team were doing Ward walk rounds to raise the profile. Claire Hebdon would also be raising it at the Senior Leaders Forum that week so was hoping it was just a blip reflecting teething issues around the change.

Rachel advised there still some work going with reference to EPaCCs around acute and patients who attended ED. Rachel had met with Claire Hebdon and Claire Shipley to ensure people were aware how they could access EPaCCS particularly in ED.

In terms of pain assessment the Rachel referred to the Trust wide QI project was about looking at a single pain assessment tool. It had been piloted on Wards and was due to be rolled out in the month. Rachel advised the Committee should see some updates of that included in the next report. In terms of the QI work there were lots of working groups which tended to be attended predominantly by the EoL Team, it would be helpful to have a wider group and would be grateful for any opportunity to get people on board through those working groups.

Rachel invited any comments or questions.

Sue Liburd thanked Rachel for the update and asked about page four of the report, and the highlighted issues around the recognition of EoL, advanced care planning and a seven day service. Sue asked who they were consulting with as the to meet the planned implementation date in August.

Rachel advised it was previously a team of two wte's but now they had a team of five wte's so they wanted to roll it out over seven days. As it was a change in working pattern it had to go out to staff for consultation who would have some time to comment and then it would be a seven day service 9-5pm

Kate Wood highlighted to the Committee that Rachel had asked the team to provide an update to the Senior Leaders Committee (SLC) too. EoL already had a regular monthly slot at SLC and it was a conscious decision with the comms team to keep raising it as often as possible to make sure it became the normal.

Fiona Osborne understood what Rachel meant with regards to the recording of EoL and the number of patients with respect forms, however the graph and the drop of in data was a little concerning. Fiona stated she was assured there was a mitigation plan in place with training and work to improve that.

Kate Wood reported that Donna Smith had left the trust and they were interviewing for a replacement within the week but in the meantime Rachel Greenbeck would be covering the community updates until a replacement started at the Trust. Robin Hewison was providing support and would most likely be updating the reports in the future.

Kate Truscott requested asked for assurance that EoL plans were tied in with the CQC action plan. Kate Wood informed that all the work Belle reported in the CQC report was provided by the Divisions as the CQC actions were divisionally owned.

Rachel Greenbeck left the meeting at 2.09pm

139/23 Annual Safe Staffing Review

Jenny Hinchliffe referred to the report distributed which was taken as read.
What was really positive on this round was they heard the investment review that resulted in an increased establishment in 2022/23 had made a significant impact on staff morale. There remained challenges with vacancies and escalation beds did put pressure on the wards. The SNCT data was quite positive now and the team could see the positive trends for the acute patients on the ward.

Jenny advised there had been an increase in supervisory time for the clinical leaders 2 days a week for 8 months of the year and stated an intention to increase that to 2 days a week for 12 months of the year.

This report did have a "Draft" watermark on it which was an error as this report was complete. Jenny advised that once we had that bed base review was complete there would be a separate paper presented with the final establishment request for 2023/24.

Fiona Osborne asked how this fitted with the 2023/24 Operational and Financial plan as this had already been approved by the Board and the ICB. Jenny advised

the reference to the bed base review actually relates to a bed configuration review based on the completed bed base that had been agreed as part of the plan. This would affect the level of nursing staff required.

Fiona expressed concern that nursing establishments were not fully mapped despite the financial plan being agreed by the Board and ICB. John Awuah stated that the bed base had been a top down decision made by ICS and as part of the financial planning the Trust had agreed to a specific number of beds. Fiona queried this as the Finance & Performance Committee had been advised the bed based had been determined by a bottom up exercise. Jenny advised this was the case.

Fiona suggested that a referral should be sent to the Finance & Performance Committee to determine how any required changes to the nursing staffing establishment would be dealt with and funded given the 2023/24 operational and financial plan had been agreed.

Action: Fiona Osborne to raise a referral to the Finance & Performance Committee to understand how nursing establishment changes will be dealt with following closure of the 2023/24 Operational & Financial Plan.

Kate Truscott highlighted the band 3 posts and looking at the whole career progression for health care professions. Kate asked what was the difference between a clinical sister and ward manager. Jenny Hinchcliffe advised wards have a ward manger and ward sister below. They then have two deputies one has a focus on the ward management and the other on training and competencies.

140/23 IPR

Dr Kate Wood referred to the report distributed which was taken as read.

VTE was no longer flagging as an outlier for the Trust. There had been some key highlights demonstrating that by doing things electronically, things could really change. Previously the weight recording in ED was too onerous, but a weight button had now been added to the system which had already improved our compliance and was a much better way to provide assurance to our providers.

Jenny Hinchcliffe reported that C.Diff ended the year slightly over target but the Trust remained one of the top performing trusts in the country.

There had been two duty of candour incidents relating to pressure ulcers and a letter had been put together which would resolve these.

Kate Truscott queried what was meant by ‘not able to update this data until a new contract was in place’ under the HSMR graph. Kate Wood advised she has picked that up with Shauna McMahon and explained that the IT team were trying to manage contracts across the group structure which would be moving to a combined contract across the Group.

Sue Liburd commended the improvement around weight recording but wondered how this could keep being improved. In response Richard Dickinson advised that he was part of the Safer Medication Group and in the background there were some

plans to transfer data from the EPMA system which should make that better, Richard knew the Pharmacists were keen to get this right.

Fiona Osborne thought it was great to hear the electronic reporting system had moved on significantly. With regards to the IPR review, Fiona asked if Kate Wood was involved in the progression. Kate Wood advised her big concern was that the quality priorities for this year were not being monitored and it was now the end of May and they were still not being reported. Fiona asked if this was appropriate to highlight to the board. Richards view was that it should be noted but to say that Information services had constrained resources to support this project and Richard did not know what the timeline was. Richard would discuss with Fiona Moore to see if they could add any more context in the next report.

141/23 Nursing & Midwifery Assurance Report

Jenny Hinchliffe referred to the report distributed which was taken as read.

Jenny advised vacancies continued to be a challenge, but recruitment was and is a priority with a team out in Kerala. They continued to be very mindful of the impact on skill mix on the Wards and would have the newly qualified midwives joining the team in September. Jenny stated that Community nursing was the best it had been in a long time which was down to the targeted recruitment.

Jenny advised there had not been any surgical site infections in 2022/23 which was really positive too.

Kate Truscott commented that it was great to see the quality improvement project about insulin being given in care homes but asked about sickness levels and vacancy rates and wondered what support was being given around that. Jenny advised that Ward C2 had a new Interim Ward manager to manage that sickness absence. GDH had done some targeted recruitment for Wards 3, 6 and 7 and were hoping the skill mix would change in the next couple of months.

Following up on what Kate Truscott had said Fiona thought it was good to hear that agency staffing utilised a pool of regular staff to pull from. She asked if the overall agency fill rate against substantive fill rates could be provided and if a ward did not have good fill rates an understanding of how could that could be improved. Jenny appreciated when substantive fill rate was low it added an additional pressure on staff and would consult with Ellie Monkhouse about reporting agency and bank fill alongside substantive fill rates.

142/23 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.

Belle advised the Divisions had continued to demonstrate improvements with pace. The number of actions with assurance ratings had increased and a paper submitted to the CQC in the month.

The Committee were asked if the appendix with details on specific actions that the Divisions were taking was useful and Belle was interested in feedback as to

whether she should continue to provide this as it did increase the size of the report.. Fiona Osborne said that she found the appendix really useful. Although it increased the size of the report she asked that it continued to be provided. The Committee were supportive of that. Kate Wood thought it was a really good addition to the report but asked how the NEDs and others felt about that being included as an addition to an already very long report. The NEDs present thought it was the right approach and appreciated it. Belle added that the Divisions were still very engaged in working with Belle to provide this information.

Fiona Osborne said the actions seemed to be progressing in a very measured way but asked if there was anything that concerned Belle. Belle hoped she had managed to articulate that a couple of actions were not quick wins and would not get signed off as quickly as initially thought. There were some actions that required financial funding but until the business case/business plans for the Divisions were approved those dependent actions could not move forward.

Belle Baron-Medlam left the meeting at 2.55pm

143/23 Key SI update including Maternity

Richard Dickinson referred to the report distributed which was taken as read and highlighted the key points.

There was a very tight process in place for managing incidents which was evident through the action plan that illustrated there were some good processes and controls in place to keep things on track. Another thing to consider was that until the investigations were completed we did not know the full story.

Fiona Osborne was assured it was managed well.

144/23 CLIP Report including Annual Report

Richard Dickinson referred to the report distributed which was taken as read and highlighted the key points. Richard felt the report needed refreshing and had already challenged a few things in the background but Richard thought it needed a whole new approach. All topics were integral so it was a case of understanding why some were more important than others. Fiona Osborne advised that she and Richard had spoken about progressing the report but it was anticipated the new report format would be ready in six months' time and would align with PSIRF. The next report would still look different as would be part of the PSIRF plan and needed to be continually refreshed rather than waiting six months. Fiona had requested in the refresh that the new report references progression from the last report and specific plans for the next period.

Sue Liburd commented that having read the PALs quarter four themes communication kept emerging and asked if there were effective routes to be able to create that change possibly through quality improvement. Richard could not fully answer that as it was not his service but from a historical point of view in different organisations communication was usually the most common theme but that did not mean it should be ignored, the focus needed to be maintained and that message should be fed into the divisions.

Jenny Hinchliffe added that the Patient Experience Team and Patient Safety lead did provide feedback through newsletters etc and tried to target if the issue was around treatment, discharge etc and then focused on that in the huddles so it was continually being addressed.

145/23 Potential Deviations from National Documentation

Richard Dickinson advised there were not any deviations to discuss.

146/23 PSIRF update

Richard Dickinson referred to the report distributed which was taken as read and summarised the key points.

Richard had structured the report slightly different as wanted to highlight steps had been taken to try to get a better way to manage expectations. One of the anxieties in the teams was around the time taken for investigations and the SEIPS model was designed to assist and give a clear roadmap. Page five of the report included a series of questions that could be used as prompts.

The supplementary documents for this item included a case work mapping visualisation document. Richard noted that the Trust was nationally required to record some things, but also had to give priority to other organisations i.e. child death reviews.

Page six was about the Patient Safety Incident cause groups. The areas ranked yellow needed further refinement to get the details. Richard had a meeting planned with the Ulysses team to look into that further.

Fiona Osborne liked the SEIPS model as it was a variation of a standardised business analysis tool. Fiona asked about training support for the teams as the model guided the questions but the difference in the robustness of answers could be vast and the person posing the question will need guidance to drill further if necessary. Richard advised he wanted the Risk and Governance Facilitators to become more active in this tool to try to get that level of detail. The rest was about effectiveness and enabling people to learn from one another.

Fiona noted there were lots of fields that they were close to deadlines. Richard knew there were some further updates for the next report so it would be more detailed but they had certainly moved on from where they were. Fiona thanked Richard for moving plans forward significantly.

147/23 Mental Health Act and Strategy

Kay Fillingham referred to the report distributed which was taken as read and summarised the key points.

Kay apologised for going out of sequence with reporting groups coming to this Committee first. The pressures were very important to be aware of for children and mental health and the increase of that within our acute trusts and as well as the national picture.

Kate Truscott thanked Kay for the paper and commented that having read the report there seemed to be an issue around documentation and Kate was concerned to read the Trust cold potentially be detaining people without legal documentation as a result of that. Kay gave assurance that the correct reporting was in place through board reports etc, but the challenge was always there to complete documentation fully and in a timely manner. The team were focussing on looking at some teaching and were in the process of arranging for some to be held on site. As well as looking at training from a medical side, sometimes it was around the admin side, it tended to be a mixture but it was challenging and staff changes were quite rapid. Kay is planning to meet with Matrons and sites to look at how to improve that mixed approach and recurrent training.

Kate Truscott looked forward to seeing the results from that training in the next six monthly report. Kate Truscott noted that one person had been on a ward for 162 days. Kay thought people may have been originally detained under the mental health act i.e. eating disorders but the process to get a suitable bed was quite a challenge. CAMHS and eating disorders were always a challenge so it was not necessarily all for the same thing.

Fiona Osborne noticed that at GDH the report mentioned there was no application of the Mental Health Act and asked if that was what they expected. Kay confirmed it was expected.

Fiona noted that with Eating Disorders there was a difference in how age groups were assigned between the two local authorities. She asked whether under the guidance of the ICS, was there any desire for the two PLACE partners to align their policies. Kay advised they were working towards MEAD guidelines it was about pulling all that together. RDASH were looking to pull together their eating disorder service but North and North East Lincs would not have a specialist eating disorder resource. It was early days but positive that they were going to make progress.

Fiona thanked Kay for the report and said she thought the report was really thorough. Fiona asked if for the next report if it could include a sense of what the actions and plans meant to the patient, describing more of their journey through the service. Kay would include them in the next report.

With regards to the improvements Kay mentioned that the data was only up to January of this year so the data used for this report was slightly behind.

Kay Fillingham left the meeting at 3.31pm

148/23 Annual Clinical Audit Programme 2023/24

Fiona Moore referred to the report distributed which was taken as read and discussed the comments.

This report had already been taken to QGG this month which was a change to the reporting programme.

The CQUINS business case was awaiting additional resource, the resource did have to end but Fiona Moore had been given provisional go ahead for one band five post who would be allocated for CQUIN support.

Improvements were being made to the data analysis and reporting, now using pivot tables and ensuring the data quality inputted at the beginning was accurate. Clinical Audit would be more check and challenge and would work across divisions with one data analysis and one data collection for all divisions to keep it streamlined.

Fiona Osborne referred to the number of clinical audits for Medicine and Surgery and wondered how much resources it would take to deliver those and what impact this would have on their work. Fiona Moore explained that the report did not give a break down of the number of audits assigned to each division. What the programme did not show was that the number of audits in Medicine was comparable to Family services.

Richard Dickinson highlighted that they were also trying to ensure digital solutions were available, which was a challenge. The team were also doing a lot of work to manage the national audit as well. there was the risk of exposure for audit alerts and looking at physical records rather than electronic so wherever possible they were having a bit of time to ensure checks as well as physical checks.

Kate Truscott thought this was massive but it was good to see the clinician interest as well but wondered where if there was any freedom in the approach to assess the risks. The report was structured but it came down to if divisions supported them it would go the Forums and if the weight was sufficient they would try to prioritise.

Fiona Osborne agreed this report was really useful. She requested in the next report that it highlights where the risks were and how those risks were being mitigated.

149/23 BAF – Quarter 4

Fiona Osborne referred to the document distributed which was taken as read. She stated that the BAF was owned by the Executive Leads Kate Wood, Shaun Stacey and Ellie Monkhouse who had carried out a review looking at the content in detail. This item gave the opportunity for the NEDS to have a look and ask any questions.

Fiona Osborne asked how comfortable the Execs were with the risk rating at 31st March 2024 as a reduction in the next 12 months from a likelihood of 3 (overall risk rating of 15) to a 2 (overall risk rating of 10) with the significant challenges in the overall healthcare environment might be extremely challenging. Kate Wood commented she did not know any health care in place without any risk at all and reach a rating of ten would be a challenge and did not think it could be achieved.

Richard Dickinson thought this document needed refreshing and suggested for some of the key components to be broken down about how great care is delivered. Richard welcomed the change in score but thought it was unrealistic to expect to improve it to that level suggested.

Sue Liburd echoed the sentiment, it felt aspirational and unrealistic to get us to a ten and it needed reviewing as was not working for the Committees.

The Committee recommended the risk rating remained at 15.

Highlight reports

150/23 Quality Governance Group (QGG)

The report was taken as read. Richard Dickinson added that the QGG report included the revised ToR for QGG for information however it was pointed out that the ToR needed to go to TMB for approval rather than this committee.

151/23 Mortality Improvement Group (MIG)

The report was taken as read.

152/23 Patient Safety Champions Group (PSC)

The report was taken as read.

Items for information

153/23 Quality Governance Group (QGG) minutes

Distributed for information.

154/23 Mortality Improvement Group (MIG) minutes

Distributed for information.

155/23 Patient Safety Champions group (PSC) minutes

Distributed for information.

156/23 Any Other Business

None raised.

157/23 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.

- Escalating of the Quality and Safety Committee terms of reference
- Maternity voice particularly about the lead risk to CNST
- EoL highlighting that the Committee supported divisional engagement at the EoL meetings
- The Committee received the Annual safe staffing review report
- Quality priorities measures need defining but there was a resource issue and needed support for the Information team.

158/23 Meeting review

Not discussed

159/23 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 20th June 2023
Time: 1.30pm – 4pm
Venue: Virtual via MS Teams

The meeting closed at 3.58pm

Annual Attendance Details:

Name	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023	April 2023	May 2023
Michael Proctor	✓	✓	✓	✓	✓									
Michael Whitworth														
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maneesh Singh	✓	✓	✓	✓	x	✓								
Dr Kate Wood	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	x	✓	✓
Ellie Monkhouse	✓	✓	✓	x	✓	x	✓	x	✓	✓	✓	x	✓	x
Dr Peter Reading	x	✓	✓	✓	x	x	x	x	✓	✓	x	x	x	x
Shaun Stacey	✓	x	x	x	x	✓	✓	x	x	x	✓	x	x	x
Susan Liburd							✓	✓	✓	x	x	✓	✓	✓
Kate Truscott							✓	✓	✓	✓	✓	✓	✓	✓

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 20 June 2023 from 1.30pm to 4pm
Via MS Teams

Present:	
Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Kate Truscott	Non-Executive Director
Sue Liburd	Non-Executive Director
In attendance:	
Mr Kishore Sasapu	Deputy Chief Medical officer
Mel Sharp	Deputy Chief Nurse
Shaun Stacey	Interim Chief Executive Officer
Richard Dickinson	Associate Director of Quality Governance
Lydia Golby	
Nicky Foster (item 168/23)	Deputy Associate Chief Nurse, Midwifery
Fiona Moore (item 169-70/23)	Head of Quality Assurance
Simon Priestley (item 170/23)	Chief Pharmacist
Jo Loughborough (item171/23)	Patient Experience Lead Nurse
Vicky Thersby (item 172/23)	Head of Safeguarding
Belle Baron-Medlam (item 174/23)	Interim Inspection Compliance & Assurance Manager
Ian Reekie	Governor (observing)
Laura Coo	PA to the Chief Medical Officer **(minute taker)**

160/23 Welcome and Apologies for Absence

Apologies for absence were received from: *Ellie Monkhouse (Mel Sharp to rep), Dr Kate Wood (Mr Kishore Sasapu to rep),*

161/23 Opening remarks

Fiona Osborne welcomed members to the meeting and advised that the CNST update had been deferred to July. The year five requirements were published at the end of May and there was not sufficient time between publication and the paper deadline to perform a gap analysis and develop an action plan. By deferring to July the Committee would receive a meaningful report. All other papers would be taken as read and attendees would be asked for a two minute introduction of their papers emphasising any key points before moving on to questions.

162/23 Declaration of Interests

There were no declarations of interest related to any agenda item.

163/23 To Approve the Minutes of the Previous Meeting held on 23 May 2023

Page 5 – grammatical error in the second sentence of the first paragraph, 'as the' needed to be removed from the sentence.

The minutes were otherwise accepted as an accurate reflection of the previous meeting.

164/23 Matters Arising

Fiona Osborne reported that in the last Highlight report to Board, the committee had requested a Board review of agency and bank usage in terms of the impact on patients. In addition the Finance and Performance Committee recommended a review in terms of finances and the Workforce Committee recommended a review in terms of staffing levels. As a result a Board review had been arranged following the Board meeting on 1st August .

165/23 Review of action log

137/23 Maternity Safety Oversight Update – Richard Dickinson had taken an action to ensure the data in the reports was consistent but had not met with Nicky yet as she had been on annual leave. Richard had conversations with Jenny Hinchliffe outside of that for a support point of view. The timing of the meeting and report contributed to the disparity last time. **Action closed.**

137/23 Three year delivery plan - Sue Liburd requested this information but had not had the update although Sue was aware that activity was taking place. Action date to be changed to July for an update.

137/23 Safety mailbox section in the Maternity Report to include mitigations for unresolved actions - mitigations had been put in place but were not included in the report. Action date to be changed to July for an update.

139/23 Annual Safe Staffing Review - Referral to the Finance and Performance Committee to understand how nursing establishment changes would be dealt with including bed reconfiguration. Fiona reported that this was on the Finance and Performance Committee agenda for June. Action date to be changed to July for an update.

Regular Reports

166/23 PSIRF update

Richard Dickinson referred to the report distributed which was taken as read and summarised the key points.

Work had been ongoing in preparation for implementation and other aspects in line with the project. Richard had met with the Medicine team as they were anxious about the level of burden this would bring, they were now clearer on what was expected of them and as a result there was now more engagement from the team.

Discussions were ongoing with all teams due to undergo changes and Richard would be attending the next Senior Leadership Council meeting.

Kate Truscott commented that looking at the report everything apart from one thing was on track and that was in regard to patient safety partners. Richard explained that was a national standard that came out and some work had been done in the Trust. Angie Legge had written a policy before her departure and did some work to progress recruitment. There was a selection process that did not really conclude and at that point it subsequently stalled. When Richard first started in post he had been trying to establish where they were with this. Richard was due to meet with two people within the week which would not be an interview but more of an informal approach and would take it from there. Richard did not think this was a critical to the project and would not hold things back.

Fiona Osborne commented that the first key risk of identifying and releasing staff to undertake training was also highlighted in the QGG report and asked if that was something that Richard needed Committee support on. Richard explained it was a risk area and some Divisions had agreed plans and some were trying to work through what they needed to do. Richard had engaged with the Divisions and had made remedial steps in the right direction.

Shaun Stacey thought it seemed that generally Richard was making some marvellous progress but there were some key things that Shaun thought needed to be brought back to the operational meeting, where the ‘problems/issues were Shaun though we needed to be careful about the pace of change and to ensure it did not disengage staff which was why Shaun thought it would be a good idea for Richard to attend another Operational Management Group as the more managers that really understand this, the better.

Action: Richard Dickinson to contact Shaun Stacey to arrange to attend an Operational Management Group (OMG).

167/23 CNST Update

Item deferred to the July meeting.

168/23 Maternity Safety Oversight (including Ockendon & metrics)

Nicky Foster referred to the report distributed which was taken as read and highlighted the key points on maternity staffing and the maternity plan.

- The Midwifery vacancy rate demonstrated a slightly improved picture in May.
- Seven international midwives had commenced in post
- Had recruited to the Maternity audit and compliance manager posts
- The Maternity matron post at DPoW had been appointed to
- Head of Midwifery and Deputy Governance Lead posts were in the recruitment process

Maternity sustainability plan

The Trust was moving towards the exit of the Maternity support safety plan. The gap analysis and assessment tool had been amalgamated. There were 15 ongoing actions and seven completed actions.

As identified in the Diagnostic review the Trust had achieved most of the actions. The Exec team were supporting and the board were kept up to date. Actions were monitored through the Divisional Governance Group and Trust Board.
This paper was a work in progress so Nicky was happy for any comments on how she could improve in providing assurance to this Committee.

Fiona Osborne noticed there was some duplication that crossed over with the nursing report and SI report and requested that the Committee to take any maternity questions in this section to ensure having the benefit of Nicky's expertise.

Sue Liburd asked now that the year five CNST requirements had been released how big the gap was between year four and five . In response Nicky advised they were currently in the process of benchmarking that and would bring the update to July.

In relation to triaging, the report stated there were a couple of challenges, Sue asked if there was a sense or timescale of when this service would be implemented. Nicky thought it would be August, there were in discussions with Unison and Simon Nearney and had a meeting planned with Estates and Facilities. To give reassurance Nicky noted they were continuing with the QI project so nothing had slowed down or stopped.

From Fiona's perspective, this was only the second report from Nicky and Fiona felt that the report had vastly improved. She requested a further improvement by updating the executive summary to direct the Committee to specific areas of improvement or concern. For example under the maternity safety champions there was an escalated issue regarding non-clinical tasks that was eating into other duties but was not included in summary. Nicky clarified that the issue was that Managers across the Trust had 15 hours for management time and one of the maternity managers had raised that she thought that was not enough time so Nicky needed to discuss it with Ellie Monkhouse.

Fiona asked what mitigation was in place for the Maternity Voice Partnership (MPV) Lead as the Committee had highlighted this to Board on the basis of the presentation in the May report. However it was reported at the Board meeting, that the services had adequate mitigations in place and lack of recruitment to this role would not mean a financial or reputational impact. Nicky explained that the mitigation was with the MPV lead from LMNS, the role was needed because of the risk to CNST. They had met with the leads to discuss funding and needed to agree on days for this post so it was ongoing.

Fiona referred to the Safety Mailbox action on the action plan as noticed that some of the text could not be read. For example stores cages blocking doors and another about tiles falling off the wall in sluice. Nicky would find out the detail and feedback at the next meeting.

Kate Truscott asked about the licenses on fetal monitoring as there was a problem with somebody being off on long term sick. Nicky confirmed that had been the case but the member of staff had returned to work so it was no longer a problem.

Shaun Stacey made an overarching comment that he thought it was good that Nicky had picked this up and demonstrated a good knowledge of the service. Both Shaun and Fiona thought Nicky was an asset to the service and looked forward to Nicky being in post for at least the next six months.

Nicky Foster left the meeting at 2.03pm

169/23 Mortality Deep Dive

Fiona Moore referred to the report distributed which was taken as read and highlighted the key points. The report reflected the requirements set in the national standards but going forward quarterly reports would be produced with an explanation of what the results meant to the services. When they were reporting against the data they would then look further into the services. Currently increases were explainable due to influenzas and pneumonia so there were no areas of concerns that needed further investigation or intervention.

Fiona reported that NLaG had maintained their SHMI score and seen a month on month improvement. The Trust continued to learn from SJRs and embedding the practice. A lot of the work tied in with EoL as a lot of the themes came from not recognising EoL sooner so they were linked.

Kishore Sasapu added that the mortality report was focused firstly on the SHMI and markers but noted the SHMI was not a marker of care provided but could highlight where there was a problem. One problem highlighted patients who were discharged and passed away within 30 days of discharge this suggested that patients were coming into the hospital who were already on their EoL pathway and very ill. Kishore explained not every death required an SJR. The Trust tended to see quite a lot of patients coming back to the hospital in their last three months of life, which might be a marker to see how the advanced care planning and respect markers were working. The Medical Examiner role was to scrutinise deaths in the Primary and Community areas this was brought in for independent review, in hospital in the first instance but was moving slowly into the community.

Having read the report Fiona Osborne thought it was excellent, the report showed themes coming from deaths, work from avoidable hospitalisation, KPIs and any learning from the Medical Examiner process.

Sue Liburd asked about the 12 month still birth rate, it had reduced but in terms of the learning was there an idea of why that was decreasing. Fiona Moore had already put that question back to Family Services and was waiting for a response. Kishore noted this was brought up in the Mortality Improvement Group (MIG) meeting and Dr Bolaji presented the data. There was a big spike in still births across the country during Covid time but nobody could understand why. NLaG results were not an outlier in terms of the data. Being aware of the reasons leads to improvements and most of the still births were linked to education, but that spike was linked to covid times.

In a similar way Richard Dickinson was going to say the data correlated with the national picture. HSIB, saving babies lives etc correlated with this.

Kate Truscott referred to the 68% of SJRs that had an overall rating of good or better and thought it would be good to see over time how those changes were assessed and how all of the work was completed for each of the workstreams. Also needed to consider where this needed to be seen so that Fiona Moore did not have to duplicate reports. Fiona Moore explained that the 68% was for the SJRs that had an overall rating of good and adequate care. When those were broken down into phases of care there was not a section that was standing out, which was positive that one particular phase of care was not standing out as a problem

Richard Dickinson referred to a point Kate Truscott had made about all the different information reporting to different places and was hoping that whilst producing this report we could identify there was some action taken and make that link, with our range of quality improvements and other developments in the organisation in terms of QI there would be other avenues to thread that in. Fiona Osborne asked if Richard was confident they could collate the information from the different sources. Richard explained there were a series of groups and PSIRF had a plan trying to line up and collate the information in a helpful way to thread it through different workstreams. Richard thought was a stepping stone in getting things more aligned.

Kishore added that PSIRF was one base that the learning might be based on. With regards to trends in learning from deaths, they were not seeing any related to poor care. The reviews were all showing adequate care but it was that bit between good and adequate care, which was difficult to assess. That was where the input from the people carrying out the SJR reviews was helpful, needed to know what was the theme i.e. could we improve on IV fluids, nutrition etc that was how we would improve.

The Committee approved the proposal and looked forward to further updates.

170/23 Quality Priority 1 – Medication Safety

Simon Priestley referred to the presentation distributed and highlighted the key points.

Simon informed that the way this was audited going forward would be changing. Previous audits had been manual audits of 40 patients per month on IAAU but a different way to audit the ePMA data had been identified. A report had been developed that would provide more accurate data and identify the areas where more targeted support was needed. Recent changes meant they had already started to see improvements in performance with 56% of patients admitted to IAAU having their actual body weight recorded on ePMA or WebV. They were currently exploring a robotic process that would mean the weight would be entered once and automatically transferred between WebV and ePMA which would be the ideal.

Kate Truscott agreed doing something once spread out amongst the many was a good approach but asked if it would be six months or a year for the robotic approach. Simon did not have timescales yet but would provide regular updates.

Simon invited any comments or questions.

Sue Liburd referred to the alert response and fatigue noted under issues on the presentation and asked whose responsibility it was to record weight and was there

an education piece for staff to follow. In response Simon informed that there was an element of it being everybody's responsibly but primarily it was the Nurses but when it came to prescribing the Clinicians have to ensure the weight is correct.

Kishore Sasapu thanked Simon for his very diplomatic answer but asked when he was prescribing and realise the weight is not there, how do the Pharmacists check weights. Simon explained the Pharmacists looked into weights, contacted the clinicians, and utilised EPMA. The process could be improved as there are still many places in the Trust where EPMA is not available. ePMA was being rolled out in line with the scopes, there were plans to roll it out further. There had been issues with rollout in ED and it had not been signed off by the company to use in Paeds and Neonates. A workshop had been arranged in the next few weeks where they would be looking at how this could be embedded into the wider digital strategy.

Kishore Sasapu confirmed it was the hardware as well as access to the hardware which was a problem and that was already being picked up through the digital teams. Fiona Osborne referred to page five of the report and suggested adding EPMA to the list of issues. Kishore agreed that escalation to EPMA needed to be looked at.

Fiona asked what the escalation was if prompts from ePMA to record weight were ignored. Simon confirmed that the system did allow staff to override the weight and there was no evidence to suggest that multiple prompts had been ignored in the past so that had not flagged as an issue If there was not a weight recorded the EPMA would continue to prompt.

Fiona asked how the success of Quality Priority would be measured as not all medications required actual weights to be recorded so when it came to the measurement of success it was only a small proportion of drugs that needed a weight. Simon explained that when you got to the point of prescribing that was not the time to be going back for a weight so it should be a standard to take the weight. The number of recorded actual weight is the most appropriate measure of success.

Fiona Osborne referred to page six headed "Support Required" and asked if this Committee needed to provide that support. Simon thought these were generally being progressed with this being the first report to the Committee and having the headlines he was looking for additional support but not from this Committee.

Simon Priestley and Fiona Moore left the meeting at 2.42pm

171/23 Patient Experience & In Patient Survey

Jo Loughborough referred to the report distributed which was taken as read and highlighted some key points.

Positives - the PALs complaints position was the lowest it had been since Jo had been in post. The roles had been spread out which allowed increase oversight and working across the divisions. The Patient Experience Manager post was temporary and due to finish in August which Jo thought was a risk.

Jo reported improvements in learning from complaints. The team had gone live with the learning log which had an element on Ulysses to ensure that what they had learnt from the complaint was meaningful.

National survey update – the action plan was a very dynamic action plan. The ED survey was a static picture compared to the 2021 survey with some minor shifts from 42nd to 30th place that was reflected in some of the high scoring headlines. Jo explained the Trust had made exceptional progress from 2021-22. The Trust was first in the last report but had dropped significantly in the latest report but Picker had said that was to be expected as the Trust had we made such improvements last time. Proposal to create an insight programme about experience in ED was very reliant on the Patient Experience Manager being able to support that.

Jo invited any comments or questions

Kate Truscott asked about PALs complaints as the trend always tended to be communication and education that needed to be looked at. Jo explained the team were improving how they involved patients and families which would significantly improve complaints and PALs. Jo thought the visiting review was a good step forward with how our visiting was managed and in ensuring families were consistently involved.

Shaun Stacey commented that one of the biggest reasons people did not get home in a timely manner was because we did not understand what was going on at home, the older and frailer we get the more we want to protect our independence and for families struggling to cope with long term illnesses it would be much easier to bring in the families. It was a good report and Shaun looked forward to seeing the outcome from that visiting survey.

Referring to what Jo had said about the Patient Experience Manager and the risk associated with the post only being funded until August Sue Liburd asked what they were going to do afterwards from an assurance point of view. This was a critically important role and function and Sue thought this Committee needed some assurance about how the team would provide continuity after August. Mel Sharp had concerns too but unfortunately the Exec team did not approve the business case. With the Patient Experience Manager in post everything had improved including the positive position on complaints responses, the post had already been extended to the end of August. Mel met with the Finance Manager to see if they could find the monies as was concerned that it was a risk to complaints, PALS and FFT but to no avail. Jo added that the post had brought the Trust to a level playing field and they were in the process of writing a paper highlighting the risks to the organisation.

In his new role as Interim Chief Executive Shaun Stacey would take some accountability for this with the Exec team but would definitely try to move this on.

Action: Shaun Stacey to refer mitigating the Patient Experience Manager post to TMB

Fiona Osborne queried how Carol's Campaign was progressing in the Trust. Jo responded that Carol's Campaign was really responsive and the next phase was to

go through sharing more widely. So far, it had been very successful and very worthwhile.

Jo Loughborough left the meeting at 3pm

172/23 DoLS & Safeguarding

Vicky Thersby referred to the report distributed which was taken as read and highlighted the key points.

- The recent Ofsted inspection in N E Lincs identified that the senior leadership team had strengthened, which was positive.
- Had reduced the backlog of consent forms and the children could now have their assessment forms done in a timely manner.
- Liberty protection was delayed until after the next parliament which could be 2025.
- Change in place for facility was progressing during the week.

Vicky reported that adult safeguarding data was increasing which was positive as it demonstrated good awareness but the number of section 11's was increasing which was a concern.

The Safeguarding Children's Team had been working on some quality improvement work for the non-mobile baby development, processes were more in parity. The team had identified there was not one in place in N E Lincs so reviewed that with the ED department and set up an urgent response working group.

Over the last 6 months the Trusts Safeguarding Training compliance had slowly increased. The Trust had met its target of 90% in level one and 85% in level two adults and children/ Prevent level one and two and FGM. All other training was below the Trust target.

The team were getting access to the GP registers, had spoken to IG and linked in with RDASH but that was more of a process issue. RDASH had access to the learning disability registers already but the could be a blockage for N E Lincs as that was N Lincs.

The Safeguarding team had been nominated for an HSJ award which Vicky was really proud of.

Fiona Osborne referred to section nine about SystmOne and asked what the challenges were. Vicky explained that not everybody had opted to go onto SystmOne, there were two different systems EMIS and SystmOne but the same approach would be used for both, our Information Governance Lead Sue Meakin was exploring options.

Vicky reported that there was an issue with read codes and was found that there were potentially 2500 people that had mild learning difficulties who were not on that register which was the first focus for the ICS.

With regards to the system information Lydia Golby thought it might be helpful to link in with the LeDER work and from the N E Lincs perspective Lydia would be happy to help Vicky moving forward with that.

Action: Lydia Golby to email Vicky Thersby with the LeDER details

Fiona asked if Vicky was comfortable with the mitigations in place for the roles that had not been approved in the Business Planning process. For the non-mobile baby, Vicky thought it was absolutely key to mitigate as much as possible. Vicky could pull somebody from another role to cover but then that role would suffer and put more pressure on the team.

Fiona Osborne thought the report was excellent but asked for next time if the executive summary could include the points Vicky had raised at the beginning.

Vicky Thersby left the meeting at 3.13pm

173/23 IPR

Mel Sharp referred to the report distributed which was taken as read. Mel advised that the number of reported pressure ulcers had increased, there was a slightly higher percentage of adult observations recorded on time and the trust was back to 100% for duty of candour. The number of falls had increased but Mel was not unduly concerned from an organisational point of view. Richard Dickinson thought it was positive that there was normal variation with our falls data.

MRSA bacteraemia whilst over target last year we were still one of the best performing trusts in the country for MRSA bacteraemia cases.

Kishore Sasapu added that when it came to recording observations the trust was not doing so good with the escalations but believed that would be picked up through PSIRF. The strides the Trust had made were phenomenal as we can see where we went wrong. Richard agreed with Kishore it was a working project and could look at the deteriorating patient. Richard attended a webinar the previous day and they picked up on deterioration, nationally they were seeing education being the biggest risk and escalation being the second. They also talked about a model called ‘Piers’ which was about the prevention of deterioration and Richard planned to pick that up with Debbie Bagley.

Fiona Osborne referred to the comment with regard to falls that ‘support would be provided’ and asked what that meant. Mel confirmed the support would be bespoke to certain areas for example QI were going into a whole Ward and looking at the area and how that worked. Bespoke solutions would be provided for the unique issues identified. Mel reported at that they found that whilst initial assessments worked the reassessments did not so she had a team going to look at that.

174/23 CQC Framework

Belle Baron-Medlam referred to the report distributed which was taken as read and highlighted the key points.

A few actions had gone up in assurance stage, a number of the actions that we had limited assurance on had progressed to the next level.

There had not been any significant changes to the actions that related to this Committee since the last meeting.

Belle invited any comments or questions

Fiona Osborne mentioned the business planning applications, Med15 and Med08 were awaiting that outcome as the Operational and Financial Plans had been approved by the Trust and the ICS so the decisions should be available. Belle explained that the business planning application in question was an application to purchase the same temperature monitors that the fridges had for the full Trust, however Belle did not think it had made the short list so had to go to a plan B mitigation which was a cheaper thermometer that would be placed in the rooms and relied on a person led way of checking. Once they had that formal feedback from the Chief Pharmacist they would move forward with that. Shaun Stacey thought it might just be report timing as everybody should have had the outcome for their business cases so if Simon Priestley did not know, Shaun suggested for Belle to speak to Ashy Shanker.

Belle Baron-Medlam left the meeting at 3.35pm

175/23 Nursing & Midwifery Assurance Report

Mel Sharp referred to the report distributed which was taken as read.

Community nursing vacancies were the lowest for over a year which was down to the bespoke recruitment and the staff in community were already starting to feel the difference.

C.Diff - the Trust had 24 cases last year against a target of 21. This year the target was 20 which reflected our previous successes but which would be very difficult to achieve. It was noted that the Trust has one of the highest performing results in the country.

Mel invited any comments or questions.

In terms of safe staffing and workforce, Sue Liburd asked how realistic did Mel think it was to achieve that 90/95% target by November. Mel explained they were aiming for the targeted levels, they are currently on target so Mel thought it was possible.

Sue asked about the support for the newly qualified staff. Mel explained they had care camps and the feedback from them was that staff were coming out of them far more confident and prepared. There had been lots of conversations with the staff on the Wards and the CPD team were very visual. They were out on the wards supporting the staff but they were not having any impact at the moment. The CPD staff bring the newly qualified staff back for a review to check on them too.

Kate Truscott noted the sickness absence levels for some of the wards were high and wondered if they were getting the right support from HR and Occupational

Health. Mel knew they had relatively new Occupational Health Nurse who was good and moving forward the telephone triage and referrals forward albeit slowly. He was proactive and encouraging staff to contact him if they had any concerns with coming back to work.

Shaun Stacey commented that the escalation bed numbers should not be included in the report any more.

Action: Mel Sharp to feedback the report change to Ellie Monkhouse

Shaun asked what was driving the increase in required supportive care shifts. Mel explained it was different at SGH to DPoW and they were currently unpicking that. The dependency and acuity of patients had changed, patients were more often than not extremely complex.

Shaun thought an explanation of the filled verses the unfilled would be useful to get an understanding and there were a number of questions unanswered but Shaun thought that overall there needed to be better understanding. Mel pointed out this was from April but there were some challenges with patients and whether to involve families it worked well in some areas.

Fiona Osborne commented that according to the graph there was not an increasing number of requests. The graph showed the overall number of requests were roughly the same as this time last year. It also showed that the Trust had become more successful in percentage fill and the actual volume for shift requests. Fiona stated that she supported the need for more understanding and this may be part of the Agency and Bank review meeting with the Board in early August.

Shaun added that supportive care was a clinical risk and was causing the length of stay to go up as patients were not getting seen soon enough. Shaun's point was why was it happening and were the right qualitative interventions.

176/23 Key SI update including Maternity

Richard Dickinson referred to the report distributed which was taken as read and highlighted the key points.

There was nothing major other than highlighting that there were a number of cases where it would be helpful to give some context relating to Paediatric Audiology. There were three additional cases identified over a two week period so were now up to 17 cases of children affected.

Richard Dickinson was leading the Trusts response to the BAA report and would contact each of the families. Staff needed a fair bit of support and training so they were looking at external placements of staff to get that support. The service was still being covered and was more Audiologist led and there was a lot of engagement but they were still relying on the Audiologist doing bank shifts on a weekend to support NLaG with this.

With regards to the service development if it was helpful Richard could provide a detailed report from the division. Shaun commented that if Richard were to produce

a report it would not be from just one division as it spanned ENT, Surgery and Critical Care as well as Paeds.

Action: Fiona Osborne and Richard Dickinson to discuss how Paediatric Audiology reporting to the Committee would progress.

At the recent Governors meeting Fiona was asked given the issues in Paediatric Audiology that had come to light through an external peer review if there were any hidden risks to patients that the Governors and NEDs were not aware of. Richard Dickinson advised that the immediate actions he took in February was that he contacted an NHSE lead for screening services. They worked through getting information from different services including linking in with other services to set up a screening group so different quality assurance processes were in play. It was recognised that there had been some variance that had been implemented over time. The Trust were getting some positive feedback for their approach and NHSE were assured that no other services had been identified as having problems.

177/23 Potential Deviations from National Documentation

Richard Dickinson advised there were not any deviations to discuss.

Highlight reports

178/23 Quality Governance Group (QGG)

The report was taken as read. Fiona Osborne asked what the status of the action plan was for the neonatal screening mentioned in the highlight report as it was not mentioned in the minutes as they were a month behind. Richard Dickinson explained they were developing a business case for a more streamlined approach, it was not resolved but was work in progress and could be a question to raise with Nicky Foster in the July meeting.

179/23 Mortality Improvement Group (MIG)

The report was taken as read.

180/23 Patient Safety Champions Group (PSC)

The report was taken as read.

Items for information

181/23 Quality Governance Group (QGG) minutes

Distributed for information.

182/23 Mortality Improvement Group (MIG) minutes

Distributed for information.

183/23 Patient Safety Champions group (PSC) minutes

Distributed for information.

184/23 Any Other Business

None raised.

185/23 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.

- Received the Annual learning from deaths report
- Support for mitigation for the Patient Experience Manager to take to TMB
- Current situation on the Paediatric Audiology issue

186/23 Meeting review

Kishore Sasapu liked the format of this meeting; it had been very useful and highlighted the key things to discuss.

Sue Liburd thought the quality of the papers continued to improve so thanked everybody for their efforts.

Shaun Stacey agreed that the quality of the papers was really good which made the debates really interesting.

187/23 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 25th July 2023
Time: 1.30pm – 4pm
Venue: Virtual via MS Teams

The meeting closed at 16:10pm

QSC Annual attendance log

Name	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023
Michael Proctor	✓	✓	✓	✓										
Michael Whitworth														
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maneesh Singh	✓	✓	✓	x	✓									
Dr Kate Wood	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	x
Ellie Monkhouse	✓	✓	x	✓	x	✓	x	✓	✓	✓	x	✓	x	x
Dr Peter Reading	✓	✓	✓	x	x	x	x	✓	✓	x	x	x	x	
Shaun Stacey	x	x	x	x	✓	✓	x	x	x	✓	x	x	x	✓
Susan Liburd						✓	✓	✓	x	x	✓	✓	✓	✓
Kate Truscott						✓	✓	✓	✓	✓	✓	✓	✓	✓

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 1 August 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 Care Hour Per Patient Day (CHPPD) data was 8.9 in May and benchmarks well. There were no wards with CHHPD below 6.0 this month. The overall combined fill rate remains good with May being 97.6% Safer Nursing Care Tool data has been collected in May/June 2023. Increases have been seen again this year in the acuity and dependency of our patients. There is a total of 220.73 whole time equivalent (WTE) (11.62%) registered and 110.58 WTE (11.01%) unregistered vacancies across the Trust as of the 31st of May 2023. Community nursing vacancies are at their lowest for over a year. The midwife to birth ratio in May 2023 is 1:23.9 for Grimsby and 1:20.3 for Scunthorpe which is below the acceptable ratio of 1:28. There has been a decrease in the number of reported falls in May 2023. Three falls were reported with severe harm, no lapses in care were identified. The number of pressure ulcer incidents reported in May 2023 has increased slightly. None of the other higher reporting wards are currently demonstrating any concerning trends. From 1st May 2023, the acute sites introduced a rapid review of all Category 3, 4 and unstageable pressure ulcers. This will result in the majority of incidents being reviewed and closed within 10 working days. New formal complaint numbers were 26 for the month of May and for a third month over 80% of those closed were in timescale. In total, 146 Patient Advice and Liaison Service (PALS) concerns were received during May and open PALS continue to reduce. Improvements are largely felt to be related to the increased oversight from the temporary Patient Experience Manager role. However, there is a pending risk, as this post was unsuccessful in its business case bid and is due to cease August 31st, 2023. Our Friends and Family Test (FFT) provider will now be Healthcare Communications- there may be delays to full implementation of the FFT delivery system due to resource availability, however mitigation is being put into place It is predicted that FFT submissions will be lower during the coming months. There was one mixed sex breach which involved 3 patients. Ten acute 15 Steps Challenges were completed.

	The Trust reported no MRSA (Methicillin-resistant Staphyloccus aureus) Bacteraemia cases this month after the reported base in March 23 which was the first case for over 26 months. For Quality Improvement, 366 of this workforce have been trained at a level of Quality Improvement, in addition 74 Quality Improvement projects have been initiated with 39 been completed showing measurable improvement with 35 still progressing.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Quality & Safety Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	NA	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	NA	
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

Nursing and Midwifery Assurance Report July 2023 (May 2023 data)

1.0 Introduction

This is a routine report in accordance with the requirements of the updated National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance (July 2016), the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014 and Developing Workforce Safeguards (2018).

Trusts must ensure the three components are used in their safe staffing processes:

- evidence-based tools (where they exist)
- professional judgement
- outcomes

The Trust is committed to providing safe, effective, caring, responsive and well led care that meets the needs of our patients. It is recognised that decisions in relation to safe clinical staffing require a triangulated approach which consider Care Hours per Patient Day (CHPPD) together with staffing data, acuity, patient outcomes and clinical oversight. This report provides evidence that processes are in place to record and manage nursing and midwifery staffing levels on a shift-by-shift basis across both hospital and community settings, and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care, thus enabling the Trust to demonstrate compliance with safer staffing guidance. It also seeks to provide information on vacancy rates and nursing metrics across all ward areas.

Oversight continues to be provided to the Quality and Safety Committee on nursing and safe staffing. The changes to ward configurations and zoning throughout the pandemic has made it challenging to make comparisons and benchmark. It is worth noting that this will affect any Model Hospital metric comparisons.

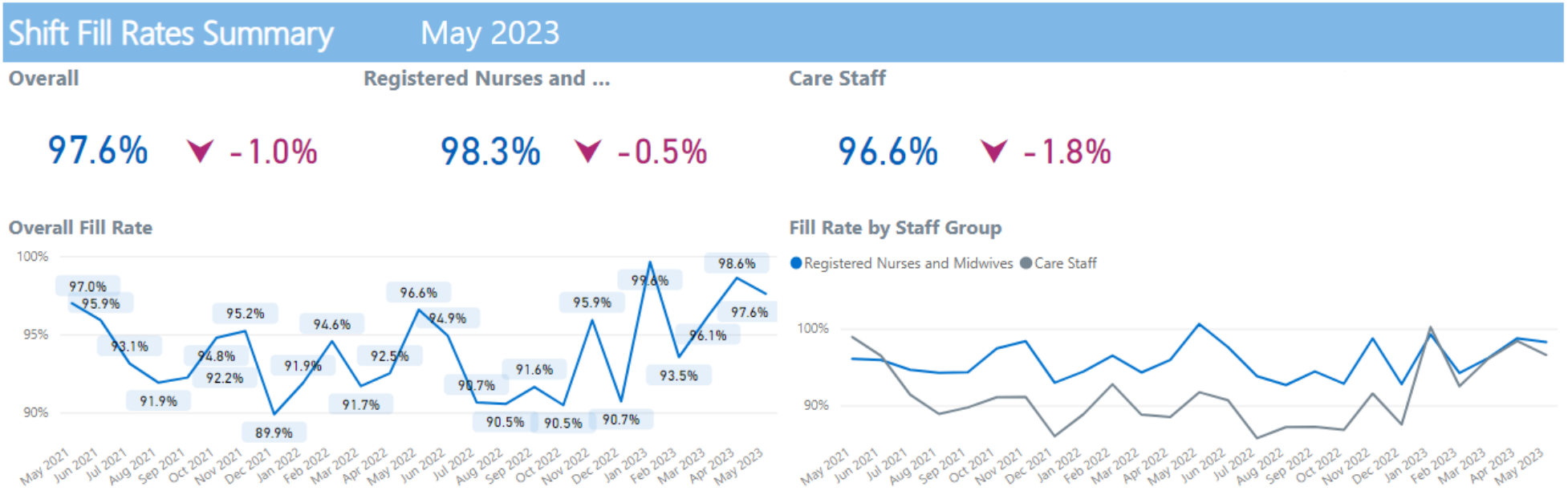
As we continue to reset ward configurations and utilise escalation beds across the Trust, any data should be viewed with caution and for this reason we continue to review individual metrics and apply professional judgement. In line with the document published in February 2021, Deployment and Assurance of Clinical Nursing Workforce during Covid 19 emergency, Quality impact assessments are undertaken with final 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
May 2023	DPoW	98.8%	-0.8%	99.6%	
May 2023	GDH	96.9%	-4.2%	101.1%	
May 2023	SGH	96.2%	-0.9%	97.1%	

Overall Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
May 2023	Medicine	100.0%	1.0%	99.0%	
May 2023	Surgery & Critical Care	101.1%	-4.3%	105.4%	
May 2023	Women & Children's	86.8%	-2.2%	89.0%	

Key – DPOW – Diana, Princess of Wales Hospital GDH – Goole Hospital SGH – Scunthorpe General Hospital

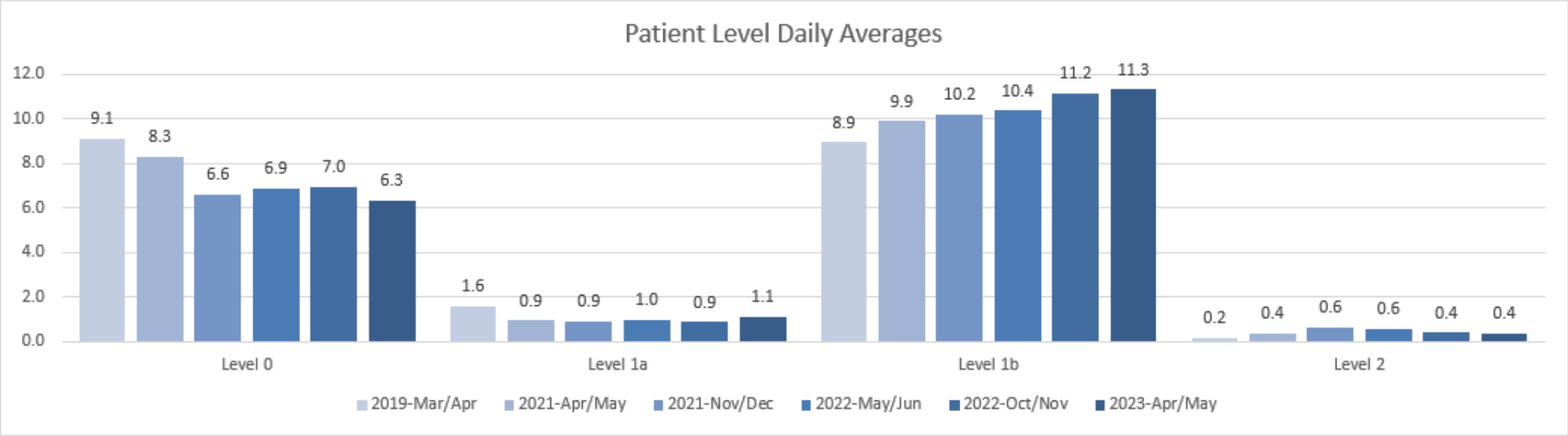
Actual shift fill rates are reported against ward establishments. Staffing reviews take place at intervals throughout the day, including a Trust wide review of SafeCare Live information at 9am.

The graphs above show the fill rate trends from the Nursing Assurance Dashboard for the in-patient wards. The overall combined fill rate remains good with May being 97.6%, a slight decrease from the 98.6% in April.

The combined fill rate for each ward varies from 74.2% to 159% (chart overleaf). Some of this high fill rate can be attributed to those wards that have unestablished escalation beds or patients that are requiring 1:1 supportive care. Ward B4 shows a high fill rate due to not being an established inpatient ward but used for escalation. This ward is now closed as an escalation area.

As part of the Chief Nurse establishment review in 2023, the Safer Nursing Care Tool (SNCT) data was collected during May/June 2023 and will be collected again over 20 days during October to account for seasonal variation and to inform the Chief Nurse Annual Safer Nursing Staffing Establishment Review. Increases have been seen again this year in the acuity and dependency of our patients.

Safer Nurse Care Tool Data 2019-2023



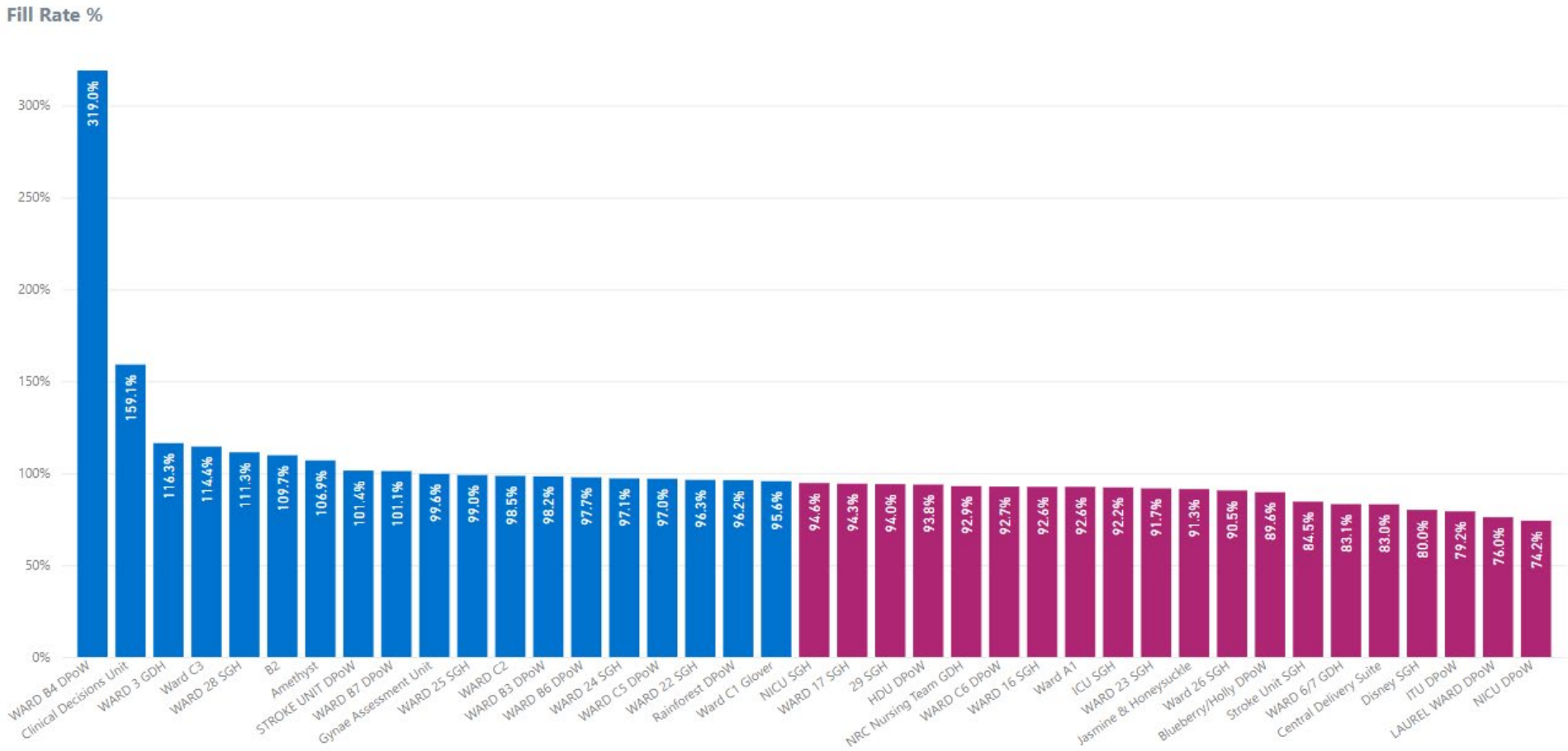
Fill Rate Wards Chart

May 2023

Site: All

Division: All

Northern Lincolnshire and Goole NHS Foundation Trust

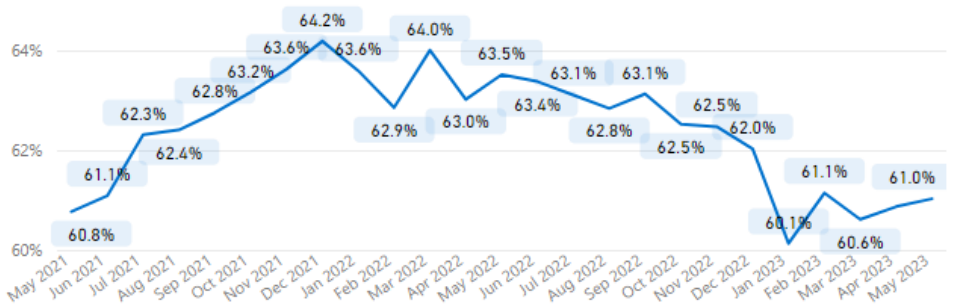


RNMW Ratio Summary May 2023

RNMW Ratio

61.0% ▲ 0.2%

RNMW Ratio



RNMW Ratio by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
May 2023	DPoW	60.0%	0.3%	59.7%	
May 2023	GDH	54.0%	-0.4%	54.4%	
May 2023	SGH	63.2%	0.0%	63.2%	

RNMW Ratio by Division

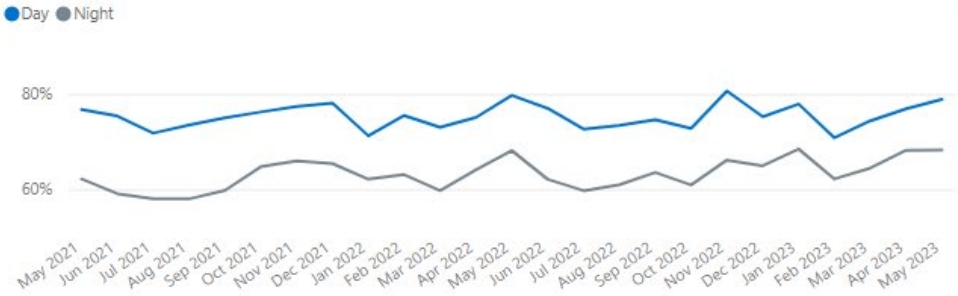
Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
May 2023	Medicine	55.0%	0.2%	54.8%	
May 2023	Surgery & Critical Care	68.2%	0.1%	68.1%	
May 2023	Women & Children's	68.8%	0.3%	68.6%	

A mix split of 60:40 is aimed for, with a higher skill mix for midwifery. Registered Nurse and Midwife to Healthcare Support Worker ratio for the Trust has been above 60% for the last year. Medicine remains the lowest Registered Nurse ratio in May at 55%. Surgery & Critical Care has the highest Registered Nurse ratio and is reflective of the number of level 2 and 3 beds within the division.

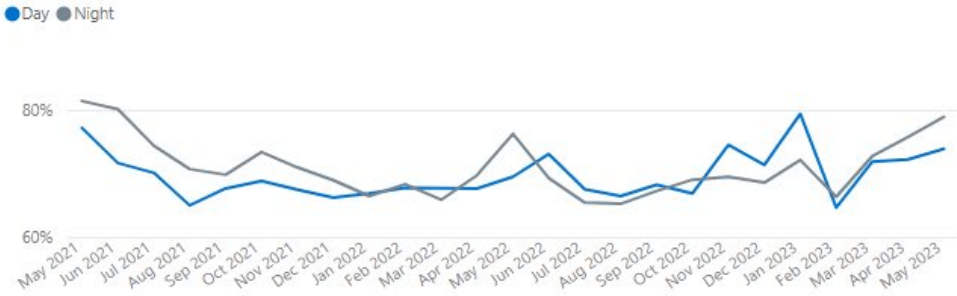
Substantive Fill Rates Summary May 2023

RNMW - Day	RNMW - Night	Care Staff - Day	Care Staff - Night
78.9% ▲ 1.9%	68.3% ▲ 0.0%	73.9% ▲ 1.7%	78.9% ▲ 3.2%

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
May 2023	DPoW	81.0%	1.6%	79.3%	
May 2023	GDH	75.5%	12.4%	63.1%	
May 2023	SGH	76.7%	0.9%	75.8%	

RNMW - Day Substantive Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
May 2023	Medicine	79.1%	3.0%	76.2%	
May 2023	Surgery & Critical Care	83.7%	3.0%	80.8%	
May 2023	Women & Children's	71.6%	-1.9%	73.5%	

Substantive versus temporary staff fill rate is monitored and an increase in substantive staff fill rate is seen for the second month for days and nights for all staff.

KEY – RNMW – Registered Nurse/Midwife

Wards with Substantive Fill Rate Below 50% **May 2023**

Staff	Registered Nurses and Midwives	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
Central Delivery Suite	36.3%	▼ -11.3%

Staff	Registered Nurses and Midwives	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
WARD C6 DPoW	48.4%	▼ -4.9%
WARD 3 GDH	46.8%	▲ 6.6%
Central Delivery Suite	38.9%	▼ -7.6%
WARD C2	37.7%	▼ -14.1%
Disney SGH	36.7%	▼ -18.9%
WARD 17 SGH	36.1%	▲ 8.8%
WARD 16 SGH	24.7%	▼ -28.6%

Staff	Care Staff	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
WARD 25 SGH	42.1%	▲ 2.0%

Staff	Care Staff	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
NRC Nursing Team GDH	46.8%	▲ 8.4%
WARD 23 SGH	43.0%	▲ 4.8%

KEY – NRC Neuro Rehabilitation Centre

Central Delivery Suite (CDS) had a substantive fill rate less than 50% on days however staffing is flexed between CDS and ward 26 to meet the patient needs. On night shifts there were 7 wards with a fill rate less than 50% for Registered Nurses which is the same as April.

Of the 7 wards that had Registered Nurse substantive fill rate less 50%, 3 of these featured in last month's report and are contained in the table below to triangulate with sickness, vacancy and fill rates. None are raising concerns when triangulated with quality and safety indicators.

The information below demonstrates the level of sickness and vacancy in the areas with the lowest substantive fill rate.

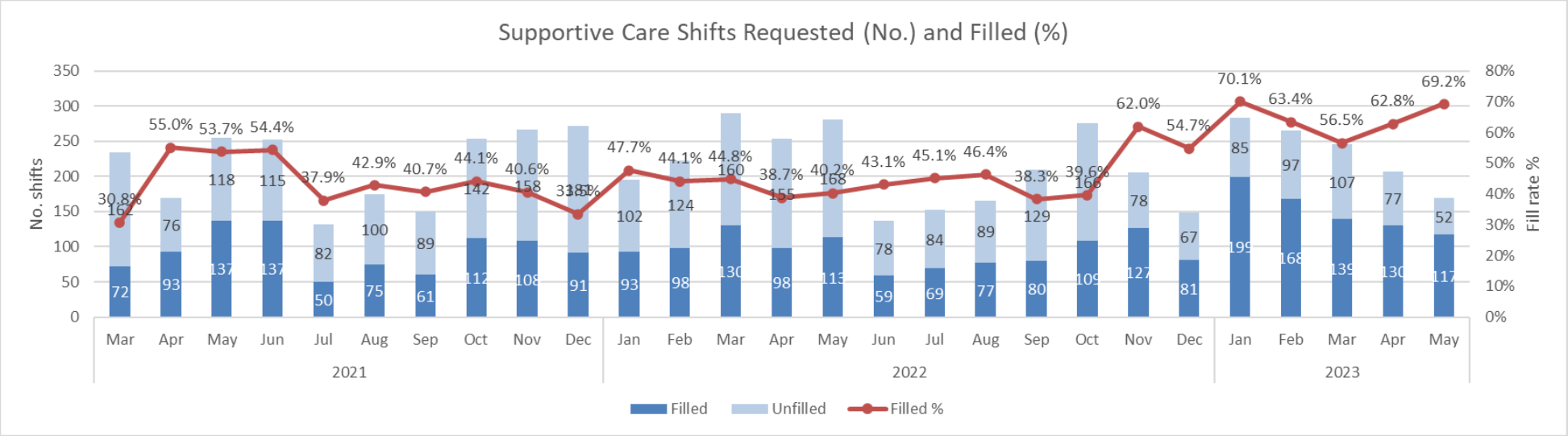
Ward	Sickness	Registered Nurse vacancy whole time equivalent WTE	Healthcare Assistant vacancy whole time equivalent WTE	Overall fill rate days		Overall fill rate Nights		Substantive fill rate Days		Substantive fill rate Nights	
				RN	HCA	RN	HCA	RN	HCA	RN	HCA
Ward 17 SGH	6.79%	7.29	6.28	98.1%	81.4%	100.0%	101.6%	84.0%	58.5%	36.1%	83.87%
Ward 3 GDH	10.37%	1.70	0.25	105.0%	132.3%	111.3%	122.4%	92.9%	125.1%	46.8%	93.55%
Central Delivery Suite	9.40%	0.96	0.17	79.2%	88.8%	80.2%	104.3%	36.3%	82.3%	38.9%	90.32%

Regular bank and agency staff are booked to mitigate the risk of low substantive fill rates.

Care Hour Per Patient Day Summary

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 8.9 in May.The latest model hospital data for January 2023 indicates a provider value of 8.9 (quartile 4 Highest 25%) against a peer median of 8.2 and provider median of 8.1. There were no wards with CHHPD below 6.0 this month.

2.2 Supportive Care



The wards are seeing an increase in the number of complex patients, may with cognitive impairment and several who 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 Avoiding Falls Level of Observation Assessment Tool (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 review patients and risk assessments and provide support and oversight of high-risk patients. 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 six months. Recruitment onto the Bank continues, and it is hoped that improvements seen can be sustained. The number of shifts requested has declined over the last five months and is a result of increased scrutiny and cohorting of high-risk patients where appropriate.

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), ward 27 (n4) and SGH gynae (n2 D2A)– total 21 beds This has an impact on staffing across all areas. Ward 19 and ward B4 are no longer in use as escalation wards.

The graph below shows the monthly bed occupancy at midnight which was the highest it has been in March 2023 and is reflective of the increased use of escalation beds. A slight decrease is seen for May.

2.4 Staffing Indicators

2.4.1 Vacancies

The information presented below shows data on **inpatient wards** only.

Vacancies Summary May 2023

Vacancies - Total

156.4 ▼ -17.8

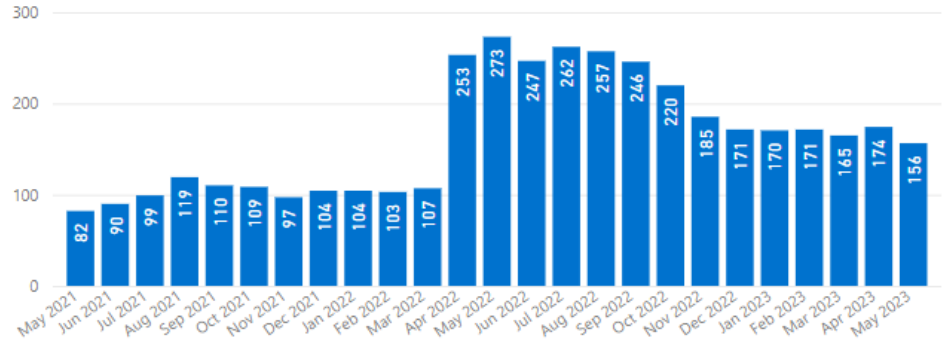
Vacancies - Qualified

96.2 ▼ -9.2

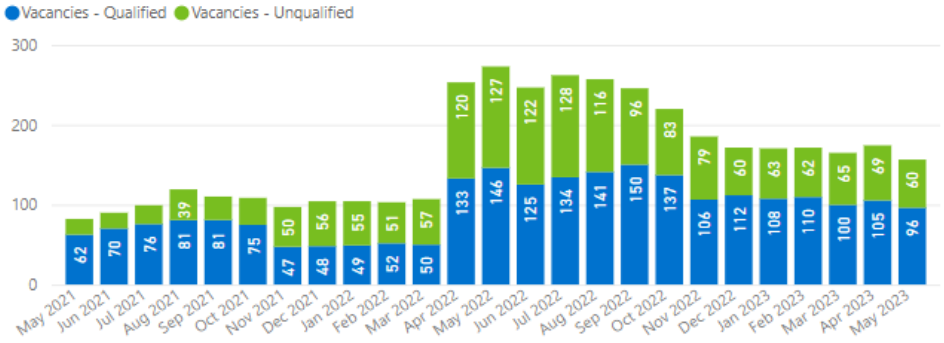
Vacancies - Unqualified

60.2 ▼ -8.6

Vacancies



Vacancies by Staff Group



Vacancies - Qualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
May 2023	DPOW	43.8	-2.6	46.4	
May 2023	GDH	10.4	0.2	10.2	
May 2023	SGH	42.0	-6.8	48.8	

Vacancies - Qualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
May 2023	Community & Therapies	10.4	0.2	10.2	
May 2023	Family Services	5.5	-3.2	8.7	
May 2023	Medicine	52.8	-3.1	55.9	
May 2023	Surgery	27.4	-3.1	30.6	

Vacancies - Unqualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
May 2023	DPOW	17.3	-4.1	21.4	
May 2023	GDH	0.8	-0.4	1.3	
May 2023	SGH	42.1	-4.1	46.2	

Vacancies - Unqualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
May 2023	Community & Therapies	0.8	-0.4	1.3	
May 2023	Family Services	1.1	-1.1	2.2	
May 2023	Medicine	47.5	-6.7	54.2	
May 2023	Surgery	10.8	-0.4	11.2	

Vacancies on the inpatient wards in April for both Registered Nurses and Healthcare Assistants show a decrease.

There is a total of 220.73 whole time equivalent (WTE) (11.62%) Registered and 110.58 whole time equivalent (WTE) (11.01%) unregistered vacancies across the Trust as of the 31st May 2023.

The overseas Pre-registration nurses who have joined the Trust continue to progress through their Objective Structured Clinical Examination (OSCE) preparation and induction programme with a 100% OSCE pass rate to May 2023. Availability of suitable training rooms for OSCE prep is a risk and is resulting in additional costs associated with transporting IENs across sites. Rooms have been sourced at UCNL (University Campus North Lincolnshire) and negotiations are ongoing with GIFHE (Grimsby Institute Further & Higher Education) with respect to utilising their rooms.

Recruitment continues for the nursing apprenticeship programmes which have proved to be popular:

- Five started on the Registered Nursing Associate – Registered Nurse Top-up programme at the University of Hull in January 2023
- Nine started on the Trainee Nursing Associate programme at the University of Lincoln in January 2023
- RNDA programme to commence September at the University of Hull

A workforce plan and Registered Nurse forecast has been developed with finance and workforce colleagues to support recruitment initiatives going forward.

Recruitment work commenced in 2022 continues and includes:

- Targeted recruitment campaigns with workforce colleagues for Emergency Departments
- Working with workforce colleagues to diversify the Internationally Educated Nurse (IEN) pipeline and ensure adequate support for ambitions
- International Midwife recruitment
- Increased engagement with Higher Education Institutes and introduction of newly qualified nurse rotational posts from Sept 2023
- Widening Access Project (NHS England funding for 12 months) – nurse has been appointed into the Chief Nurse team and work has commenced with the aim of widening the unregistered recruitment pipeline by engaging in alternative methods of attracting people from more diverse backgrounds. This includes working with organisations who support people back into work, charities, and local colleges
- Increasing student placement capacity which increased from 265,867 hours to 399,090 hours
- Support of T-level student placements

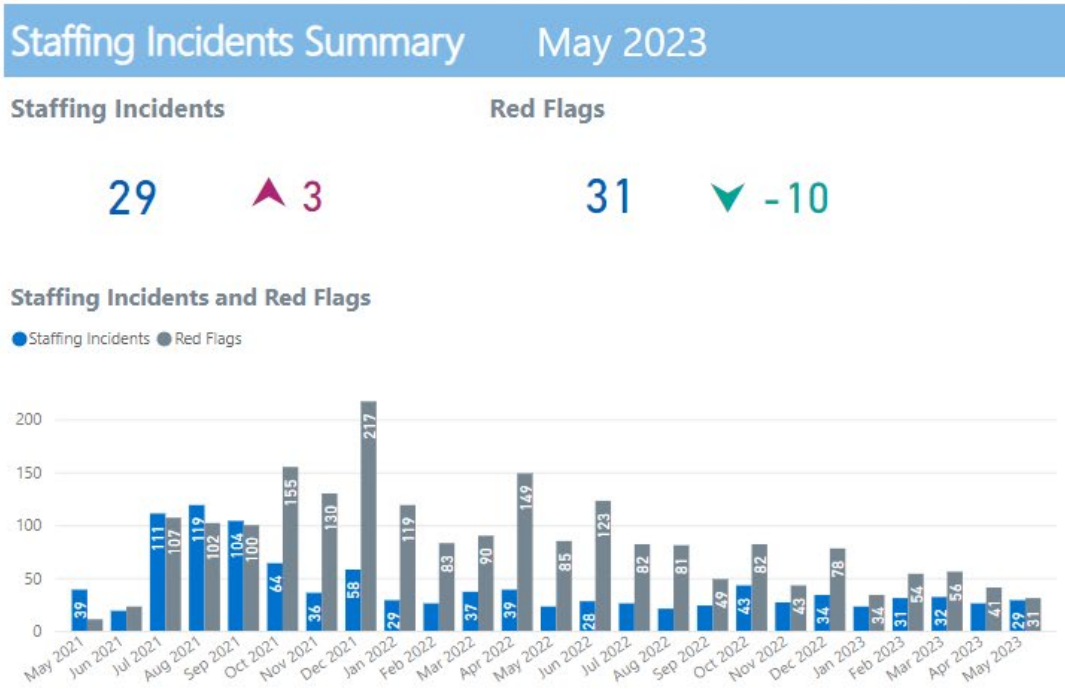
Again, retention work commenced in 2022 continues and includes:

- 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
- Health Care Assistant Buddy programme to support onboarding and support for new to care Health Care Assistants
- Development of Health Care Assistant council across sites. Plans in place to develop this into Shared Decision-Making Council
- Legacy mentor project (NHS England 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 Internationally Education Nurse (IEN) membership
    - Development of Team Channel for IENs
    - Buddy system
    - Updated Ward Manager and Staff Guide
    - Preceptorship Workbook pilot
    - IEN experience survey
    - Welcome/celebration events
    - Application for NHS Pastoral Care Quality Award
    - Collaborative work with the Equality, Diversity and Inclusion team
- Development of Advanced Clinical Practitioner Strategic Group to drive development of advanced practice roles forward.

Work programmes will be refreshed following publication and review of NHS England's Long Term Workforce Plan (June 2023).

2.4.2 Staffing Incidents

The information presented below shows data on inpatient wards only.



Wards with Incidents

Indicator	Staffing Incidents		Red Flags	
Site - Ward	Value	Change	Value	Change
DPOW - C3 Short Stay	1	▲ 1	9	▲ 5
DPOW - Maternity	6	▼ -2	0	0
DPOW - Rainforest	6	▲ 3	0	0
DPOW - B4	2	▲ 1	2	▲ 1
DPOW - Stroke DPW	0	0	4	▼ -4
SGH - NICU SGH	3	0	0	0
SGH - Ward 24 Assessment Unit	1	▲ 1	2	▲ 1
SGH - Ward 27	0	0	3	▲ 3
DPOW - A1	0	▼ -2	2	0
DPOW - Amethyst	0	0	2	▼ -1
DPOW - B3	1	▲ 1	1	▲ 1
DPOW - C2	0	0	2	▼ -3
DPOW - HDU	2	▲ 2	0	0
SGH - CDS	2	▲ 1	0	0
SGH - Ward 22	1	▲ 1	1	0
DPOW - C6	0	0	1	▲ 1
DPOW - ITU	0	0	1	▲ 1
DPOW - Laurel	0	0	1	▼ -1
DPOW - NICU DPW	1	▼ -4	0	▼ -1
SGH - Disney	1	▲ 1	0	0
SGH - Stroke SGH	1	▼ -2	0	▼ -2
SGH - Ward 26	1	▲ 1	0	0

Key – NICU – Newborn Intensive Care Unit; HDU – High Dependency Unit; CDS – Central Delivery Suite; ITU - Intensive Therapy Unit

In total 29 nurse staffing incidents were reported in May 2023 on the Ulysses system compared to 26 in April 2023.

2.4.3 Red Flags

A total of 31 staffing red flags were reported (27 on Safecare Live and 4 on Ulysses). This was a decrease compared to 41 in April. Some fluctuation is seen month by month.

Red Flags on SafeCare Live

Red Flag type, Ward	No.
Below Safe Staffing Levels	14
C3 Short Stay	3
Ward 27	3
Stroke DPW	3
A1	2
Ward 24 Assessment Unit	1
C2	1
Ward 22	1
Trained Nurse less than 12m	3
Amethyst	1
Laurel	1
C6	1

Red Flag type, Ward	No.
Less than 50% substantive staff on shift	3
C2	1
Stroke DPW	1
C3 Short Stay	1
Delay in Medicine Rounds by 1 Hour	2
C3 Short Stay	2
Delay of IV Medication by 1hr x3 Patients	2
C3 Short Stay	2
Co-ordinators Non Supernumerary	1
ITU	1
Patient Transfer 2200-0600 due to bed pressures	1
C3 Short Stay	1
More than 50% Staff under 12months Qualified	1
Amethyst	1

Red Flags on Ulysses

Red Flag type, Ward	No.
Less than 50% substantive staff on a shift	2
B4	2
Not Completed	1
Ward 24 Assessment Unit	1
Delay of more than 30 minutes to provide acute pain	1
B3	1
Less than 2 trained nurses on a clinical area	1
SDEC DPW	1

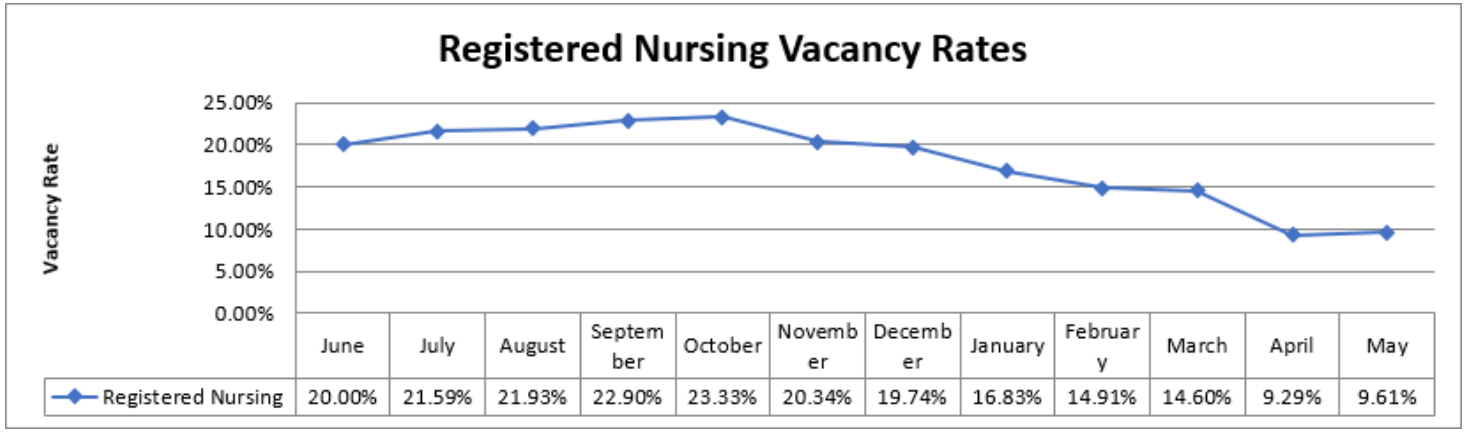
Ward C3 reported the highest number of red flags for May 2023 and although no concerning trends, remains under review.

3.0 Community Nursing

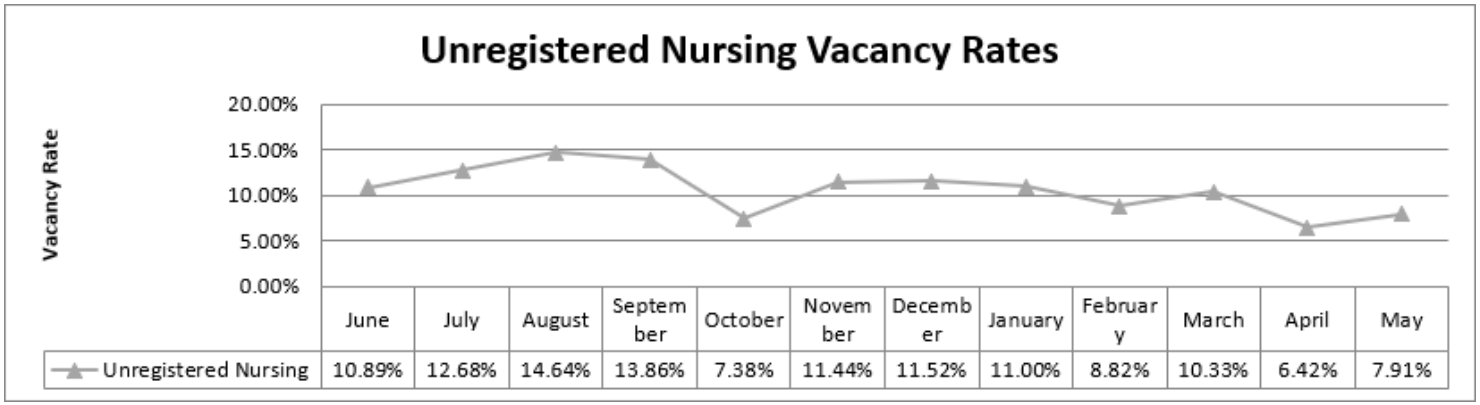
3.1 Safe Staffing

3.1.1 Vacancies

The vacancy rate, as shown in the graphs below, is decreasing with the vacancies for both Registered and Unregistered Nurses being the lowest for over a year, with a significant decrease since March 2023 for Registered Nurse vacancies overall for Community Nursing although there was a slight increase in May 2023.

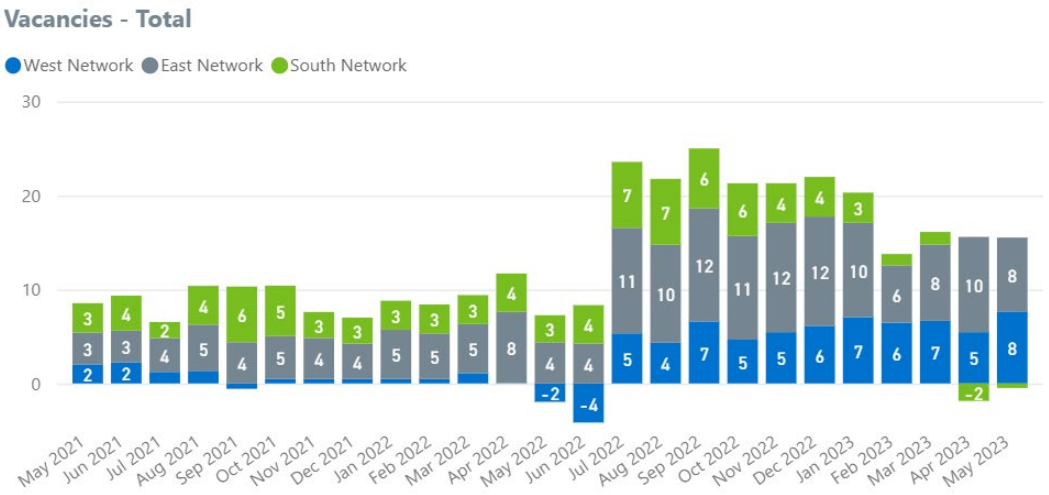


	June	July	August	September	October	November	December	January	February	March	April	May
Registered Nursing	20.00%	21.59%	21.93%	22.90%	23.33%	20.34%	19.74%	16.83%	14.91%	14.60%	9.29%	9.61%



	June	July	August	September	October	November	December	January	February	March	April	May
Unregistered Nursing	10.89%	12.68%	14.64%	13.86%	7.38%	11.44%	11.52%	11.00%	8.82%	10.33%	6.42%	7.91%

Ongoing work to recruit to vacancies and retain new and existing staff to improve staffing capacity, particularly in community nursing remains a focused piece of work. In the nursing networks the vacancies are split as below, there have been some changes due to realignment of caseloads. Once all the newly recruited band 5 nurses and the September cohort newly qualified nurses are in post there will be minimal band 5 vacancy.



STAFF GRADE	OVERALL NETWORK VACANCY
B7	27.5%
B6	1.2%
B5	-2%
B4	-42% due to development roles.
B3	0%

EAST NETWORK

	Est WTE	In post	Shortfall	Vacancy %	Due In	Leavers		Vacancy %
B7	1	0	1	100%	0	0	1	100%
B6	4	4	0	0%	0	0	0	0%
B5	17.48	17.31	0.17	1%	2	0		0%
B4	6.78	5	1.78	26%	0	0	1.78	26%
B3	2.73	4	-1.27	-47%	0	0	0	0%

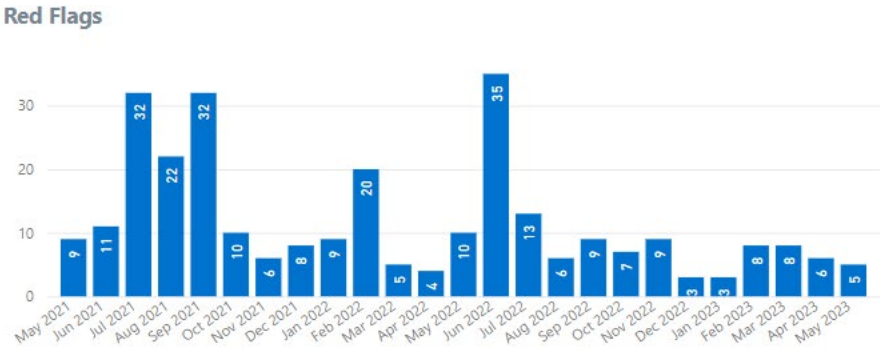
SOUTH NETWORK

	Est WTE	In post	Shortfall	Vacancy %	Due In	Leavers	Forecast	Vacancy %
B7	2	2	0	0%	0	0	0	0%
B6	4.8	3.8	1	21%	0	0	1	21%
B5	23.71	24.8	-1.09	-5%	3.88	0	0	0%
B4	6.78	6.6	0.18	3%	0	0	0	0%
B3	2.73	2.28	0.45	16%	0	0	0.45	16%

WEST NETWORK

	Est WTE	In post	Shortfall	Vacancy %	Due In	Leavers	Forecast	Vacancy %
B7	1	1	0	0%	0	0	0	0%
B6	3.8	3.6	0	0%	0	0	0	0%
B5	20.35	20.7	-0.35	-2%	0	0	3	15%
B4	6.78	8.4	-1.62	-24%	0	0	0	0%
B3	2.73	2.73	0	0%	0	0	0	0%

3.1.2 Community Red Flag incidents



Red Flags by Team **May 2023**

Team	Red Flags
East Network	2
South Network	2
West Network	1
Total	**5**

The total nursing red flag incidents for May 2023 is 5, 0 of these relate to shortages in staffing.

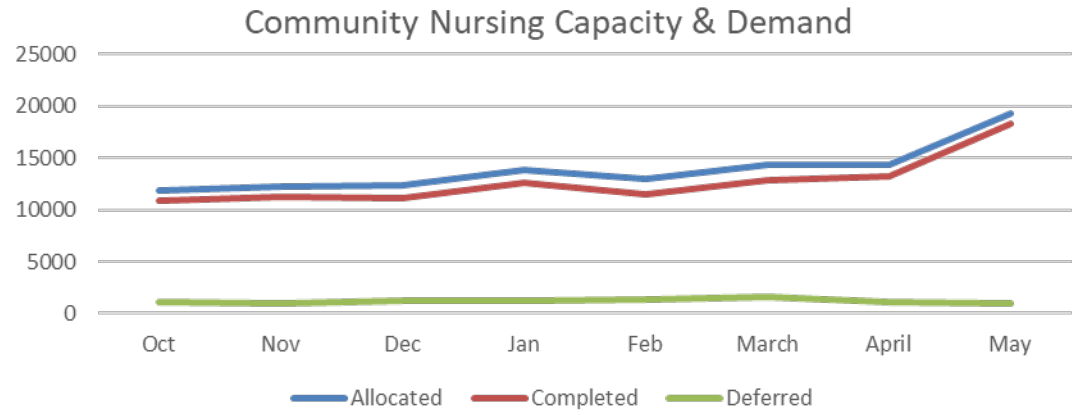
3.2 Activity

There is limited activity information for May 2023 due to the ongoing issues with the data warehousing.

Activity delivered/not delivered - Community Nursing Networks

Information from the electronic allocation tool shows significant increase in the number of visits during May, with 95% of visits completed and 5% deferred, which is the lowest number we have seen despite the increase in demand.

Visits Allocated May 23 (Completed + Deferred)	Visits Completed May 23 (Visits Activity Report)	Visits Deferred / Cancelled Moved TO May 23 (Moved Visits Report)
19306	**18321** **(average 591 per day)** 95% completed	**985 moved** 5% deferred



Community Nursing Capacity/demand

What have we done?

- Demand being more consistently managed within limits of daily capacity to proactively reprioritise visits over 7 days
- Minimum rostered and actual staffing levels being monitored weekly
- Community Nursing Safer Staffing Tool (CNSST) census week completed May 2023, awaiting data, meeting scheduled for July 2023 to review data
- Roster approval processes / confirm and challenge & Monthly C&D performance reviews
- Moving the District Nurses out of the nursing hub to enable oversight and management of caseloads
- Flexible working
- Regular team meetings

So what?

- Red flags remain static
- Staff feel that workload is being more appropriately allocated
- Reduction in PALs concern associated with missed visits
- Good patient feedback through 15 steps and leadership engagement

What next?

- Quality Improvement project to combine District Nursing Hub & Single Point of Access (SPA) into a true SPA with dedicated resource underway, timescale planned for beginning of July 2023
- Quality Improvement projects to embed virtual consultation and delegation of insulin in dedicated care homes. All District Nurses will have completed the delegation of insulin to care home staff training by the end of June, to enable roll out by the end of Q2.
- Focus on retention of experienced and new staff, including:
    - Training and development to ensure we have a skilled and competent workforce
    - Rotation of Community Nursing staff through wound clinic and bladder and bowel team
    - Support sessions for Newly Qualified Nurses

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 was undertaken in 2022 and the final report presented to Trust Management Board in November. The Trust is compliant with Birthrate Plus calculations with a positive variance of 2.55wte.

4.2 Maternity Fill Rates and Care Hours Per Patient Day (CHPPD)

Maternity Wards Fill Rates and CHPPD — **May 2023**

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**89.6%**	**▼ -3.0%**	**83.5%**	**▼ -0.5%**	**11.8**	**▼ -4.19**
Registered Nurses and Midwives	86.5%	▼ -2.2%	79.8%	▼ -0.3%	7.2	▼ -2.50
Care Staff	95.0%	▼ -4.5%	90.1%	▼ -0.9%	4.5	▼ -1.69
Central Delivery Suite	**83.0%**	**▼ -1.6%**	**47.1%**	**▼ -5.9%**	**26.1**	**▲ 0.37**
Registered Nurses and Midwives	79.7%	▼ -3.3%	37.6%	▼ -9.5%	20.2	▼ -0.15
Care Staff	96.6%	▲ 5.5%	86.3%	▲ 8.8%	5.9	▲ 0.52
Jasmine & Honeysuckle	**91.3%**	**▲ 2.5%**	**78.3%**	**▼ -1.3%**	**11.0**	**▲ 0.62**
Registered Nurses and Midwives	90.5%	▲ 7.6%	79.2%	▲ 5.7%	7.3	▲ 0.81
Care Staff	93.2%	▼ -8.0%	76.2%	▼ -15.6%	3.7	▼ -0.20
Ward 26 SGH	**90.5%**	**▼ -1.3%**	**65.2%**	**▲ 2.0%**	**7.5**	**▼ -1.47**
Registered Nurses and Midwives	89.5%	▼ -1.6%	61.5%	▼ -4.3%	5.4	▼ -1.09
Care Staff	93.5%	▼ -0.4%	75.4%	▲ 19.1%	2.1	▼ -0.38
Total	**88.8%**	**▼ -0.8%**	**69.9%**	**▼ -1.4%**	**11.4**	**▼ -1.48**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	61.5%	▲ 0.5%
Central Delivery Suite	77.3%	▼ -1.7%
Jasmine & Honeysuckle	66.6%	▲ 3.9%
Ward 26 SGH	72.2%	▼ -0.3%
Total	**68.6%**	**▲ 0.8%**

The fill rate in maternity remains <95 %, in all areas. 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 09.00-hour 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.

4.3 Midwife: Birth ratio

Assurance that safety was maintained within the maternity units is supported by the Midwife to Birth ratio data. In May 2023 the data for both units is Grimsby 23.9 and Scunthorpe 20.3 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 May 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 use a maternity Operational Pressure Escalation Levels (OPEL) status to provide an oversight of their current position. This is provided to the Trust Operational meetings and reported regionally. A decrease in fill rates for both sites is seen in May 2023.

4.4 Maternity Dashboards

Diana, Princess of Wales Hospital

DPOW Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023
Midwife to Birth Ratio	24.8 ↘	26.5 ↗	26.5	25.6 ↘	25.5 ↘	23.3 ↘	24.8 ↗	25.4 ↗	24.3 ↘	23.9 ↘	23.9 ↘	23.9 ↘
Red Flags	2.0	7.0 ↗	9.0 ↗	5.0 ↘	3.0 ↘	3.0	2.0 ↘	2.0	1.0 ↘	1.0	4.0 ↗	11.0 ↗
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0 ↗
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	1.0 ↗	2.0 ↗	0.0 ↘	1.0 ↗	1.0	0.0 ↘	0.0	0.0	0.0	1.0 ↗	1.0	1.0
(c) Missed medication during an admission to hospital	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0	1.0 ↗	0.0 ↘
(d) Delay of more than 30 minutes in providing pain relief	0.0	2.0 ↗	2.0	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	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	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	1.0 ↗	2.0 ↗	4.0 ↗	2.0 ↘	0.0 ↘	1.0 ↗	0.0 ↘	1.0 ↗	1.0	0.0 ↘	1.0 ↗	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.	0.0 ↘	0.0	2.0 ↗	2.0	2.0	1.0 ↘	1.0	1.0	0.0 ↘	0.0	0.0	6.0 ↗
Continuity of Carer %	21.0	23.0 ↗	24.0 ↗	24.0	25.0 ↗							
In Receipt of %	15.0 ↗	13.0 ↘	14.0 ↗	15.0 ↗	15.0							
CoC In Receipt of %	72.0 ↘	89.0 ↗	72.0 ↘	68.0 ↘	66.0 ↘							
Continuity Team Caseload	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	0.0
Actual v Planned Staffing %	92.2 ↗	86.0 ↘	86.0	89.0 ↗	89.5 ↗	97.9 ↗	91.9 ↘	89.9 ↘	91.6 ↗	93.3 ↗	95.3 ↗	95.1 ↘
Labour Co-ordinator Supernumerary Status %	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	19.1 ↘	20.2 ↗	20.3 ↗	26.3 ↗	20.7 ↘	20.5 ↘	20.1 ↘	22.4 ↗	21.3 ↘	19.4 ↘	-3.0 ↘	-4.5 ↘
Vacancies - Registered	17.5 ↗	17.7 ↗	17.8 ↗	19.5 ↗	19.1 ↘	16.1 ↘	16.2 ↗	17.9 ↗	18.0 ↗	16.5 ↘	-0.8 ↘	-1.5 ↘
Vacancies - Unregistered	1.5 ↘	2.5 ↗	2.5	6.8 ↗	1.5 ↘	4.4 ↗	3.9 ↘	4.5 ↗	3.3 ↘	2.8 ↘	-2.2 ↘	-3.0 ↘
Serious Incidents	0.0	0.0	1.0 ↗	1.0	0.0 ↘	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	1.0
Complaints	1.0	2.0 ↗	1.0 ↘	0.0 ↘	0.0	1.0 ↗	0.0 ↘	0.0	1.0 ↗	1.0	0.0 ↘	1.0 ↗
PALS	3.0 ↘	1.0 ↘	5.0 ↗	2.0 ↘	2.0	3.0 ↗	2.0 ↘	2.0	2.0	2.0	1.0 ↘	1.0

Scunthorpe General Hospital

SGH Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023
Midwife to Birth Ratio	25.5 ↗	25.8 ↗	25.8	26.0 ↗	23.8 ↘	22.4 ↘	23.4 ↗	21.6 ↘	22.1 ↗	20.2 ↘	20.5 ↗	20.3 ↘
Red Flags	15.0 ↘	27.0 ↗	6.0 ↘	4.0 ↘	14.0 ↗	6.0 ↘	14.0 ↗			2.0	1.0 ↘	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)	1.0 ↗	5.0 ↗	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)	2.0	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	0.0	1.0 ↗	0.0 ↘	1.0 ↗
(c) Missed medication during an admission to hospital	0.0	1.0 ↗	0.0 ↘	0.0	0.0	2.0 ↗	0.0 ↘	0.0	0.0	0.0	1.0 ↗	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	5.0 ↘	11.0 ↗	1.0 ↘	2.0 ↗	5.0 ↗	2.0 ↘	9.0 ↗	0.0 ↘	0.0	1.0 ↗	0.0 ↘	2.0 ↗
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	1.0 ↗	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.	7.0 ↘	10.0 ↗	4.0 ↘	1.0 ↘	9.0 ↗	2.0 ↘	4.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0
Continuity of Carer %	13.0 ↘											
In Receipt of %	5.0 ↘	3.0 ↘										
CoC In Receipt of %	30.0 ↘	33.0 ↗										
Continuity Team Caseload	174.0	0.0 ↘	0.0	0.0	0.0							
Divert / Unit Closures	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	82.7 ↘	81.4 ↘	81.4	80.9 ↘	88.3 ↗	94.0 ↗	89.8 ↘	97.5 ↗	93.2 ↘	102.4 ↗	101.0 ↘	102.3 ↗
Labour Co-ordinator Supernumerary Status %	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	98.9 ↘	100.0 ↗	100.0	100.0
Vacancies	25.1 ↘	24.9 ↘	25.5 ↗	26.1 ↗	21.5 ↘	21.2 ↘	21.0 ↘	20.6 ↘	20.4 ↘	15.0 ↘	19.0 ↗	15.1 ↘
Vacancies - Registered	21.9 ↘	22.7 ↗	23.4 ↗	23.2 ↘	21.3 ↘	18.9 ↘	19.0 ↗	19.0 ↗	19.3 ↗	13.9 ↘	18.4 ↗	15.5 ↘
Vacancies - Unregistered	3.2 ↘	2.2 ↘	2.0 ↘	2.8 ↗	0.3 ↘	2.3 ↗	2.1 ↘	1.6 ↘	1.1 ↘	1.1	0.6 ↘	-0.4 ↘
Serious Incidents	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0
Complaints	2.0 ↗	0.0 ↘	2.0 ↗	1.0 ↘	3.0 ↗	1.0 ↘	0.0 ↘	1.0 ↗	1.0	0.0 ↘	1.0 ↗	0.0 ↘
PALS	1.0 ↘	0.0 ↘	1.0 ↗	3.0 ↗	3.0	1.0 ↘	1.0	1.0	1.0	0.0 ↘	0.0	5.0 ↗

Trustwide

Trustwide Maternity Dashboard

Indicator	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023
Midwife to Birth Ratio	25.0	26.2	26.2	25.8	24.8	22.9	24.2	23.7	23.4	22.2	22.4	22.3
Red Flags	18.0	34.0	16.0	9.0	17.0	9.0	19.0	3.0	1.0	3.0	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)	1.0	5.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	3.0	2.0	2.0	1.0	1.0	0.0	3.0	1.0	0.0	2.0	2.0	2.0
(c) Missed medication during an admission to hospital	0.0	2.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	2.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	2.0	2.0	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	1.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	1.0	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	6.0	13.0	5.0	4.0	5.0	3.0	9.0	1.0	1.0	1.0	1.0	3.0
(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	1.0	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.	8.0	10.0	6.0	3.0	11.0	3.0	5.0	1.0	0.0	0.0	0.0	6.0
Continuity of Carer %	18.0	12.0	12.0	12.0	14.0							
In Receipt of %	11.0	9.0	8.0	9.0	8.0							
CoC In Receipt of %	58.0	70.0	72.0	68.0	66.0							
Continuity Team Caseload	488.0	305.0	305.0	295.0	311.0							
Divert / Unit Closures	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	88.1	84.1	84.1	85.5	89.0	96.2	91.0	93.1	92.3	97.2	97.8	98.2
Labour Co-ordinator Supernumerary Status %	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	99.5	100.0	100.0	100.0
Vacancies	43.5	44.5	45.2	51.8	41.6	41.1	40.4	42.2	41.7	34.4	16.0	10.5
Vacancies - Registered	38.8	39.8	40.6	42.2	39.8	34.4	34.4	36.0	37.3	30.5	17.6	13.9
Vacancies - Unregistered	4.7	4.7	4.6	9.6	1.8	6.7	6.0	6.1	4.4	3.9	-1.6	-3.4
Serious Incidents	0.0	0.0	2.0	1.0	0.0	0.0	2.0	0.0	0.0	0.0	1.0	1.0
Complaints	3.0	2.0	3.0	1.0	3.0	2.0	0.0	1.0	2.0	1.0	1.0	1.0
PALS	5.0	1.0	6.0	5.0	6.0	4.0	3.0	3.0	3.0	3.0	1.0	6.0
Sickness Absence (Division) %	5.8	6.8	6.4	6.0								

5.0 Quality

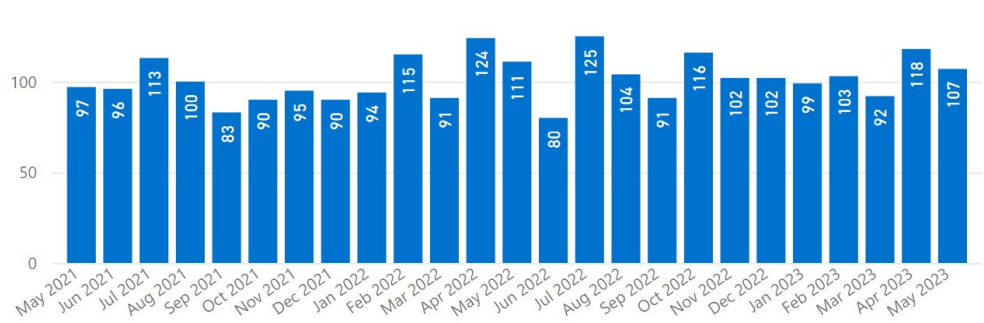
5.1 Reported Falls Incidents

The information presented shows data for inpatient wards only and is the standard throughout the report.

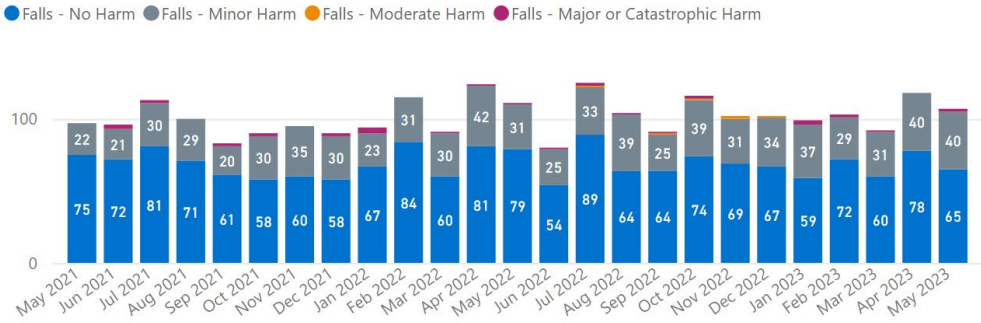
Falls Incidents Summary May 2023

Falls - Total	No Harm	Minor Harm	Moderate Harm	Major or Catestrophic
107 ▼ -11	65 ▼ -13	40	0	2 ▲ 2

Falls - Total



Falls by Category



Falls - Total by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
May 2023	DPOW	68	! 13	55	
May 2023	GDH	4	✓ -2	6	
May 2023	SGH	35	✓ -22	57	

Falls - Total by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
May 2023	Community & Therapies	4	✓ -2	6	
May 2023	Family Services	1	◆ 0	1	
May 2023	Medicine	72	✓ -16	88	
May 2023	Surgery	30	! 7	23	

There has been a decrease in the number of reported falls in May 2023. There has been an increase in the number of falls reported at the Grimsby site and a decrease in the number of falls reported at the Scunthorpe site.

There were three falls reported with severe harm in May 2023. One fall occurred in the Emergency Care Centre (ECC) at Scunthorpe and the patient sustained a fracture femur. As the fall did not occur in an in-patient area, this is not included in the data presented. The huddle identified that there were no lapses in care and good standards of documentation. The huddle was completed within 2 working days of the incident. One fall occurred on Ward B3 and the patient sustained a fractured femur. No lapses in care were identified at the huddle which was completed within 2 working days of the incident. One fall occurred on Ward 16 and the patient sustained a fractured femur. No lapses in care were identified and the huddle found that there were high standards of documentation. The huddle was completed within 2 days of the incident.

5.2 Falls per 1,000 Bed Days

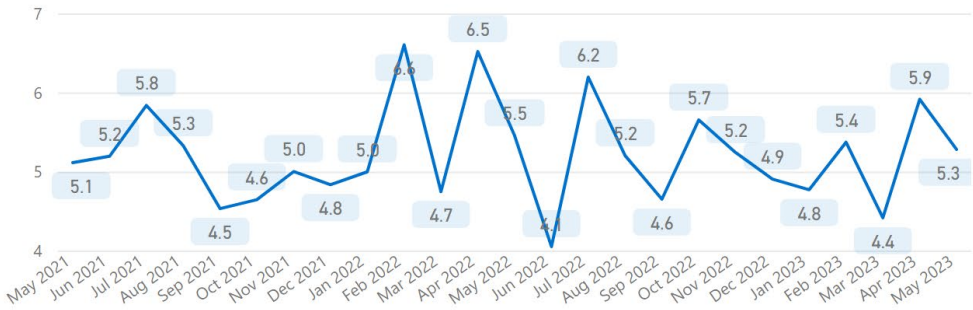
The falls per 1000 bed days across the Trust has decreased in May 2023.

Falls per 1,000 Bed Days Summary May 2023

Falls per 1,000 bed days

5.3 ▼ -0.6

Falls per 1,000 Bed Days



Falls per 1,000 Bed Days by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
May 2023	DPOW	6.6	! 1.3	5.3	
May 2023	GDH	3.8	✓ -1.7	5.6	
May 2023	SGH	3.9	✓ -2.8	6.7	

Falls per 1,000 Bed Days by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
May 2023	Community & Therapies	3.8	✓ -1.7	5.6	
May 2023	Family Services	0.4	✓ 0.0	0.5	
May 2023	Medicine	5.9	✓ -1.6	7.5	
May 2023	Surgery	6.3	! 1.8	4.5	

5.3 Wards with Highest Incidence of Falls

Highest Reporting Wards with Falls Incidents May 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	5	▲ 2	6	▼ -1	0	0	0	0	11	▲ 1
DPOW - B3	5	▲ 2	4	▲ 4	0	0	1	▲ 1	10	▲ 7
DPOW - B2 Assessment Unit	7	▲ 4	0	0	0	0	0	0	7	▲ 4
DPOW - C3 Short Stay	2	0	4	▲ 1	0	0	0	0	6	▲ 1
DPOW - Stroke DPW	6	▲ 4	0	▼ -3	0	0	0	0	6	▲ 1
SGH - Ward 16	4	▼ -2	1	▼ -1	0	0	1	▲ 1	6	▼ -2

Highest Reporting Wards - Falls per 1,000 Bed Days

Site - Ward	Falls per 1000 Bed Days	Change
DPOW - C2	13.3	▲ 0.7
DPOW - B3	13.0	▲ 9.0
DPOW - B4	12.7	▲ 3.3
SGH - Stroke SGH	10.1	▼ -10.1
SGH - Ward 16	8.6	▼ -3.1

Ward 16 at Scunthorpe has triggered as higher reporting wards for the fourth consecutive month, however, there has been a reduction in the number of falls reported in May 2023. A review of the data with the Deputy Ward Sister indicates the complexity and frailty of the patients over the past few months is a likely contributory factor. There are no concerning trends on the ward with multiple falls or falls with harm.

Ward C2 has triggered as a higher reporting ward for the second consecutive month.

None of the 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 Pressure Ulcers

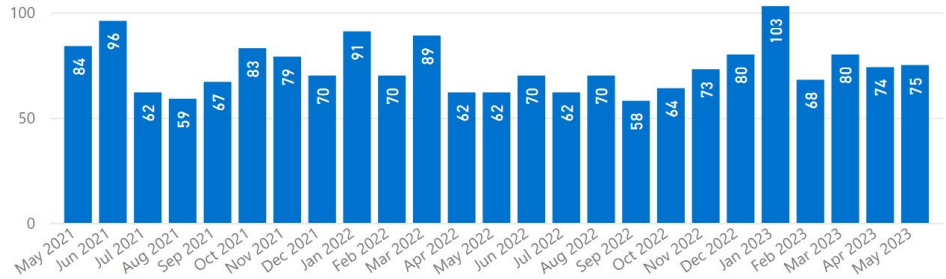
6.1 Hospital Acquired Pressure Ulcer Incidents

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.

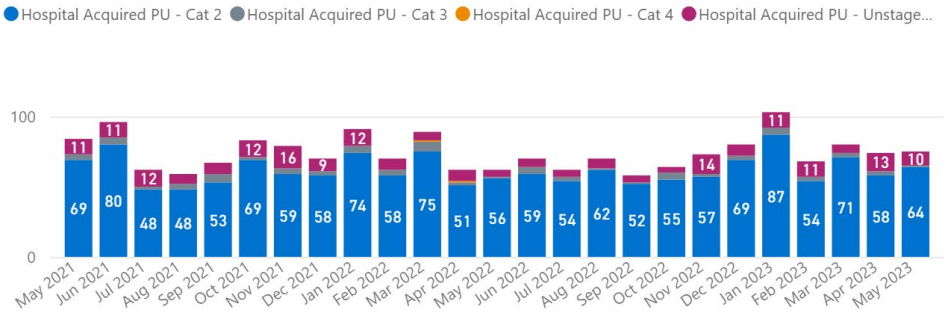
Hospital Acquired PU Incidents Summary May 2023

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
75 ▲ 1	64 ▲ 6	1 ▼ -2	0	10 ▼ -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
May 2023	DPOW	43	▲ 7	36	
May 2023	GDH	3	◆ 0	3	
May 2023	SGH	29	▼ -6	35	

Hospital Acquired PU - Total by Division

Latest Month	Divison	Result	Variance to Previous	Previous Month	Trend
May 2023	Community & Therapies	3	◆ 0	3	
May 2023	Family Services	0	◆ 0		
May 2023	Medicine	41	▲ 1	40	
May 2023	Surgery	31	◆ 0	31	

PU – Pressure Ulcers

The number of pressure ulcer incidents reported in May 2023 has increased slightly. There has been an increase in the number of reported Category 2 pressure ulcers and a decrease in the numbers of reported Category 3 and unstageable pressure ulcers. The decrease in the number of Category 3 and unstageable pressure ulcers may be as a result of the change in process for managing moderate harm incidents within the Acute Trust. As a result of this change in process, all moderate harm incidents are now reviewed by the Ward Sister within a week of reporting. This has led to a timelier validation of incidents which could have contributed to the decrease in the numbers of Category 3 and unstageable pressure ulcers reported.

From 1st May 2023, the acute sites introduced a rapid review of all Category 3, 4 and unstageable pressure ulcers. This will result in the majority of incidents being reviewed and closed within 10 working days. Timely and supportive interventions can be implemented if needed and the new process will release time for Ward Sisters and Charge Nurses to support and deliver improvements.

6.2 Hospital Acquired Pressure Ulcers per 1,000 Bed Days

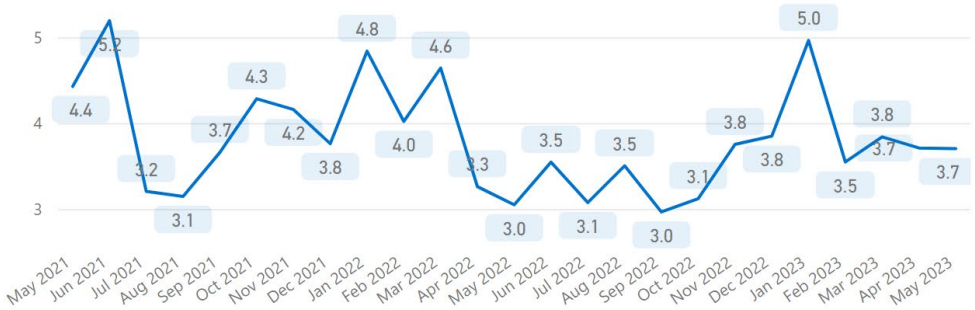
The incidence of reported pressure ulcers per 1000 occupied bed days remains largely static and is higher at the Scunthorpe site.

Hospital Acquired PU per 1,000 Bed Days Summary — May 2023

PU per 1,000 bed days

3.7 ▼ 0.0

PU per 1,000 Bed Days



PU per 1,000 Bed Days by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
May 2023	DPOW	4.2	▲ 0.7	3.5	
May 2023	GDH	2.9	▲ 0.1	2.8	
May 2023	SGH	3.3	▼ -0.9	4.1	

PU per 1,000 Bed Days by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
May 2023	Community & Therapies	2.9	▲ 0.1	2.8	
May 2023	Family Services	0.0	◆ 0.0		
May 2023	Medicine	3.4	▼ -0.1	3.4	
May 2023	Surgery	6.5	▲ 0.5	6.1	

6.3 Wards with the Highest Incidence

Highest Reporting Wards with PU Incidents **May 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 - C3 Short Stay	6	▲ 2	0	0	0	0	0	0	6	▲ 2
SGH - Ward 28	6	▲ 2	0	0	0	0	0	▼ -1	6	▲ 1
DPOW - B3	4	0	0	0	0	0	1	0	5	0
DPOW - A1	2	▲ 2	0	0	0	0	2	▼ -1	4	▲ 1
SGH - Ward 16	4	▲ 3	0	▼ -3	0	0	0	0	4	0

Highest Reporting Wards - PU per 1,000 Bed Days

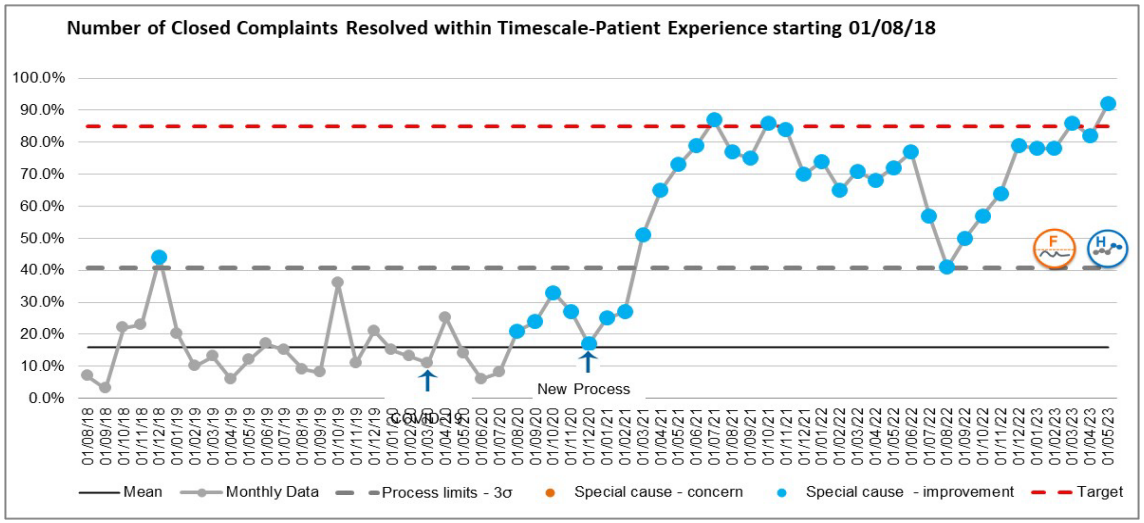
Site - Ward	Hospital Acquired PU per 1000 Bed Days	Change
DPOW - HDU	17.5	▲ 6.0
GDH - Ward 6	16.1	▲ 16.1
DPOW - ITU	14.0	▲ 7.4
SGH - ICU	9.9	▲ 4.8
SGH - Ward 28	7.4	▲ 1.1

Ward 28 has triggered as a higher reporting ward for the second consecutive month. All pressure ulcers reported by Ward 28 during May 2022 were Category 2, this indicates that appropriate preventative measures were in place to prevent further deterioration.

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.

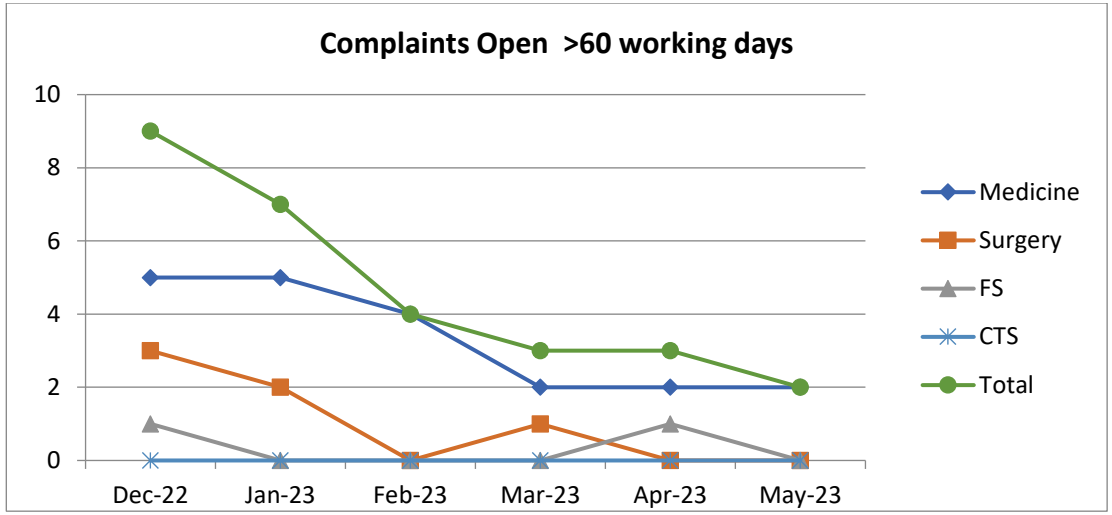
7.0 Patient Experience

New formal complaint numbers were 26 for the month of May and for a third month over 80% of those closed were in timescale, with 92% of May's complaint closures being achieved in timescale. The impact of separating out the Patient Advice & Liaison Service (PALS) management from complaints has been felt directly within the central team. This includes the transition of PALS to formal complaints and the reduction in overall PALS, allowing increased focus on both concerns and formal complaints by divisions.



Graph A

Open complaints over 60 working days shows a downward trend, supporting the positive position of closed complaints as seen in graph B. Divisional engagement remains high and weekly or fortnightly meetings with the central team have helped ensure increased oversight and the opportunity to address escalations and concerns to the process.

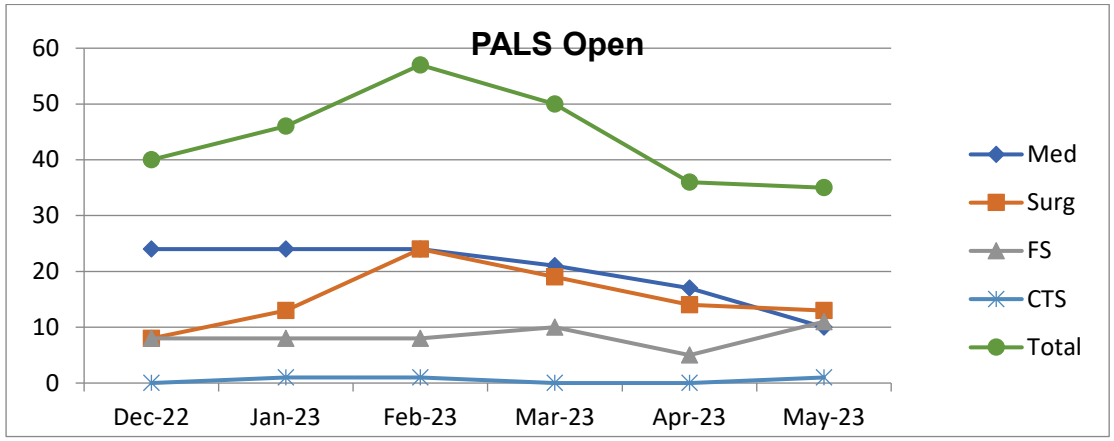


Graph B

The central team have launched a pilot for the new electronic learning log in Ullyses. This will be used to capture measurable and meaningful learning which divisional teams can monitor and identify themes from more readily. The pilot will evaluated continually with a formal review in August to identify successes and challenges.

Following noting some minor anomalies in previous data extraction for formal complaints which has been esclalated, a reviewed process has been immediatley implemented to minimise this risk and this is being replicated across Patient Advice and Liaison Service (PALS) data extraction.

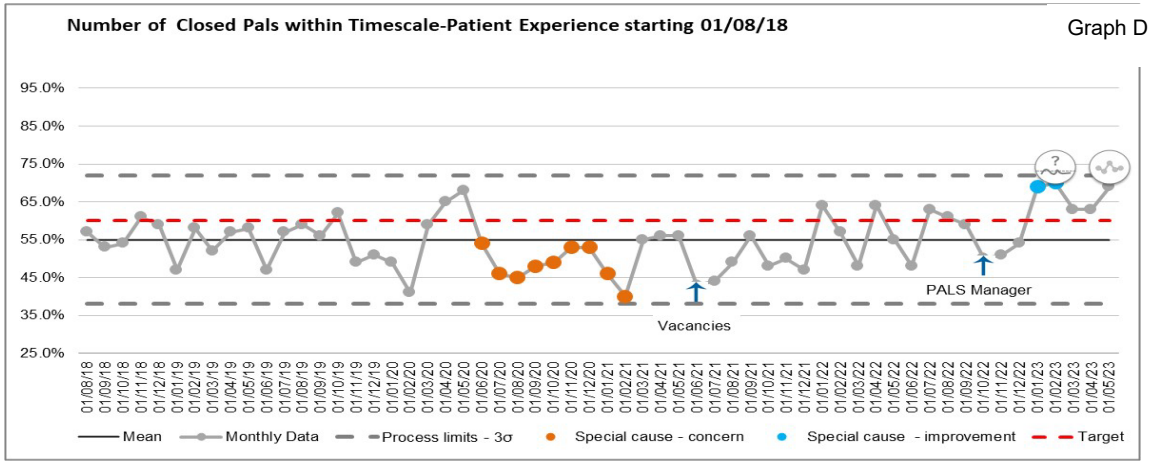
Trust wide the number of new PALS concerns received was 146 during May and open PALS, as highlighted earlier, continues to reduce as seen below in Graph C.



Graph C

In total 144 Patient Advice and Liaison Service (PALS) concerns were closed in May. In total 69% of those PALS were closed in timescale and was the 5th consecutive month that over 60% have been closed in 5 working days or less as seen in graph D below. This consistency has not been seen since reporting this metric commenced in 2018.

This is, again, largely felt to be related to the increased oversight from the temporary Patient Experience Manager role. However, there is a pending risk, as this post was unsuccessful in its business case bid and is due to cease August 31st, 2023. This risk has been highlighted.



May saw an increased total of 60 compliments, compared to 43 in April, logged through Ulysses and 3 were logged via the national platform, Care Opinion. The Patient Experience Manager continues to engage with staff regarding how these positive accounts can help influence ward morale and ultimately culture.

This morning I attended A and E at Diana Princess of Wales hospital in Grimsby.

One hears so many bad reports of the NHS that I thought I would like to briefly relate my good experience today.

I arrived, checked in with reception, was seen by a nurse, she fetched a more senior nurse who also inspected my wound, I was then X-rayed, seen by the A and E consultant, given a tetanus injection, given antibiotics, and had an appointment made for me at Hull for tomorrow morning at 9:30 to have surgery.

All this took a few minutes over one hour.

A faultless performance in my opinion.

May Friends and Family Test (FFT) numbers were significantly increased as noted in table E below. 88% of this feedback was positive, with kindness, caring and communication being the headline positive themes. Themes for improvement remain unchanged from the previous month and focus on communication and include attitude within this. June will mark the final month with the current Friends and Family Test (FFT) provider as the Trust migrates to use Healthcare Communications to deliver this valuable patient feedback tool. Following discussions via the Trust Digital Solutions Board, whilst implementation of the system is not a new project, there may be delays to full implementation of the Friends and Family Test (FFT) delivery system due to resource availability. This will not be fully clear until mid-July, however mitigation is being put into place in the form of paper feedback collections in key areas. It is predicted that Friends and Family Test (FFT) submissions will be lower during the coming months.

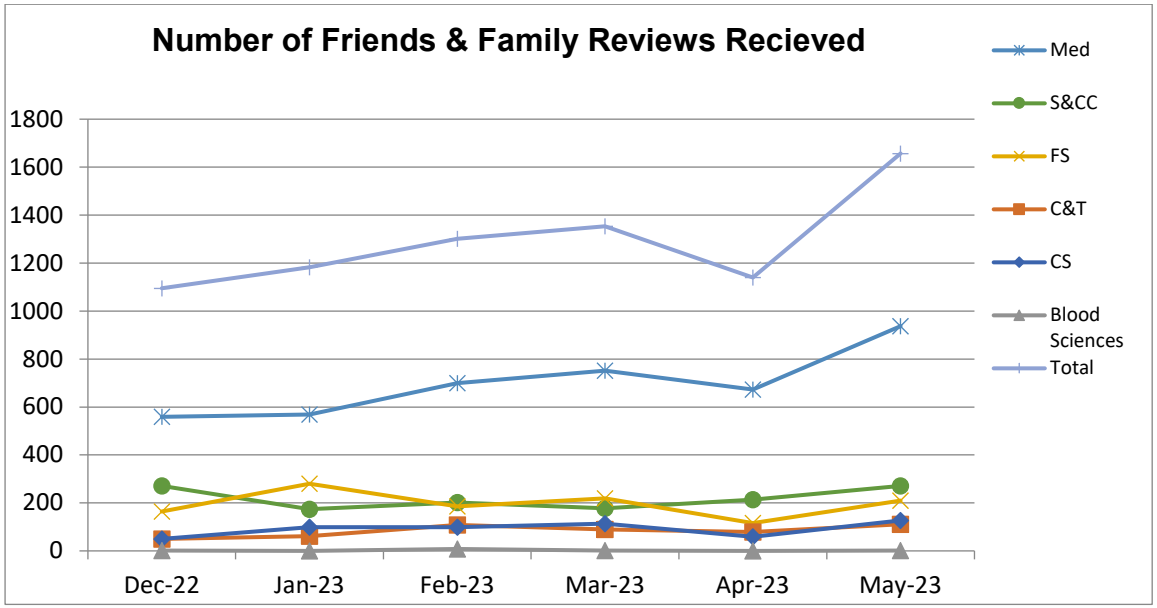


Table E

During May the Trust ran a “visiting arrangements” survey as part of a piece of patient, visitor, public and staff engagement. This is directly linked to Carol’s Campaign which is the co-designed patient experience improvement project currently being undertaken. The feedback provided will help influence what visiting should and could look like within the Trust and this will be collated and discussed during the coming weeks.

8.0 Mixed Sex Breaches

In May the Trust declared one mixed sex breach which involved three patients who were not fit for the ward. One action plan was commenced which contained the actions for all patients affected.

Site	Speciality	Date	Sex	No. that occurred	Reason
Grimsby	HOBS (High Observation)	14/05/23	F	1	Patient flow- unable to support step down- escalated at the time- Gold aware
Grimsby	HOBS	14/05/23	F	**0**	Patient flow- unable to support step down- escalated at the time- Gold aware
Grimsby	HOBS	14/05/23	M	**0**	Patient flow- unable to support step down- escalated at the time- Gold aware
Grimsby	HOBS	14/05/23	M	**0**	Patient flow- unable to support step down- escalated at the time- Gold aware

9.0 15 Steps Assurance Challenge

Ten 15 Steps Challenge visits were completed during May 2023. One visit was rescheduled due annual leave and competing priorities within the 15 Steps Team. One supportive visit was completed on the newly located Emergency Department at Scunthorpe.

Acute 15 Steps Challenge Visits				
Date	**Area**	**Rating**	**Rating**	**Most Recent Rating**
03/05/2023	Ward 23	02/09/2021	12/04/2022	03/05/2023
04/05/2023	Outpatients B Floor (Physio)	N/A	14/04/2022	04/05/2023
10/05/2023	Ward A1	08/07/2020	18/02/2022	10/05/2023
11/05/2023	**Ward 29 Revisit**	04/08/2022	03/11/2022	11/05/2023
16/05/2023	Endoscopy SGH	N/A	01/11/2022	16/05/2023
17/05/2023	**Rainforest Revisit**	Sep-21	08/11/2022	17/05/2023
18/05/2023	MRI DPOW	N/A	26/04/2022	18/05/2023
23/05/2023	**Discharge Lounge DPOW Revisit**	N/A	01/01/2023	23/05/2023
24/05/2023	**Ward C6 Revisit**	03/11/2021	01/11/2022	24/05/2023
25/05/2023	PIU	N/A	19/05/2022	25/05/2023
30/05/2023	A&E SGH - supportive visit	30/09/2021	01/02/2022	30/05/2023

SGH – Scunthorpe General Hospital
DPOW – Diana, Princess of Wales Hospital
MRI – Magnetic Resonance Imaging
PIU – Planned Investigation Unit
N/A – not applicable

Themes reported through 15 Steps Challenge

Standards	Themes	Actions
Standard 1: Observation	• Patient identifiers on display	• Laminated sheets applied to front of wall document holders • New notes holders in place for bedside documentation • Expected standards for safe and secure storage of confidential information communicated with staff
	• Out of date stock	• Email findings over the last few months out to Ward Manager, Matrons and Associate Chief Nurse' • Quality Times and Senior Leadership meeting focusing on stock rotation • New processes in place to manage stock including a review of 'top up'
Standard 2: Documentation	• Missed skin checks for patients at risk	• Staff made aware of gaps in skin checks and significance of avoidable harm to patients • Discuss recent serious incidents and learning lessons • Ward Assurance Tool (WAT) to be completed and check for consistent themes (e.g., potential reasons for last skin check missed)
	• Best Interest Meetings not organised following capacity assessments where required	• Quality priority to help staff understand the expected standards and education to improve compliance • Ongoing information and support from nurse specialists and vulnerabilities teams
Standard 3: Patient Feedback	• Issues with facilities within the environment	• Report log implemented for reporting of environmental/ estates concerns where log numbers can be stored and followed up - updated
Standard 4: Staff Feedback	• Staff unaware of learning lessons or themes for learning, complaints, pals, insights, FFT	• Information on learning lessons and themes from assurance reports Ward Assurance Tool (WAT) communicated with staff • Displayed on 'time to shine' Project support and Lead nurse, assurance provided links to Power Bi and Standard Operating Procedure (SOP) for completing time to shine board for displaying INSIGHTS and patient feedback

10.0 Infection, Prevention & Control

- The National Board Assurance Framework has now been reviewed with relevant departments and updated. Actions required will be reported through the Infection Prevention & Control committee.
- Following on from the screening of Intensive Care Unit (ICU) patients for VRE (vancomycin-resistant enterococcus) we identified a cluster of patients on ward 17. There is no evidence to suggest this is an outbreak as pre-admission screening was not required at this time. The team have worked with ward 17 and mitigating actions put in place. This included a full deep clean of the ward, swabbing of patient contacts, education to staff and Infection Prevention and Control (IPC) audits including equipment cleaning and hand hygiene.
- The team have worked with colleagues within Medicine in relation to a recent patient identified with TB (tuberculosis) whilst an in patient at Grimsby. A contact tracing exercise was required. There is learning from this and the team are developing new processes for any future cases to support a timely contact tracing exercise.
- The Infection Prevention and Control team are working closely with Trust colleagues to look at the Trust preparedness for Measles. THE United Kingdom Health Security Agency (UKHSA) have released documents in relation to the increase in measles in some parts of the country. Humber and North Yorkshire (H&NY) Integrated Care Board are drafting a Standard Operating Procedure (SOP) to assist organisations managing a measles outbreak. In the interim the team are working through some planning and a meeting is being arranged with key services including Occupational Health to ensure preparedness.
- The Infection Prevention and Control team have devised the new ward boards and these are currently being changed across all areas. The focus is on invasive devices including cannulae, catheters and enteral feeding.

Mandatory alert organism

Overview 2023/24 YTD
Healthcare-associated cases

	April – January 2023					2022/23	
	PHE Trust-level Targets	Trust	DPOW	SGH	GDH	2022/23 Targets	2022/23 Actuals
C. difficile	20	2	1	1	0	21	24
MRSA	No Target	0	0	0	0	0	1
MSSA	No Target	2	1	1	0	No Target	20
E. coli	46	12	7	3	2	65	65
Klebsiella spp.	22	4	1	3	0	25	23
P. aeruginosa	7	1	1	0	0	7	15

Targets 2023/24

Healthcare-associated cases (HOHA and COHA)
Baseline dataset 12 months ending November 2022
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-clostridioidesdifficile-and-gram-negative-bloodstream-infections/

MSSA – Methicillin-susceptible Staphylococcus aureas
HOHA – Hospital Onset – Healthcare Associated
COHA – Community Onset – Healthcare Associated

INFECTION PREVENTION & CONTROL

Cannula Care

Catheter Care

Enteral Feeding

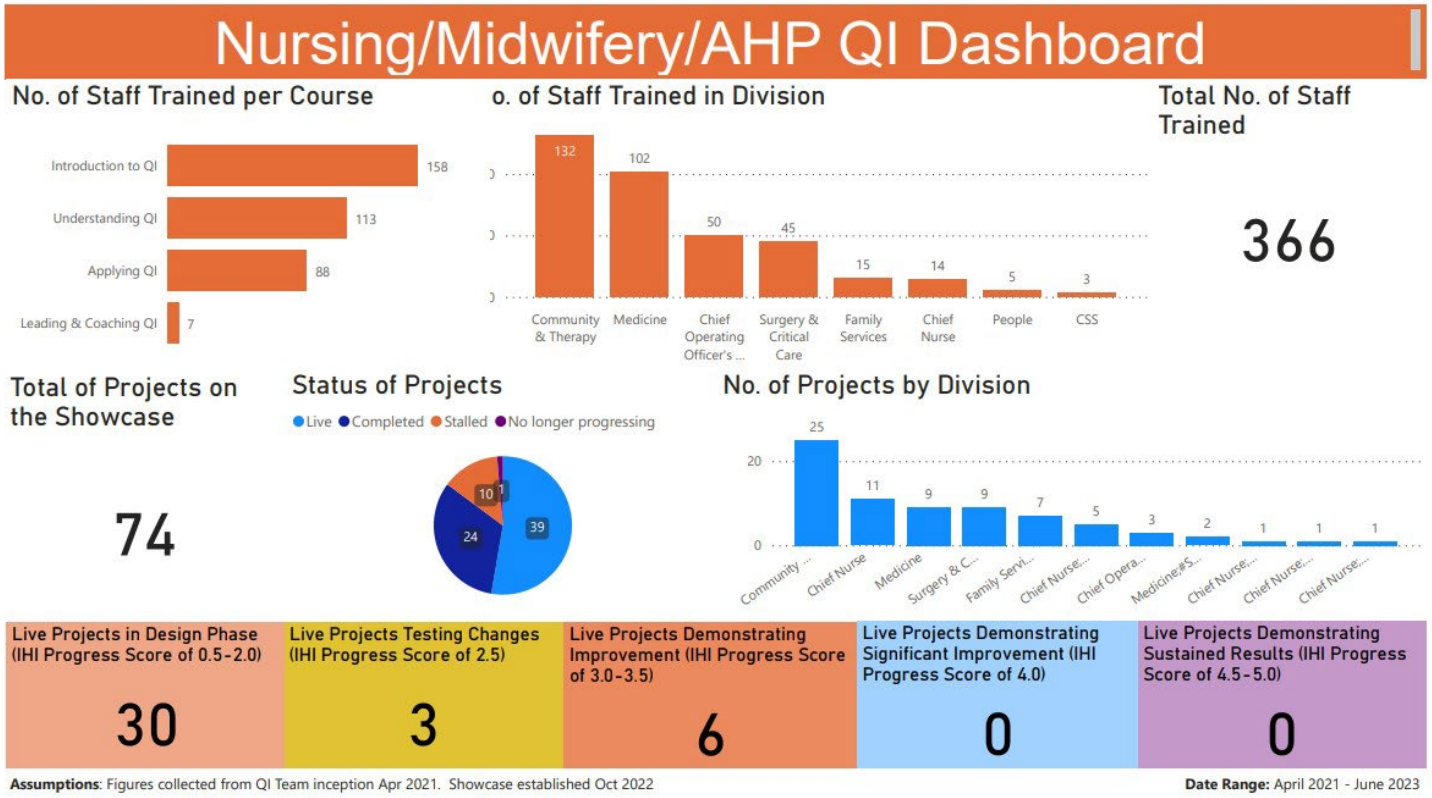
IV CARE

HYDRATION

Mouth Care

11.0 Quality Improvement (QI)

In focus this month is the Quality Improvement Showcase. The below charts capture the number of Nurses, Midwives and Advanced Healthcare Practitioners (AHPs) training in QI by division across the various levels of QI education in accordance with the QI dosing model. To date 366 of this workforce have been trained at some level of QI, in addition 74 QI projects have been initiated with 39 been completed showing measurable improvement with 35 still progressing.



The QI academy has continued to support the development of frontline QI projects during the month. In addition, they have held a specific “Applying QI” session for Medicine Ward Managers / Deputies at the request of the Associate Chief Nurse for Medicine. This is in an effort to further support ward teams by increasing their knowledge of QI approaches whilst also applying these newly found skills to focus on one of four key nursing metrics. These are falls, escalation, weighing of patients and pressure ulcers. Each ward will initiate a QI project focusing on one of these four metrics to feedback in September to allow wards to learn and share from each other and celebrate successes.

The testing of a “Ward Improvement Program” has commenced to provide wards with an approach / tool to work through areas for improvement whilst engaging their ward team. Initial testing has commenced with C2 whom have worked with the corporate nursing team to develop a QI huddle board. This approach is in the early stages of testing, but the ward team have been positive to the concept and have helped to shape the approach. The QI Huddle will involve a weekly meeting of the ward team for 15 min to allow them to identify problems and put forward ideas to be testing in the coming week on key areas that have been identified for improvement i.e. from 15 steps or from the ward team themselves. Key nursing metrics as well as staff morale will be monitored over the coming months to see if this approach can make a measurable impact.

12.0 Conclusion

The overall Care Hour Per Patient Day (CHPPD) was 8.9 in May.The latest model hospital data for January 2023 indicates a provider value of 8.9 (quartile 4 Highest 25%) against a peer median of 8.2 and provider median of 8.1. There were no wards with CHHPD below 6.0 this month. The number of open escalation beds has reduced with wards 19 and B4 no longer in use as escalation areas. The overall combined fill rate remains good with May being 97.6%, a slight decrease from the 98.6% in April. As part of the Chief Nurse establishment review in 2023, the Safer Nursing Care Tool data was collected during May/June 2023 and will be collected again over 20 days during October to account for seasonal variation and to inform the Chief Nurse Annual Safer Nursing Staffing Establishment Review. Increases have been seen again this year in the acuity and dependency of our patients.

Community nursing activity shows significant increase in the number of visits during May, with 95% of visits completed and 5% deferred, which is the lowest number being deferred seen despite the increase in demand.

Vacancies on the inpatient wards in April for both Registered Nurses and Healthcare Assistants show a decrease. There is a total of 220.73 whole time equivalent (WTE) (11.62%) Registered and 110.58 whole time equivalent (WTE) (11.01%) unregistered vacancies across the Trust as of the 31st May 2023. Community nursing vacancies are at their lowest for over a year. Recruitment and retention work programmes continue and will be refreshed following publication and review of NHS England's Long Term Workforce Plan (June 2023). The midwife to birth ratio in May 2023 is 1:23.9 for Grimsby and 1:20.3 for Scunthorpe which is below the acceptable ratio of 1:28. There has been a decrease in the number of reported falls in May 2023; an increase in the number of falls reported at the Grimsby site and a decrease in the number of falls reported at the Scunthorpe site. Three falls were reported with severe harm, no lapses in care were identified.

The number of pressure ulcer incidents reported in May 2023 has increased slightly. There has been an increase in the number of reported Category 2 pressure ulcers and a decrease in the numbers of reported Category 3 and unstageable pressure ulcers. None of the other higher reporting wards are currently demonstrating any concerning trends. From 1st May 2023, the acute sites introduced a rapid review of all Category 3, 4 and unstageable pressure ulcers. This will result in most incidents being reviewed and closed within 10 working days. Timely and supportive interventions can be implemented if needed and the new process will release time for Ward Sisters and Charge Nurses to support and deliver improvements.

New formal complaint numbers were 26 for the month of May and for a third month over 80% of those closed were in timescale, with 92% of May's complaint closures being achieved in timescale, and open complaints over 60 working days shows a downward trend. Trust wide the number of new Patient Advice and Liaison Service (PALS) concerns received was 146 during May and open PALS continue to reduce. In total 144 PALS concerns were closed in May. 69% of those PALS were closed in timescale and was the 5th consecutive month that over 60% have been closed in 5 working days or less. Improvements are largely felt to be related to the increased oversight from the temporary Patient Experience Manager role. However, there is a pending risk, as this post was unsuccessful in its business case bid and is due to cease August 31st, 2023.

The testing of a “Ward Improvement Program” has commenced with C2, who along with the QI team have developed a Quality Improvement huddle board along with a weekly Quality Improvement Huddle. This involves a 15 min huddle to identify problems, offer ideas and capture staff morale.

NLG(23)154

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	01 August 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 - May 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	The Workforce Committee Minutes from the meeting held on Monday 22 May 2023, and approved at its meeting on Tuesday 18 July 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.
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NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

WORKFORCE COMMITTEE

Meeting held on Monday, 22 May 2023 at 14:30 hours via Microsoft Teams

Present:

Susan Liburd	Non-Executive Director (Chair)
Linda Jackson	Vice Chair and Non-Executive Director
Kate Truscott	Non-Executive Director

In Attendance:

John Awuah	Interim Deputy Chief Operating Officer
Jenny Hinchliffe	Deputy Chief Nurse
Simon Nearney	Interim Director of People
Robert Pickersgill	Governor, Membership Office
Karl Portz	Equality, Diversity, and Inclusion Lead (agenda item 06)
Valerie Almira Smith	Head of Organisational Development, Wellbeing, and Inclusion (agenda item 07)
Annabelle Baron-Medlam	Head of Compliance and Assurance (agenda item 08)
Kathryn Hallam	Undergraduate Education Manager, HYMS (agenda item 09)
David Sprawka	Head of Recruitment and Employment Services (agenda item 12)
Mike Smith	Finance Manager, Cost Improvement & Efficiency Team (agenda item 14)
Liz Houchin	Freedom to Speak Up (FTSU) Guardian (agenda item 15)
Wendy Stokes	Executive Personal Assistant to Director of People *(taking minutes)*

1 Welcome and apologies for absence

Apologies received from Abolfazl Abdi, Sean Lyons and Shaun Stacey

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, 21 March 2023

Page 4, item 7, paragraph 4, line 6 should read: Jenny Hinchliffe noted that the Trust had not made improvements in staff perception that service users are the Trust's top priority and is one of the worst performing organisations.

Page 7, item 8, paragraph 2 should read: Paul Bunyan reported that a temporary band 5 nurse is in post and trained and if all goes well the department should be back to business as usual from May. It has invested £11k in temporary staffing. Peter O'Sullivan has been appointed as Head of Occupational Health, he has previous experience and commences in post on 24 April 2023. The ICB are exploring whether NLaG, HUTH and York can appoint our own Occupational Health Physician with a view to improving clinical services and being a lead for wellbeing particularly around mental health. Also to develop a programme to build our own internal occupational health nurse capacity.

With the above amendments the minutes from the previous meeting held on Tuesday, 21 March 2023 were accepted as a true and accurate record.

4 Matters arising from the previous minutes

There were no matters arising from the previous minutes.

4.1 Review of Action Log

Action 04 – Nursing and Pharmacy Recruitment – Prepare a response to the Quality and Safety Committee
The Chair confirmed she gave a verbal response to the Chair of Quality and Safety Committee. It was agreed to remove this item from the action log.

Action 05 – FTSU Guardian – Check second bullet point on page 3 of the report with Model Hospital and put reasonable adjustments into the highlight report
Liz Houchin confirmed that both actions had been completed. It was agreed to remove this item from the action log.

Action 06 – Paediatric nurses in emergency departments (EDs) – find out if extending the current model meets CQC requirements for safe staffing levels
Jenny Hinchcliffe reported that the paediatric emergency nurse (PEN) service will not provide two RSCNs on duty 24/7 in the emergency department. Following a consultation the PEN service will be extended to run from 8 am to 11 pm from October. Mitigation for overnight includes:

- RSCN from the paediatric ward will attend ED if there is an emergency and ward commitments allow
- The medical team have secured an additional SHO on nights therefore additional capacity to attend ED
- A fast-track pathway is in place which supports a doctor attending ED or transferring patients from ED to the ward if a high number of children in ED
- Paediatric competencies being completed by RNs (level 1 RCN and level 1 Trauma competencies) plus attend two paediatric study days

It was agreed to remove this item from the action log.

5 People Strategy Delivery Plan – End of Year Review and Objectives for 2023/24

Simon Nearney presented the following highlights from the People Directorate Objectives Review 2022/23 and the introduction to 2023/24 Objectives, available on SharePoint.

In terms of 'Trust Priority 1 - Our People', increasing flexible and hybrid working opportunities clinically and non-clinically for new starters, a new online flexible working system has been

developed that will be launching in quarter one. This will offer a much better candidate and manager experience and replace the paper-based process. For staff working in patient care there is still a lot of work to do around working differently, shift patterns, overcoming barriers and promoting the Flexible Working Policy.

After an establishment review in April 2022 it resulted in more substantive staff being in post in March 2023 compared with April 2022 including 100 WTE registered nurses, 122 WTE unregistered nurses and 25 WTE medics. The trust's innovative recruitment process for HCAs, including new to care candidates, has been recognized regionally and nationally as best practice with large numbers appointed on an ongoing basis to maintain a pool of candidates for quicker deployment. NHSE/I targets for international nurse recruitment have been exceeded with 91 starting at the trust by December 2022. This does come with challenges, and some wards cannot bring in more international nurses because of the resources needed to train them. A total of 89 newly qualified nurses have also been recruited.

A full recruitment review was undertaken in 2022 to make sure recruitment practices are fair, inclusive, responsive and provide a positive candidate experience.

New roles are being developed (including nurse apprenticeships) to attract staff and support existing workforce shortages. The trust is also looking at how it can utilize advanced practitioners.

The trust continues to raise awareness of and expand access to health and wellbeing services for staff and has developed Schwartz Rounds which gives an opportunity to reflect on the emotional and social challenges that come with working in healthcare.

The Just and Learning Culture progresses reducing employment case load by 93%. It is a mature conversation about people taking responsibility and ownership.

Kate Truscott asked about the total number of staff working flexibly. Simon Nearney confirmed from 2023/24 that is being logged via ESR and the trust will have the data going forward.

Kate Truscott went on to ask does the trust guarantee newly qualified nurses a job at interview. Jenny Hinchcliffe confirmed they are all given offers, but they have found that some may request DPOWH and if they do not get a place at DPOWH they may then go to Hull. The trust can lose around ten newly qualified nurses but if they were to offer everyone places at DPOWH it would be over established.

Kate Truscott asked does the trust have a pathway for nursing apprenticeships and associates from band 2 to band 4, there doesn't seem to be enough band 3 posts available. Regarding the ratio between non-qualified and qualified, would being creative about band 3 posts help. Jenny Hinchcliffe replied that a few years ago not all wards had band 3 staff and there are some opportunities to do health care assistant apprenticeships.

The committee felt that the report covered a lot of information and was an easy read. Robert Pickersgill felt CoG may find it helpful to see more summarized data including targets against what has been achieved, how that is measured and what the trust wants to achieve as the end outcome. Simon Nearney highlighted that his team have collaborated closely with Jenny Hinchcliffe and other managers to compile the report. The Workforce Integrated Performance Report at agenda item 11 gives a one-page summary of all the targets and that will give the detail Robert is looking for. Robert Pickersgill reiterated if everything were in one place it would be useful and easier for CoG. The Chair noted Robert's comments and highlighted that deep dives can be undertaken as required throughout the year.

6 Equality, Diversity, and Inclusion Strategy 2023 to 2027

Karl Portz presented highlights from the Equality, Diversity, and Inclusion Strategy 2023 to 2027, available on SharePoint.

Kate Truscott noted the BAME network had 76 members and asked what proportion that was of staff population. Karl Portz reported it was a small portion and they are trying to increase membership and identify more challenged groups. They are already working separately with international nurses and with other organisations. The EDI team capacity has increased by 100% and that gives more capacity to bring groups together to form a bigger network.

Kate Truscott asked who monitors EDI from a patient perspective. Karl Portz highlighted there is a patient experience team and Jug Johal chairs the NLaG Health and Equalities Steering Group. Karl is trying to work more closely with the ICB to be able to look across all services.
Linda Jackson agreed to discuss that further at the next NEDs meeting.
Action: Linda Jackson

The Chair commented that due to intersectionality some staff may not want to sit in the BAME group but may want to be members of another group.

The Chair confirmed the committee received and approved the Equality, Diversity, and Inclusion Strategy 2023 to 20237.

7 BAF 2022-2023 – Quarter 4 Report

Regarding SO2, at quarter 4 the risk remains at 20. The committee asked if a risk of 4 would ever be achieved. Simon Nearney replied that the trust should see numbers reducing. The committee agreed the risk should remain at 20 for quarter 01 and on 31 March 2024 the position should be 15.

Regarding SO5, at quarter 4 the risk remains at 12. This is probably due to group changes, destabilization and roll out of the leadership programme later in the year. The committee agreed the risk should remain at 12 for quarter 01 and on 31 March 2024 the position should be 8.

Simon Nearney reported that Peter O'Sullivan, Head of Occupational Health is in discussions with the ICB regarding employing a consultant. Wait times have started to reduce and there is a development plan for nurses.

For the next meeting, the Chair asked for a progress report on occupational health including ICB discussions about a physician, waiting times to commence work and waiting times for health referral. She went on to also ask for a report on DBS clearances and how long they are taking.
Action: Simon Nearney / Paul Bunyan

The Chair confirmed the committee noted the progress made in turnover, sickness, PADRs, role specific mandatory training and employment cases.

Robert Pickersgill felt the gap on role specific analysis was crucial, and he gave the example of staff shortages in diagnostic services which creates a bottleneck for the whole service.

8 CQC Report Update

Annabelle Baron-Medlam reported a note of accuracy on page 2; there is a total of 4 trust wide actions and 34 medicine actions.

Appendix 1 on page 28 shows Workforce Committee actions being broken down into main themes including culture and leadership, appraisals, mandatory training, and staffing including skill mix and numbers/ratios. Going forward there will be more information available on skill mix and numbers/ratios.

Linda Jackson felt the appendix was useful, but she would like to see some realistic timeframes between December 2022 to June 2024. Annabelle confirmed that deadlines were set in December 2022 and that could be added. Linda Jackson went on to ask for smaller milestones between now and June 2024, to be able to see actions being moved forward. The Chair agreed she would prefer to see shorter deadlines to keep the momentum going.

Kate Truscott felt it would be helpful to include staff numbers as well as percentages, particularly for the smaller cohorts. Annabelle agreed to go back to divisions and ask for trajectories and what they might achieve by September 2023 and March 2024.

Kate Truscott raised the issue of accommodation for training. Annabelle stated this was one of the actions linked to safeguarding training. It is e-learning and a physical training session which is fully booked until October. Jenny Hinchcliffe highlighted that training room capacity is on the risk register and is affecting some of the mandatory training compliance. Simon Nearney agreed to speak to Jug Johal.
Action: Simon Nearney

The Chair asked Annabelle if there was any other reason for low mandatory training numbers. It was confirmed that Christine Ramsden, Head of Education Training and Development is reviewing mandatory training and available resources. Annabelle confirmed the information given is what divisions tell her. There are historic issues with divisions focusing on filling shifts and if they perhaps focused on fewer areas of training, they may be able to increase compliance.

9 Undergraduate Medical Education – Six-monthly Progress Report

Kathryn Hallam reported the main risk was capacity for teaching fellows and clinical development facilitators. A business case has been approved to help with fifth year students from August. Student numbers have almost doubled since the first cohort in 2003. The trust has fantastic tutors, and it gets good local feedback from students and has been nominated for Team Excellence Awards for both Grimsby and Scunthorpe Clinical Skills Teams, Grimsby Student Liaison Team and for administrative support provided. The trust has annual monitoring visits from both HYMS and Sheffield medical schools. A separate meeting is being held with the HYMS Programme Director, Clinical Dean, and representatives from HASR to ensure schools are aware of any potential service changes that may impact on the current curriculum delivery to factor that into future planning. After five years at university a lot of students want to go back to their family or larger cities, and any advice on how to recruit more students would be welcomed.

The Chair asked if the trust has enough teaching fellows to support the fifth-year students from August. Kathryn Hallam confirmed they have enough, and although other sites are in a stronger position, that will be good for the fifth-year expansion.

Kate Truscott asked about availability of accommodation and whether that was an issue. Kathryn Hallam stated that had been an issue in the past. She is working closely with accommodation and is part of the stakeholder group. In Scunthorpe estates and facilities continue to explore options to increase capacity including Project Anchor and Larchwood and at present there are no issues.

10 Quality and Safety Actions

Occupational health discussed above under agenda item 07.

11 Workforce Integrated Performance Report (IPR) - Trust and Directorate

Not discussed.

12 Recruitment KPIs/Dashboard

David Sprawka produced a simplified Recruitment KPIs/Dashboard available on SharePoint.

Regarding the nursing pipeline the next report will include a 3-year forecast. Over recent months there has been some difficulties with the time taken to hire and to send conditional offers and start letters. Peter O'Sullivan has arranged a QI process mapping day with the occupational health team to identify and map issues. Simon Nearney asked if it would be possible to capture the length of time taken to onboard someone including occupational health and when the conditional offer goes out to give a good indication of the level of staff experience. David Sprawka confirmed those indicators could be added.

Linda Jackson stated un-registered nursing vacancies currently stand at 97.80 WTEs and she questioned why that had only reduced slightly in the last two months when a lot of effort has gone into recruitment, and it is still a priority for the trust. Consultant vacancies remain the same and she went on to ask if there is enough targeting being done to address the issues. David Sprawka highlighted that the numbers are for staff that have started in post, not being recruited. Quarterly HCA recruitment drives are taking place and the trust is working closely with the job centre. The issue isn't sourcing HCAs, a large of number of applications are being received. Issues are around occupational health and the ability to train new HCAs. Regarding is the trust doing enough, Jenny Hinchcliffe stated that one of her team is doing some work to validate operational zero which stood at 15 two years ago. While waiting for recruitment checks, people are put into a pool although the trust will lose people if they sit in the pool to long. Regular meetings also take place with ward managers to make sure they have accurate data. Jenny and her team are also being asked why midwifery support workers and outpatient vacancies are not being filled at present. Linda Jackson stated if there is a pool available to cover vacancies it would be good to know that. It is about how that data is presented and triangulated.

Simon Nearney agreed the biggest issue for the trust is recruitment and overall the vacancy level is around 10%. Regarding un-registered there is a potential issue with band 2 staff. The trust is expecting a formal letter from UNISON about an evaluation of posts. They are questioning what care the trust wants to provide and whether that is contributing to the vacancy rate.
Simon Nearney added the trust is making progress and people are putting in huge efforts to reduce the vacancy rate by 4% next year but that is difficult. Linda Jackson added if not much improvement is seen perhaps the trust needs to do things differently to get more traction going forward.

The committee is watching with interest the progression from band 2 to band 3 as well as medical recruitment, particularly for consultants. Simon Nearney added that medical consultants are the hardest to recruit. NLaG does not have a trauma centre, enough research and when looking overseas there is a rigorous GMC process. More effort has been put into the Certificate of Eligibility for Specialist Registration (CESR) Framework during the last twelve-months and the recruitment team visited Kerala in India and serious conversations are needed with Shaun Stacey and Kate Wood around the infrastructure to train medics from abroad. One of the benefits of the group structure is combined services and when appointing doctors that will be an attraction on both the North and South bank.

David Sprawka highlighted that a business case has been approved for an extra resource in the talent acquisition team to focus on senior medical recruitment and the ten consultants awaiting to start at the trust.

13 Staff Survey Action Plan

Valerie Almira-Smith gave highlights from the Staff Survey action Plan available on SharePoint.

The Chair thanked Valerie for a comprehensive update on the plan which was easy to understand.

14 Agency Financial Spend Report

Mike Smith from the Cost Improvement and Efficiency Team gave brief highlights from the Agency Financial Spend Report available on SharePoint.

Linda Jackson asked if a deep dive was necessary, or should the committee do something differently to support medicine. It is a busy directorate covering both planned and emergency care and has spent £16m of the £30m agency budget. Mike Smith added that workforce plans for this year are tagged to recruitment plans and although last year was quite difficult, they are on track at the end of month 01. The turnover rate is 7% which is much better than other NHS and private sector organisations.

Kate Truscott asked about bank usage because some people prefer to work more flexibly. Mike Smith replied that bank usage is not as large as it is expected to be, in terms of cost premium that is nowhere as high as agency spend. Simon Nearney added that the Group model and working more closely with HUTH and using the major trauma centre may help, and that is why the trust is using the CESR Academy. It is also about spending money to relieve the pressure in the system.

Jenny Hinchcliffe stated that the trust has unestablished escalation beds and HOBS units, and both had to have red and green wards during Covid. This is now being reviewed with the bed reconfiguration work that is ongoing with divisions to look at coding of additional requests for staff. The number of codes has been reduced and they are working with the bank team around recruiting additional staff on the bank and giving them a better induction to hopefully retain them. All bank staff are offered substantives posts, and this should also help reduce agency spend. Mike Smith did not want to speculate; they are trying to tighten up the request reasons because ‘unknown’ was the fourth biggest reason for additional requests.

The Chair thanked Mike Smith for the update.

15 Freedom to Speak Up (FTSU) Guardian – Quarter 4 and Annual Report 2022-2023

Liz Houchin gave highlights from the Freedom to Speak Up (FTSU) Guardian Quarter 4 and Annual Report 2022-2023 available on SharePoint.

Main themes raised were around process, behaviors, worker safety and patient safety.
Liz Houchin brought item 4.4 on page three to the attention of the committee. It states 20% of cases had an element of patient safety, compared to 13% against peer providers. Liz confirmed she was comparing NLaG to the ICB rather than its peers.

Kate Truscott asked does the trust need to do to more work to signpost staff. Liz Houchin highlighted the plan for culture transformation champions with FTSU training being able to signpost and spread the word about how people can speak up. Liz added she is trying to be more proactive and often hears anecdotally about concerns before staff speak to her. It is about developing and working with trust leaders, making them feel secure and creating an environment that makes staff feel safe. It is not about what is said, it is about the way it is said.

16 Workforce Committee Terms of Reference – Annual Review

Item deferred.

17 Annual Workplan

The Chair noted an action to review the annual workplan and discuss that with Simon Nearney and Kate Truscott.

18 Workforce Committee Self-Assessment – Annual Review of Committee

The Self-Assessment Annual Review of Committee was received. The Chair stated that consideration of the report will contribute to planning and shaping of the proposed Workforce Committee in Common to be formed within the group structure.

19 Trust Board Highlight Report

The Chair confirmed the following to be highlighted to Trust Board:

- Recruitment – some improvement seen in staff turnover and reduced reliance on bank and agency staff. This remains one of the top priorities for the Interim Director of People.
- Equality, Diversity, and Inclusion Strategy, 2023 to 2027 – the committee received and approved the strategy.
- Agency spend – the committee undertook a deep dive to gain a better understanding of the drivers for the utilisation of agency staff. This remains one of the top priorities for the trust.
- Freedom To Speak Up (FTSU) Guardian Quarter 4 Update and Annual Report for 2022-2023 – the committee received and approved the report.
- Self-Assessment Annual Review of Committee - received by committee.

20 Items for information* (please refer to Appendix A)

Nothing discussed.

21 Any other urgent business

21.1 Industrial Action

Nothing discussed.

22 Date, time, and venue of next meeting:

The next meeting will take place as follows:

Date: Tuesday, 18 July 2023
Time: 14:00 hours to 16:30 hours
Venue: Virtual via Microsoft Teams

The meeting closed at 16:47 hours

Meeting Attendance from April 2023 to March 2024

Attendee Name	Possible	Actual	Attendee Name	Possible	Actual
Sue Liburd	1	1	Jenny Hinchcliffe *****	1	1
Kate Truscott	1	1	John Awuah *****	1	1
Linda Jackson	1	1			
Simon Nearney	1	1			
Shaun Stacey	1	0			
Ellie Monkhouse	1	0			

***** Rep for Executive Director

NLG(23)155

Name of the Meeting	**Trust Board - Public**	
Date of the Meeting	01 August 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 – Quarter 1 Report 2023-2024**	
Purpose of the Report and Executive Summary (to include recommendations)	The FTSU Guardian Quarter 1 Report for 2023-24 gives an update from the last board report, an overview of number of concerns raised, national and regional updates, the proactive work undertaken by the trust's FTSU Guardian, and future FTSU plans. 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.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up (FTSU) Guardian – Quarter 1 Report 2023-2024
April to June 2023

Liz Houchin
05 July 2023

Contents

1. Executive Summary

1.1 This paper provides an update regarding NLaG activity for Q1 2023-24 (which covers the period April –June 2023). 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

2.1 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

3.1 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 Q1 2023-24 the number of concerns received were 68

- 7 concerns were raised anonymously in Q1. A high percentage of these have come through the Staff App.
- 20 concerns involved an element of patient safety (12 month rolling average). This puts the Trust in the high quartile nationally, the peer figure being 7 (figures accessed from Model Hospital data June 2023). For Q1, 11 concerns involved an element of patient safety.
- 10 concerns involved an element of bullying and harassment (12 month rolling average) which puts the Trust in the mid-high quartile nationally, the peer median figure being 9. For Q1 9 concerns involved an element of bullying and harassment.

4.2 The Q1 figure of 68 is significantly higher than Q1 in 2022-23 which was 35.

4.3 The main themes raised were around behaviours, worker safety 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.

Concerns		Q4. 2022-23 (January - March 2023)	Q1. 2023-2024 (April - June 2023)
		64	**68**
Themes	Behaviour / relationships	18	26
	Bullying & Harassment	6	9
	Culture	0	0
	Leadership	0	1
	Patient Safety	10	11
	Process/Systems	29	29
	Personal Grievance	0	0
	Worker Safety	12	13
How raised	Openly	24	12
	Confidentially	40	49
	Anonymously	0	7
Perceived detriment		0	0

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

Report Breakdown by Role

Q4. 2022-2023 (January – March 2023)		Q1. 2023-2024 (April – June 2023)	
Role	**Number**	**Role**	**Number**
Doctor/Dentist	7	Doctor/Dentist	6
Nurse/Midwives	14	Nurse/Midwives	17
HCA	18	HCA	9
Healthcare Scientists	4	Healthcare Scientists	2
Admin	9	Admin	12
AHP	3	AHP	3
Other	9	Other	12
Not Known	0	Not Known	7

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 2023-24	Feedback received	Would you speak up again? Yes
Q1	8	7
Q2		
Q3		
Q4		

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

I found the whole process very positive; I was very worried coming up to the meeting, Liz immediately put me at ease, very welcoming, and genuinely wanted to help/listen. She acknowledged and understood my concerns – and gave good clear options – including the option to visit again. Such an amazing service.

I didn't feel enough time was spent looking into the issue.
Getting Liz involved moved things forward after months of nothing happening, thank you.

4.7 Case Study

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

The FTSU Guardian received several separate concerns relating to an admin team within one of the divisions, colleagues cited similar concerns relating to workload, role expectations and behaviours not in line with Trust values. After identifying the area and the number of concerns being raised, the FTSUG contacted the management team to highlight the issues being raised and they decided to hold a series of listening meetings, after each meeting actions and timeframes were shared with the teams and further meetings were scheduled to monitor progress. Colleagues reported that they felt their voice had been heard.

5. 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). Figures for 2022-23 will be published by the NGO in early July 2023.

All FTSU Guardians now must take an annual competency test, the FTSUG has passed this for 2023.

Q1 data for 2023-24 will be submitted to the NGO by the Guardian when the data collection period opens.

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. Recent discussions included how organisations support staff through trauma incidents, how organisations support internationally educated colleagues and the Guardian training.

6. Proactive work of the FTSUG during Q1

- 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 and Culture Transformation Board
- Attendance at all Trust inductions
- Walk Rounds at SGH with Trust Chair
- Meeting with NED for FTSU
- Walk rounds with Comms team to inform FTSU communications plan

Future Plans

- Work to define the future work of combined Champions to include Pride and Respect, FTSU and Health and Wellbeing is ongoing by the People Directorate
- Continue to work with the Divisions to ensure that learning from concerns is embedded into practice.
- Continue to raise profile of the Guardian
- Attendance at all relevant meetings

7. Conclusion

7.1 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. Recommendations

The Trust Board is asked to:

a) Note the report for information

Compiled By: Liz Houchin

Date: 05 July 2023

NLG(23)156

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	1 August 2023	
Director Lead	Dr Kate Wood	
Contact Officer/Author	Dr Elizabeth Evans	
Title of the Report	**Guardian of Safe Working Annual Report**	
Purpose of the Report and Executive Summary (to include recommendations)	The Annual Report of the Guardian of Safe Working Hours shows the exception report information for the annual period of April 2022 to March 2023. The date of the reporting period has been adjusted to match the financial year at the request of the Chief Medical officer. Quarterly reports continue to be generated and shared at Trust Management Board (TMB), the Joint Local Negotiating Committee (JLNC), the Junior Doctor's Forum (JDF) and with colleagues at Health Education England (HEE).	
Background Information and/or Supporting Document(s) (if applicable)	Terms & Conditions of Service (TCS) 2016/2018 – Junior Doctors	
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 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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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 Annual Report

Dr Liz Evans
Guardian of Safe Working
April 2023

Contents

Executive summary

The Annual Report of the Guardian of Safe Working (GoSW) Hours shows the exception report information for the annual period of April 2022 to March 2023. The date of the reporting period has been adjusted to match the financial year at the request of the Medical Director. Quarterly reports continue to be generated and shared at Trust Management Board (TMB), Joint Negotiating Committee (JLNC), the Junior Doctor's Forum (JDF) and with colleagues at Health Education England (HEE).

There are no trainees within the Dentistry service at NLaG and so the Annual Report applies only to doctors in training.

We are now in the seventh year of the 2016 national contract for doctors in training which aimed to encourage stronger safeguards to prevent doctors working excessive hours. Exception reporting (ER) of extra hours, missed breaks and missed educational opportunities is well established in Northern Lincolnshire and Goole NHS Foundation Trust and we continue to positively promote exception reporting through induction, training, drop ins and the monthly Junior Doctors' Forum.

The 2016 contract was subject to review in 2019 and although largely unchanged there were some notable differences which the Trust has implemented.

Exception reporting is a valuable instrument that provides up to date information regarding pressure points in the system. It ensures safe working hours and improves the morale of doctors in training, the quality of medical training and patient safety. It is also the agreed contractual mechanism for ensuring that trainees are paid for all work done.

The safety of patients is a paramount concern for the NHS and for us as a Trust. Staff fatigue is a hazard to both patients and staff. The safeguards for working hours of doctors in training are outlined in the terms and conditions of service (TCS) and are designed to ensure that this risk is mitigated, and that this mitigation is assured.

Fill rates for doctors in training at the Trust continue to be high, over 80%, which has helped with rotas, working hours, and ensuring access to educational opportunities.

Rota design and co-ordination now sits within the Workforce Resource Centre. This provides oversight of rota design and ensures that the terms and conditions of service as per the Junior Doctors Contract are met within that design.

High level data – as of March 2023

Number of training posts (total): 311
Number of doctors in training posts: 249.9
Number of training post vacancies: 61.1
Number of LTFT trainees: 20

Source: Recruitment via establishment spreadsheets and vacancy spreadsheets.

Exception report analysis

The table below, from the Allocate software, provides a breakdown by speciality of the total number of exception reports received during the period April 2022 to March 2023.

Department	Total number of exceptions submitted
Accident and emergency	1
Acute Medicine	10
Anaesthetics	1
Cardiology	12
Gastroenterology	29
General medicine	136
General surgery	30
Geriatric medicine	5
Obstetrics and Gynaecology	10
Paediatrics	4
Respiratory Medicine	1
Trauma & Orthopaedic Surgery	10
Urology	3
Grand Total	**252**

This data shows the areas that generate the highest number of exception reports. This enables specific focus to be given to these areas in order to support the specialty in reducing exception reporting and providing a good learning environment for the doctors in training.

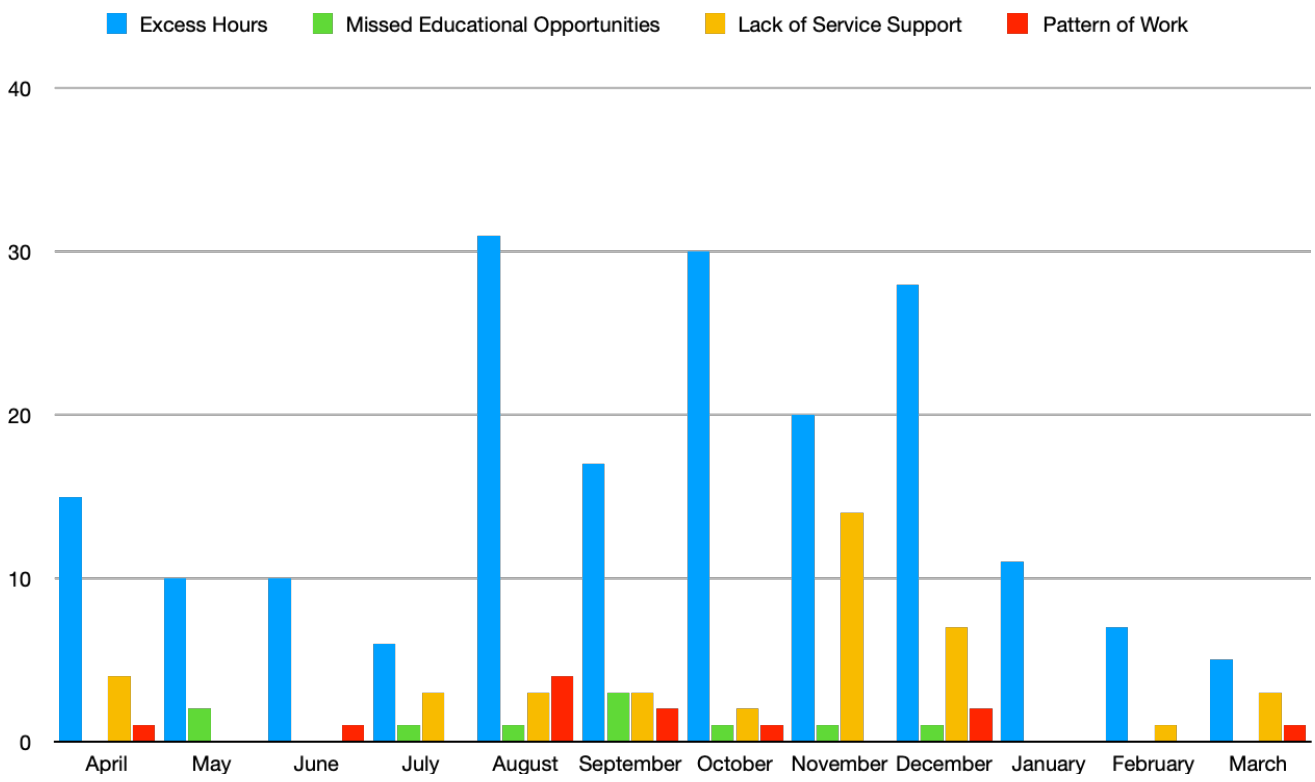


Figure 1: Reasons for exception reporting by month.

The above table (figure 1) shows the number of exception reports submitted from all departments by month, broken down to show the reasons reports were submitted. As is usual the vast majority of the reports received concern excess hours worked. The reason for this is likely to be that it is an easily recognisable incident which can be quantified, and thus is more likely to be reported. There appears to be a large increase in the number of reports submitted in August, which is to be anticipated owing to the Junior Doctors rotating jobs. There was a high level of reporting for excess hours during what was a very difficult winter. There is also a high level of reporting for lack of service support during clinical commitments during November and December. This reflects an issue which was escalated by the Doctors in Training from Gastroenterology and Cardiology in DPOW, concerning a lack of support at registrar level. This issue was escalated to the medical director, and a meeting was organised with the clinical leads for medicine. During this meeting a plan was agreed upon which re- enforced staffing in the affected departments, and an establishment review has been planned, in addition to work to manage and reduce sickness in the department. This work is ongoing, but a the time of writing the level of reporting has markedly decreased, and anecdotal feedback from the doctors in training shows that the situation has improved.

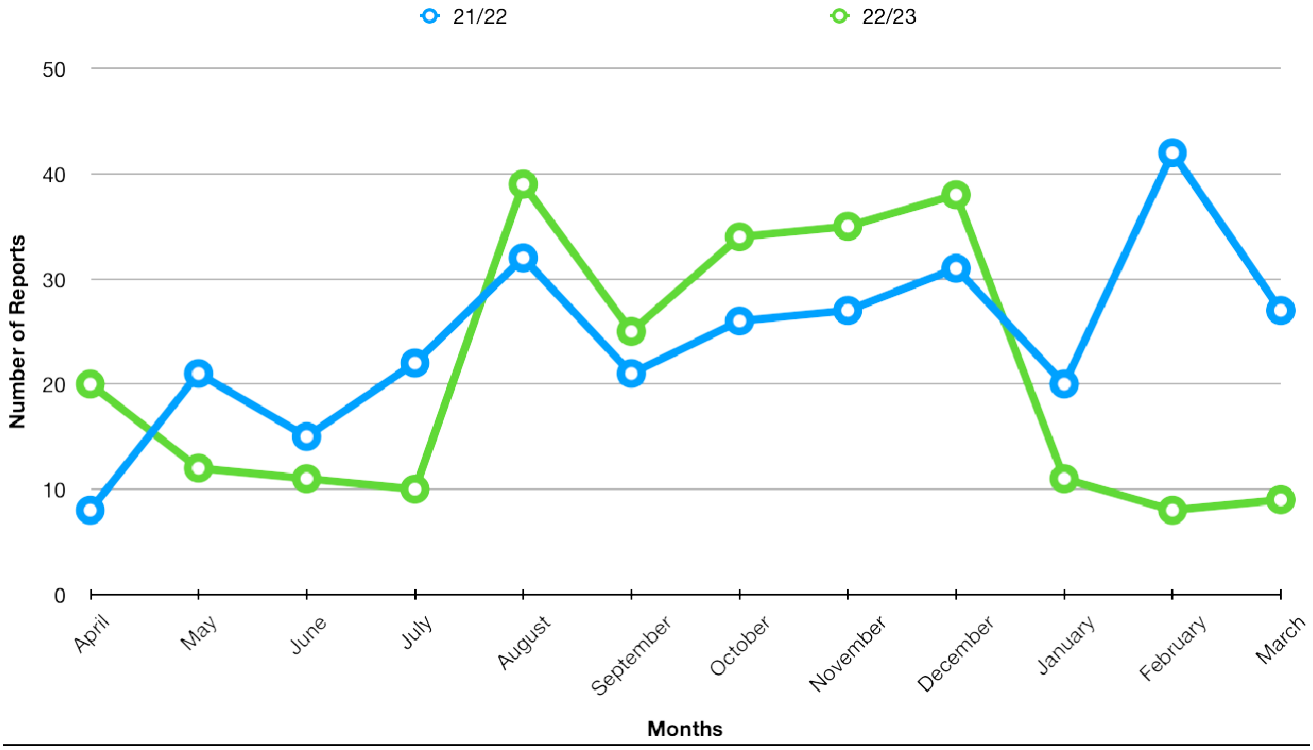
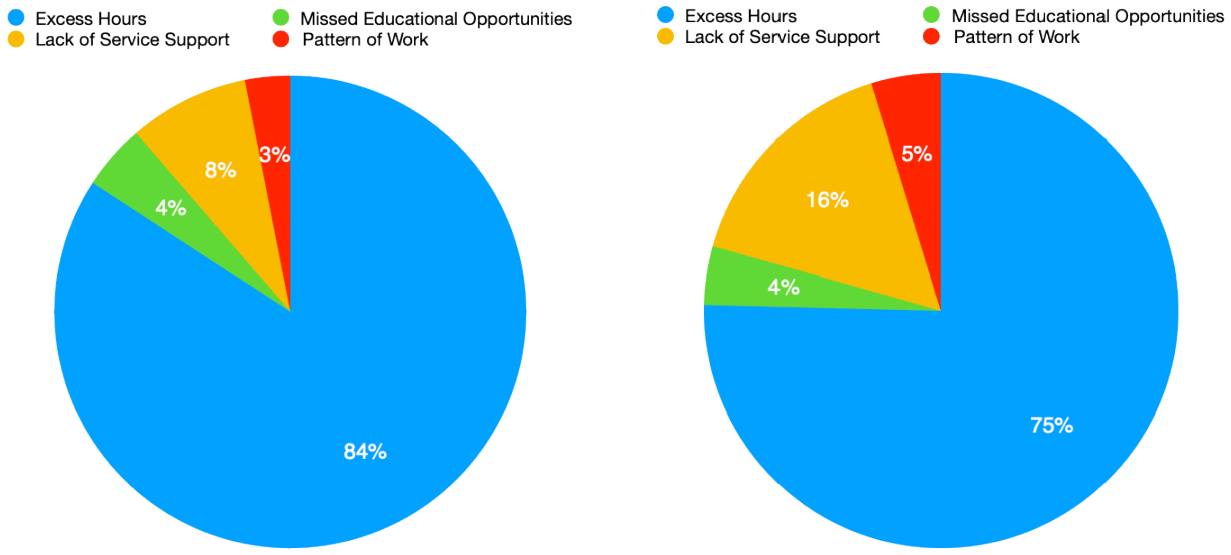


Figure 2: Exception reports by month

As figure 2 shows the rate of exception reporting follows roughly the same pattern for the majority of the year. There was a higher level of exception reporting in January and February 2022, which was likely due to high levels of sickness due to covid-19. It is reassuring that this level has reduced, and this is a change we hope to see continuing moving forward. The peak in august which is due to the new doctors rotating into the trust reflects the decrease in efficiency by new doctors rotating and is an expected finding.

Figure 3: Reasons for Exception Reporting by Year



As shown in figure 3, the reasons for exception reporting show some consistency comparing this year with the last. By far the most common reason for exception reporting remains excess hours, and this is a pattern we would expect to see continue moving forward. This is because excess hours is the most easily quantifiable type of breech, which makes the doctors much more likely to report it. A higher proportion of the reports this year concerned issues with service support, owing to the issues in the medical specialties in DPOW. It is encouraging that the doctors in training felt that they were able to escalate their concerns in this way, and that positive change could be made in response.

Summary

1. The Trust was granted £60,000 of national money in 2021 to improve facilities for doctors in training and working in partnership with the doctors this has now been used to upgrade the doctors rest facilities and enhance the doctor's mess. This work has now been completed and upgraded rest areas are available on both sites.

2. Fill rates remain high, but this does not always translate in the reduction in need for locums and further work at Directorate level is required to understand the demands for locums, with the aim to reduce the reliance on locum doctors.

3. There have been 2 fines imposed for breaches of the Doctors in Training Contract. These fines were imposed for doctors missing breaks, and for excessive working hours. There are plans to spend this money on wellbeing resources for the doctors, after discussion at the Junior Doctors Forum.

4. This past year continued to see an improvement in engagement with our doctors in training. We will continue to build on this during the next academic year.

5. The GoSW attends meetings between the Trust and HEE to monitor the learning environment. During the past year these meetings have concentrated on Medicine and Gastroenterology, following concerns raised in the GMC annual trainee survey. There has been significant progress towards moving out of enhanced monitoring, with Health Education England being reassured by our support of the Doctors in Training.

6. The GoSW holds Junior Doctor Forums every month and these are a valuable opportunity for our Doctors representatives to meet with the Guardian, MD office, Director of Medical Education (DME) office, BMA and LNC in one place. We have regular attendance from the freedom to speak up guardian, and the trusts Chief Medical Information Officer, Dr Alastair Pickering. This enables the Doctors in Training to engage in the improvements to the digital infrastructure and gives them the opportunity to shape their working environment.

7. Issues addressed at the JDF over the past year have included:

    - Rota concerns
    - Working conditions
    - Attendance at the JDF
    - The impact of the Humber Acute Service Review (HASR)

8. There is a defined slot at the JDF to discuss quality improvement and there is a dedicated point of contact within the quality improvement office to support the Junior doctors.

9. The GoSW has regular meet ups with the Freedom to Speak Up Guardian and the representatives of PGME to identify common themes. These have been very successful at identifying areas of difficulty, enabling us to provide more holistic support to the Doctors in Training.

10. There are around 175 educational supervisors in the trust. Of these, 30 have been through the re- accreditation training run by PGME, with further dates proposed in July, September and November.

Recommendations

1. To continue to support and encourage the work of the Guardian and the DME in engaging Educational Supervisors and Consultants in the exception reporting system.

2. To ensure a positive regard for the education of trainee doctors recognising the importance of the medical workforce and safeguarding the balance of service provision and education.

3. To support initiatives to improve the experience of doctors in training at NLaG. The main areas of focus are the medical departments, with an aim of removing HEEs requirement for improvement. This will strengthen the Trust's reputation and attractiveness as a training provider/employer.

4. To promote the engagement of the Junior Doctors in the exception reporting process, and to promote the system as an agent for positive change and patient safety within the trust.

Dr Liz Evans - Guardian of Safe Working

Date: May 2023

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	1st August 2023
Director Lead	Dr Kate Wood, Chief Medical Officer
Contact Officer/Author	Rachael Smith
Title of the Report	**Annual Revalidation Report**
Purpose of the Report and Executive Summary (to include recommendations)	This report is an essential requirement done on an annual basis summarising the appraisal position for doctors connected to Northern Lincolnshire and Goole NHS Trust as their Designated Body. The purpose of this paper is to provide the board with information about processes in place at Northern Lincolnshire and Goole NHS Foundation Trust for medical appraisals, revalidation recommendations to the General Medical Council, and medical governance arrangements. The report will therefore help Northern Lincolnshire and Goole NHS Foundation Trust in its pursuit of quality improvement, provide the necessary assurance to the higher-level responsible officer and can act as evidence for Care Quality Commission inspections. Furthermore, the purpose of this paper is to provide assurance to the board that the organisation continues to implement and comply with the Responsible Officer Regulations and legislation; Medical Profession (Responsible Officers) (Amendment) Regulations 2013. The report follows the NHS England template framework for annual board reporting and the report covers: The Board, through the Chief Executive Officer, are required to sign the ‘Statement of compliance’ at the end of the report confirming that the organisation is compliant with the Responsible Officer regulations.

	The approved annual report and signed statement of compliance will be submitted to NHSEI by the Responsible Officer's office.	
Background Information and/or Supporting Document(s) (if applicable)	Supporting documents include. Annual Revalidation Report Appendix 1 – MIAD Report Annual Revalidation Report Appendix 2- MIAD/Northern Lincolnshire and Goole NHS Foundation Trust Action Plan	
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
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Annual Revalidation Report 2023

Contents

1. Background to appraisal and revalidation

Medical revalidation was launched by the Department of Health and Social Care and the General Medical Council in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety, and increasing public trust and confidence in the medical system. It was launched to be a proactive system of ensuring doctors are fit to practice in the UK. The revalidation process was not designed to “catch out” doctors who were not practising to the accepted standards as laid down by Good Medical Practice.

Prior to the introduction of revalidation there was no consistent mechanisms of ensuring doctors were fit to practice and if there were concerns around fitness to practice, a patient had already come to harm. The General Medical Council also stated that they believed it was important for regulators to be in continuous contact with registered doctors throughout their career, and not just when a doctor is being investigated by the General Medical Council.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that executive teams will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations

- Checking there are effective systems in place for monitoring the conduct and performance of their doctors

- Confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctor

- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are conducted to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

All doctors are allocated to a designated body through the General Medical Council. Northern Lincolnshire and Goole NHS Trust is the designated body for all our non-training grade doctors such as Consultants, Specialty Doctors, International Training Initiative doctors and Trust Grade doctors. Dr Kate Wood is the Responsible Officer (Responsible Officer), and Mr Ajay Chawla is the Appraisal Clinical Leader for the Trust.

Doctors in training are connected to the deanery (Health Education England – Yorkshire and Humber) and locum agency doctors are connected to their respective locum agency for revalidation. Therefore, these groups of doctors are not included in this report.

2. General Information

2.1 Medical appraisal and Revalidation process post COVID-19

During the pandemic, a new medical appraisal format ("Appraisal 2020" format) was released by the Academy of Medical Royal Colleges which was designed in a way to allow doctors to work through the form more efficiently by condensing the form. For example, the Continuing Professional Development (CPD), Quality Improvement Activities (QIA) and feedback, use to be separate pages but these are all now condensed onto one page.

The form also allows more free-flowing reflection which is a core component that underpins a clinician's professional development and therefore assures fitness to practice.

Lastly, the form was designed to be more wellbeing focused which allows clinicians to reflect on their self and mind over the last 12 months.
Anecdotal feedback from the pandemic years in relation to appraisal suggest that clinicians value their appraisal time to discuss wellbeing issues.

The Appraisal 2020 format proved to be popular and therefore further collaboration between the Academy of Royal Medical Colleges and General Medical Council to improve the appraisal format even further resulting in "Appraisal 2022" which has now been fully implemented nationally and Northern Lincolnshire and Goole NHS Foundation Trust has adopted this new format

2.2 Responsible Officer Role

Dr Kate Wood, Chief Medical Officer, is the nominated Responsible Officer for this Trust. The Responsible Officer has received Responsible Officer training and is a licensed medical practitioner. Therefore, Northern Lincolnshire and Goole NHS Foundation Trust is compliant with Regulation 5 of The Medical Profession (Responsible Officers) Regulations 2010.

The Responsible Officer also attends the NHS England and NHS Improvement quarterly Responsible Officer network meetings and best practice is shared with the Clinical Lead for Appraisal and the Revalidation Coordinator.

The Responsible Officer also makes recommendation of revalidation to the General Medical Council for doctors who are due to revalidate. These recommendations are based on an evidence-based approach which consist of appraisal output summaries which are submitted by the appraisers.

2.3 Funds, capacity, and resources

To date the organisation has been compliant with Regulation 14 of The Medical Profession (Responsible Officers) Regulations 2010, which states that each designated body must provide the appointed/nominated Responsible Officer with sufficient funds and other resources necessary to enable the Responsible Officer to discharge their responsibilities.

2.4 Records of Northern Lincolnshire and Goole NHS Foundation Trust licensed medical practitioners

The Revalidation and Medical Appraisal Coordinator is the Trust-wide coordinator who maintains records of Northern Lincolnshire and Goole NHS Foundation Trust licensed medical practitioners. This includes.

General Medical Council Connect: A database of Medical Practitioners who have a prescribed connection to Northern Lincolnshire and Goole NHS Foundation Trust where the revalidation recommendations are submitted.

L2P Appraisal software system. All Medical Practitioners who are on the Northern Lincolnshire and Goole NHS Foundation Trust General Medical Council connect database will have an L2P account which is an online appraisal system.

To ensure that these lists are accurately maintained, the coordinator exports starter and leaver reports from Business Intelligence system.

2.5 Northern Lincolnshire and Goole NHS Foundation Trust Medical Appraisal Procedure policy document

This procedure will be due for review in September 2023. A draft of the updated policy has been discussed and agreed with Joint Local Negotiating Committee (JLNC) for approval and is due to be ratified at the Trust Management Board during July 2023.

2.6 Short-term placement and locum doctors

Short term contract holders, such as NHS locum Consultants, fixed terms speciality doctors and Trust Grade doctors, are supported in their continuing professional development (CPD), revalidation and governance in coherence with substantive medical staff, i.e., they are not considered or managed differently to permanent medical staff.

Short term contract holders are expected to maintain their professional development through the appropriate Trust processes, such as Study leave, participating in mandatory training, attending medical teaching sessions, to name a few.
They are also expected to engage with medical appraisal and revalidation. Upon appointment short term contract holders are incorporated into the local appraisal software system, L2P, are duly welcomed by the coordinator via email, advised of medical appraisal 1:1 session, and the General Medical Council are informed that the doctor has a prescribed connection to Northern Lincolnshire and Goole NHS Foundation Trust .

In terms of governance all new short-term contract holders are initially made aware of governance procedures, such as incident reporting, through the Trust's induction Policy as are all new starters to the Trust.

3. Ensuring Effective Appraisal and Appraisal Data

3.1 The Medical Appraisal

Doctors who have prescribed connection to Northern Lincolnshire and Goole NHS Foundation Trust use the L2P software system. The doctors are required to fill their appraisal form via the L2P system and there are three basic elements to the appraisal.

Appraisal Inputs – doctor fills in each section of the L2P form and uploading supporting information/evidence which covers their scope of practice, which may include non-NHS work. The doctor must cover and reflect on each section which are displayed below. Once the inputs are complete, the doctor completes a checklist which acts a prompt to ensure that they have considered the various aspects for their appraisal. An example of the checklist can also be seen below. The form is then submitted to appraiser ahead of appraisal meeting.

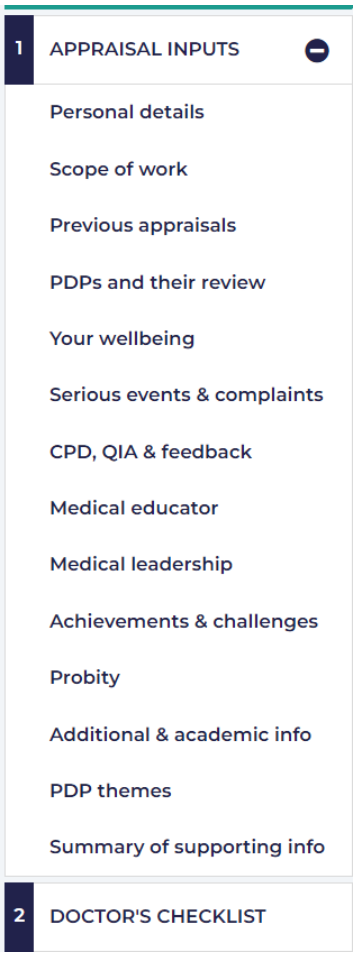


Figure 1 Sections of appraisal inputs

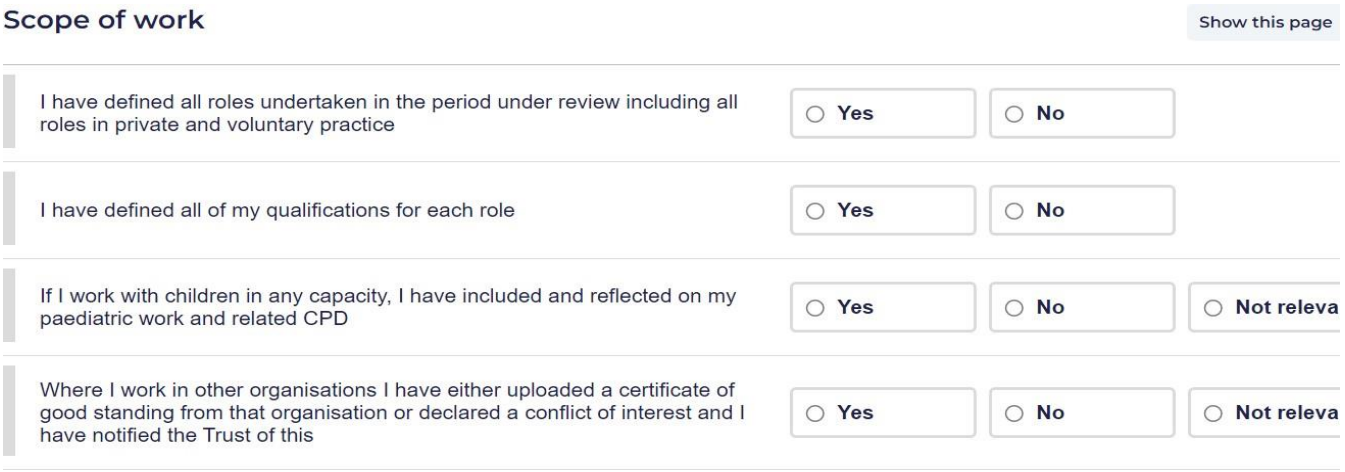


Figure 2 Excerpt of the doctor checklist

1. Appraisal meeting – meeting between doctor and assigned appraiser. This is where the confidential discussion will take place, verbal reflection, and discussions around wellbeing, professional development, and quality improvement.

2. Appraisal outputs – Doctor and appraiser agree a Personal Development Plan for the year going forward and the appraiser writes up a summary on how the doctor meets the four domains of Good Medical Practice, an overview of reflective discussions and quality improvements identified, with the supporting evidence provided. The appraiser then confirms five statements as detailed below. The appraiser and doctor both sign off the appraisal. The appraiser then completes their own checklist, as detailed below, submits to the Responsible Officer office for completion.

Figure 3 appraisal output sections

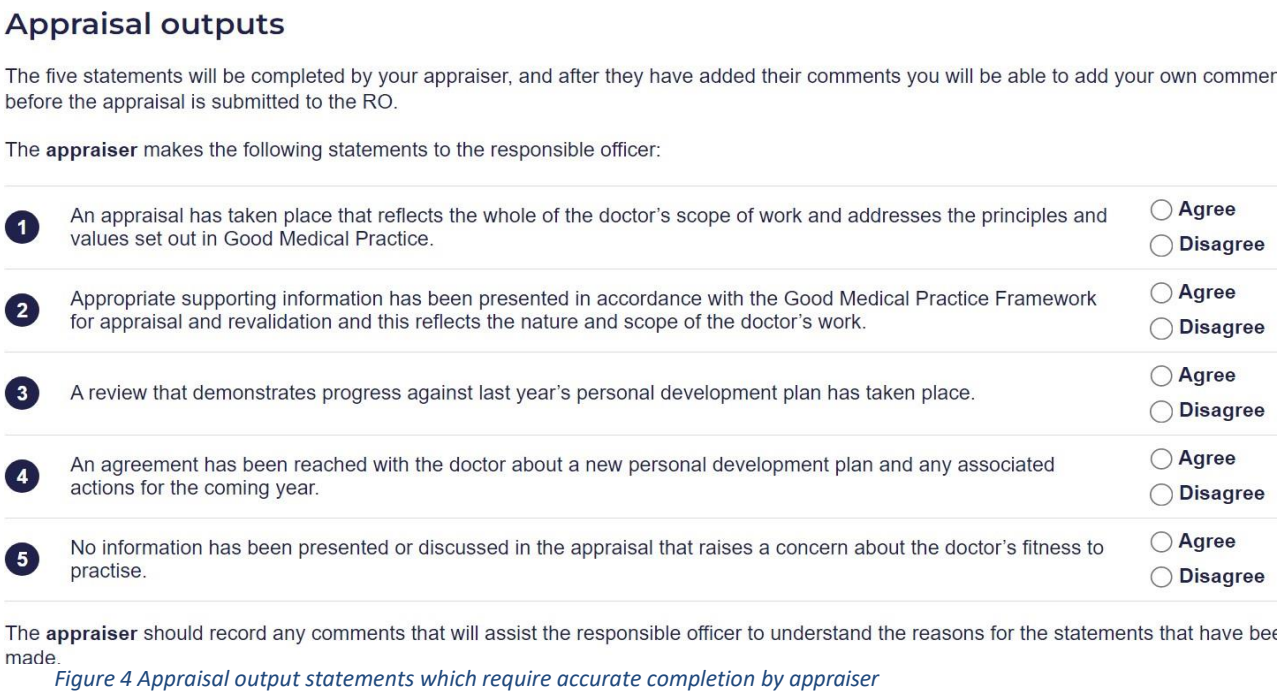


Figure 4 Appraisal output statements which require accurate completion by appraiser

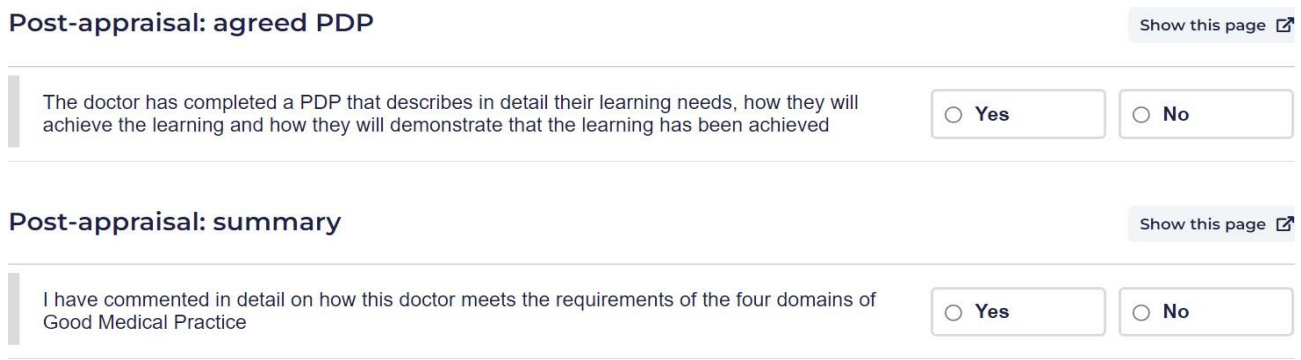


Figure 5 appraiser checklist

The appraiser is not automatically obliged to confirm all the statements as seen above if they feel that one or more is not reflected in the appraisal.

All doctors at Northern Lincolnshire and Goole NHS Foundation Trust are reminded that their annual appraisal must cover their entire scope of practice, which may include charity work, private work etc. and the doctor must provide evidence that they are fit to practice every single role they carry out whether this be clinical, managerial or educational because every single role a doctor carries out in their practice, does have an impact on patient care.

Supporting information to demonstrate fitness to practice against a scope of work does vary significantly as no doctor is the same as the other.
However, some supporting information is absolutely expected content for example, clinical governance information and its reflection.

As part of the support infrastructure, the coordinator has an established process for collection of clinical governance and supplying that information to doctors who are due for appraisal. This is a very efficient and seamless process, and the coordinator has shared best practice with other neighbouring organisations. It includes:

- Incidents that they have been named in the past 12 months; if a doctor is named in a significant event or incident, they must summarise the event and demonstrate reflective practice. Any doctors that are informed of a significant event/never event/SI, but upon Responsible Officer review the information is not included in appraisal, the appraisal will be referred to the doctor to rectify. This is because it is a General Medical Council requirement that a doctor must comply with. For other incidents, it is down the discretion of the doctor as to whether they can obtain learning from the incident and/or identify quality improvements. Doctors in this instance are encouraged to have this discussion with their own appraiser

- Formal Complaints that they have been named in the past 12 months.

Other expected content is patient and colleague feedback which must be done once every 5 years, in line with revalidation. Patient and colleague feedback module is installed on the L2P system. Upon receiving results of the feedback data, doctors are required to reflect on the results.

Doctors are encouraged to upload or provide evidence of medical indemnity/insurance. Where this is omitted, doctors are required to confirm that they understand the legal obligations on having medical indemnity/insurance for their role(s) and ensure that they are covered. The coordinator has produced a leaflet on medical indemnity which is installed on the L2P system and copies can be provided on an individual basis by the coordinator.

In relation to mandatory training, it is not a mandatory requirement for appraisal and/or revalidation. Compliance with mandatory training is overseen by a separate policy however continued significant failure to comply with mandatory training may prevent a doctor from revalidating, depending on the context and severity of the case.

To encourage improved compliance, the coordinator and appraisal lead have communicated to doctors that mandatory training courses do attract Continuing Professional Development points if there can be reflection on the learning obtained by completing the mandatory courses. If a doctor can reflect on the mandatory training courses completed, it can be counted as continuing professional development as this is an accepted practice at Northern Lincolnshire and Goole NHS Foundation Trust .

All supporting information which is presented by the doctor must be fully reflected on how they meet the four domains of Good Medical Practice. Reflective practice also drives quality improvements as well as professional and personal development.

All doctors are contractually and professionally obliged to engage with appraisal. Doctors are sent reminders via the L2P system and the Responsible Officer office that they are due for appraisal. Doctors who are late with appraisal are then supported by the Responsible Officer office and the Associate Medical Director.

3. Consistent non-engagement with appraisal, despite efforts from the Responsible Officer team and the Associate Medical Director, results in the Responsible Officer discussing the doctor's individual case with the General Medical Council Employment Liaison Advisor. The General Medical Council will issue an early warning to the doctor requiring the doctor to engage by a deadline. If this deadline is not met, the doctor is referred to the General Medical Council for non–engagement.

No submissions of non-engagement have been made during 2022-2023.

3.2 Medical Appraisers

Between April 2022 and March 2023, Northern Lincolnshire and Goole NHS Foundation Trust had 55 trained appraisers, which also includes 6 senior appraisers. The appraisers are allocated 0.25 Programmed Activity per week and can be allocated a maximum of 10 doctors to appraise. The budget for medical appraiser role has been moved from the operational divisions and now is within the Chief Medical Officer's directorate. The coordinator and appraisal lead oversee recruitment of appraisers.

Each Medical appraiser undergoes quality reviews. This consists of two parts; A report which collates appraisee's feedback via the post-appraisal questionnaire (PAQ). An example of Post Appraisal Questionnaire can be referred to in section 4.2.2. This report is sent to every appraiser to reflect upon and identify improvements where needed which increases the quality of appraisals and improves the process for doctors.

Secondly, a quality assurance report on the medical appraisal outputs that the appraisers have produced over a set time using 'EXCELLENCE' audit tool. The audit is completed by the coordinator with appraisal lead oversight. The Coordinator and Appraisal lead use the final audit results to identify and implement improvement to local process which is then picked up in the annual training sessions.

The quality assurance of medical outputs is usually conducted by the coordinator and appraisal lead however during 2022-2023, MIAD Healthcare LTD were procured to conduct an external quality review and this included them using the EXCELLENCE audit tool to review for the organisation's medical appraisers.

3.2.1 External Quality Assurance of Medical Appraisal Process by MIAD Healthcare LTD.

In June 2022, the Responsible Officer wished to establish a clear overview of all aspects of Medical Appraisal and Revalidation within the Trust and Miad Healthcare was commissioned to conduct an external review of the appraisal and revalidation system in Northern Lincolnshire and Goole NHS Trust Miad Healthcare is an external organisation with knowledge of revalidation and skills to assess systems and processes to provide support and make recommendations in line with NHS England Core Revalidation Standards, 2014.

The purpose of the external review:

- To provide a benchmark and basis on which to further enhance the quality of appraisal and revalidation processes at Northern Lincolnshire & Goole NHS Foundation Trust
- To provide signposts to further develop the infrastructure to support revalidation and appraisal
- To provide steers to strengthen links with Clinical Governance
- To provide feedback and recommendations

The external review provides an indication of the quality of the appraisal process as part of revalidation; this includes acknowledgements of good practice, identifies potential areas for development and lists recommendations and suggestions to provide a quality appraisal service which will support the Responsible Officer 's decision making. Additionally, a policy review was conducted to help identify any required amendments to the key policies relating to the implementation and conduct of medical appraisal and revalidation within the Trust.

The headline findings are as followed.

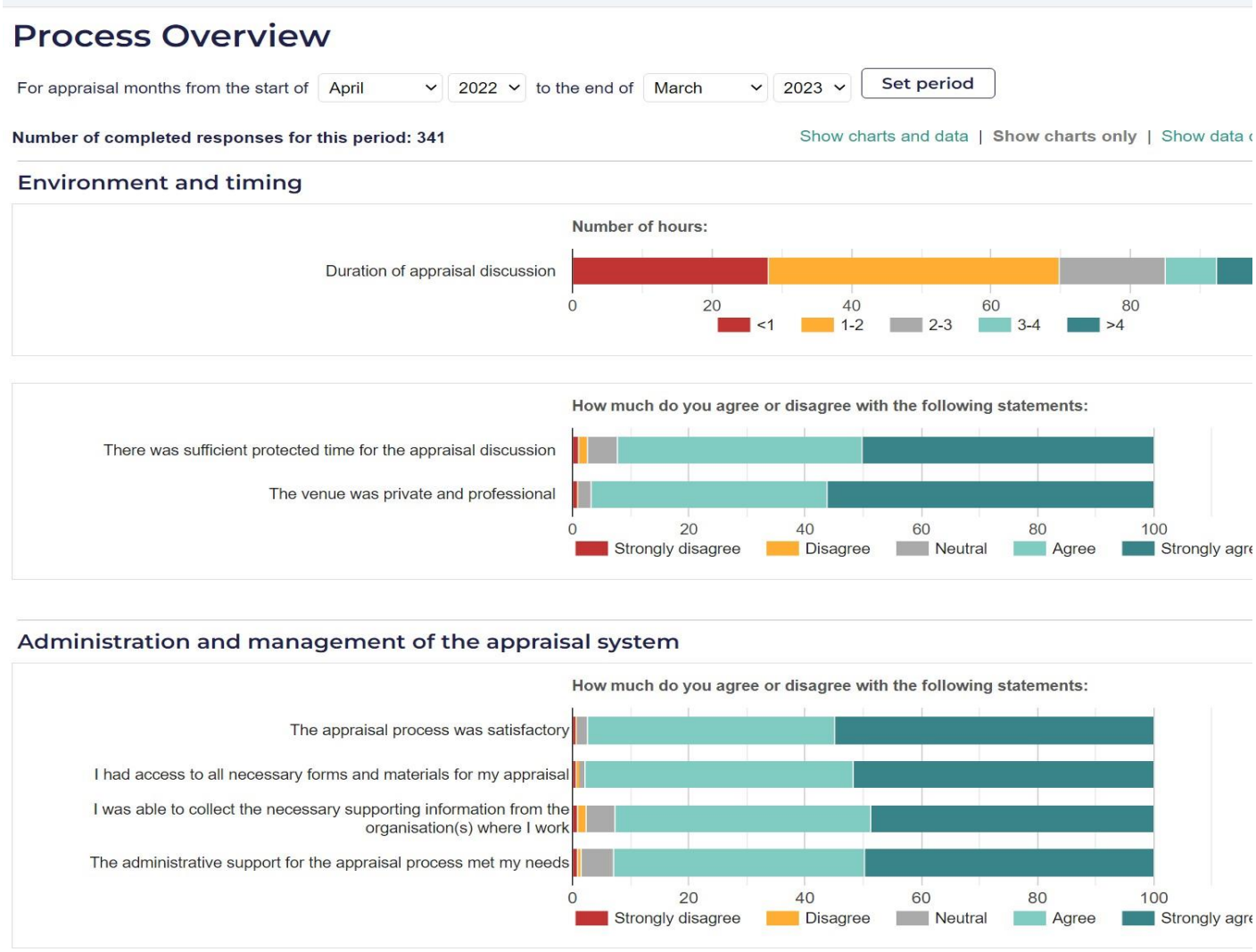
- The trust has in place a knowledgeable and stable medical appraisal and revalidation leadership team who have developed sound structure and process to support medical appraisal.
- There is excellent communication between the coordinator and appraisees through a various medium of platforms. The review highlighted that the coordinator is sensitive and supportive of the need of international doctors recruited to the Trust.
- There is appropriate access, security, and confidentiality with respect to the L2P system.
- There is a good recruitment process for the appraiser role and that the Trust does have a cohort of committed and enthusiastic appraisers
- There is a good supportive 'open door' policy of access to the appraisal lead.
- 77% of appraisees asked, said they felt supported in getting set up with appraisal. The remaining 23% did not require assistance
- 96% appraisees agreed there was a contact point for them if needed with comments that the contact point was easy to approach and immensely helpful
- 100% appraisees agreed that an appraiser had been allocated quickly
- 100% of appraisees found their appraiser to be approachable and supportive. 96% of whom said the appraiser set clear expectations.
- 100% appraisees said that the appraisal discussion was supportive and clear.
- 96% said the appraiser was helpful in setting up a new Personal Development Plan.

Improvements were also identified which have been formulated into a comprehensive action plan which is appended to this report.
The action plan is reviewed at the Chief Medical Officer Senior Management Team meeting on a bi-monthly basis. The coordinator and appraisal lead are taking operational lead on implementing the action plan.

To measure whether improvements are having the desired impact, a further EXCELLENCE audit will be conducted in August 2023 which will be one year on from when MIAD conducted the EXCELLENCE audit in August 2022.

3.2.2 Medical Appraisal Post Appraisal Questionnaire (PAQ) result

Process Overview



The headline feedback from doctors for 'Process Overview'

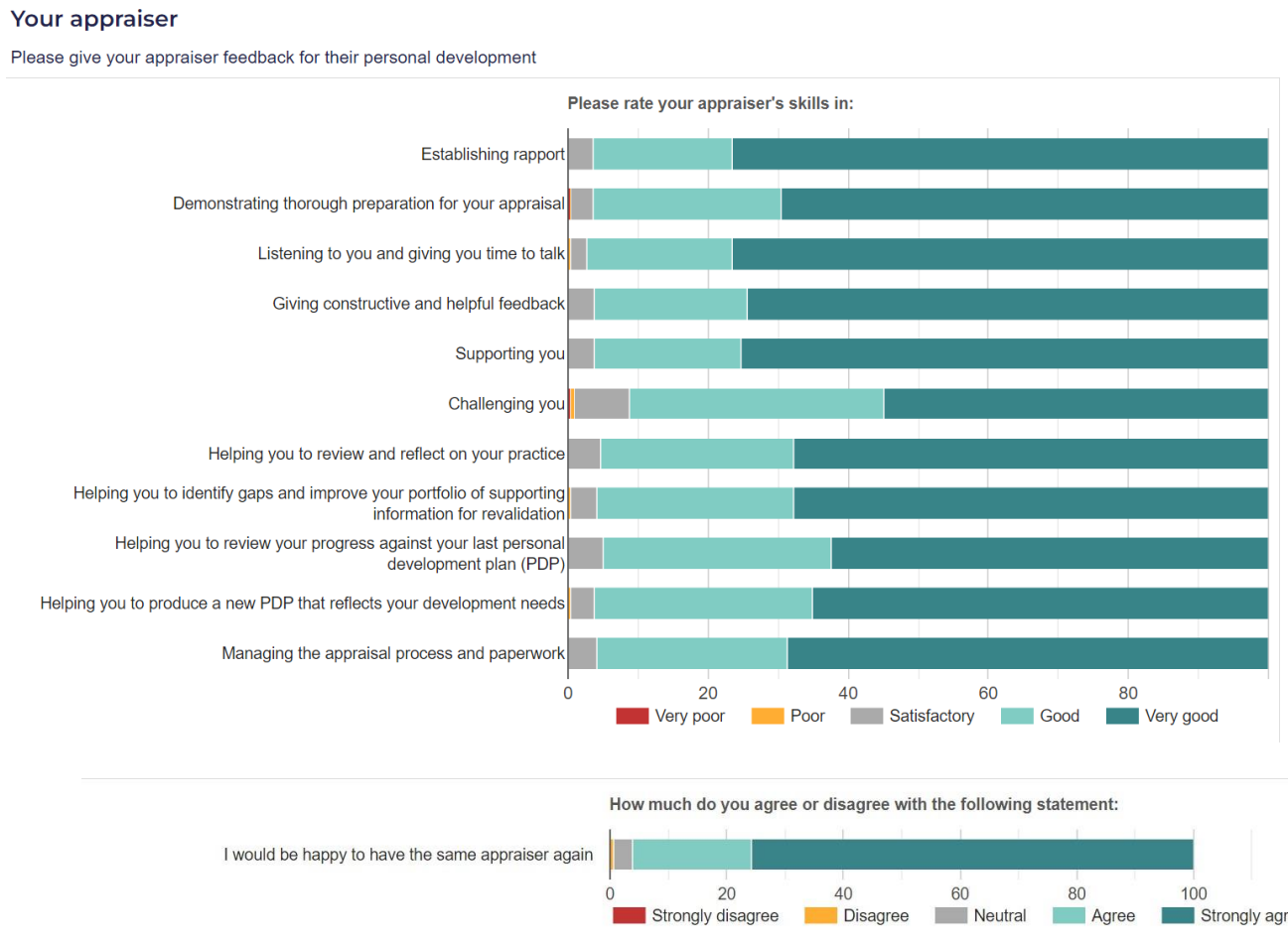
- Appraisal meetings typically last up 2 hours however emphasis is on ensuring that meetings are meaningful regardless of length.
- 92% of doctors agreed that they had protected sufficient time to complete their appraisal
- 96% of doctors agreed that the venue was private and professional
- 98% of doctors agreed that the appraisal process was satisfactory
- 97% of doctors had access to all necessary forms and materials for my appraisal
- 93% of doctors were able to collect the necessary supporting information from the organisation where I work.

- 93% of doctors agreed that the administrative support for the appraisal process met their needs

Improvement identified:

Whilst majority of doctors can collect support information with no problem, there are actions that could be put in place to assist doctors. This may include better communication about points of access as to where certain types of information can be accessed, for example theatre logs or confirmation of attending certain meetings. Comments from the Post Appraisal Questionnaire suggest that other than clinical governance information, other pieces of information held by the organisation is not so easy to obtain as it is difficult to know who to approach. To understand specifics, further enquiries through targeted feedback will be required to understand which pieces of information are difficult to obtain.

Appraiser Overview



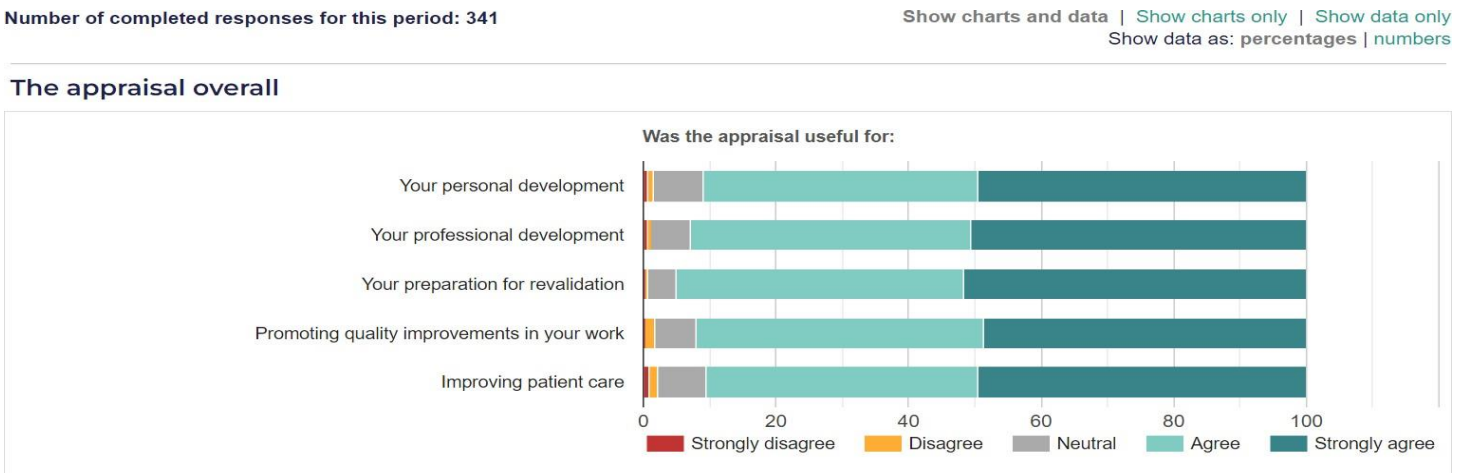
99.5% of doctors indicated that they would be happy to have the same appraiser again which is a reflection on the quality of appraisers the Trust has and the confidence that is instilled in them by the doctors. This is supported by the feedback received by doctors who shows that most appraisers are exceptionally good at the following key skills (as demonstrate by the dark green bar in the data above)

- Establishing rapport
- being thoroughly prepared for the appraisal meeting

- listening and giving time for the doctor to talk
- giving constructive and helpful feedback
- were challenging and supportive
- Assisting doctors to reflect on their practice
- helping doctors identify gaps in their appraisal portfolio for revalidation
- helping doctors review progress against last year's Personal Development Plan
- Developing a new Personal Development Plan that reflects the doctors' developmental needs
- the appraiser had a good handle on the appraisal paperwork

All the above is an excellent and positive reflection of the skill, knowledge, and experience of the Trust's appraisers. Continued investment in the appraiser role is clearly in the Trust's best interest, whether through off site training or the 0.25 Programmed Activity allocation. The investment is being returned through excellent compliance rates which assures high level stakeholders (Care Quality Commission for example), and high-quality medical appraisals engages the medical workforce with their professional development which is the key focus for doctors to remain fit to practice and therefore contributes quality of care and patient safety.

Appraisal Overall



Not only are the doctors benefiting on a professional and personal level, but the benefits have the potential to impact on the organisation from an operational perspective:

92% of doctors agreed that their appraisal promoted quality improvement in their work.

91% of doctors agreed that their appraisal was useful for improving patient care.

3.3 L2P appraisal software

The Trust procured L2P in November 2021. All medical appraisal documentation is stored electronically on the system and only the coordinator has full administration rights. The coordinator only accesses

and views full appraisal documentation when it is appropriate and

reasonable of which this is set out in the Access Statement in the Medical Appraisal Procedure policy document.

Access and use of data adhere to the requirements of the Data Protection Act (1998). L2P is registered with the Information Commissioner's Office: Registration number. z2384214

If external individuals require a copy of a doctor's appraisal, then the requester must approach the doctor concerned in writing. The request must be reasonable and clearly stated. On rare occasions this may not be possible particularly in police, legal or General Medical Council matters whereby appraisal information can be released without consent depending on the severity of the issue and what level of patient harm has occurred. These cases should they arise are judged case by case in relation to releasing appraisal information and in line with internal Trust polices.

There are clear guidelines regarding access arrangements for medical appraisal documentation for medical staff in the Medical Appraisal Procedure.

With regards to maintaining patient confidentiality, doctors are notified that supporting information that has patient identifiable data must be removed or redacted before uploading documents to the L2P form. They are required to tick a confirmation every time they upload evidence.

For the Board's information there have been no breaches of patient data or staff data in relation to medical appraisal documentation to date in during 2022-2023.

L2P also has several reporting mechanisms. This includes.

- NHS England quarterly compliance
- NHS England annual compliance
- Past appraisal performance by grade
- Past appraisal performance by department
- Resource forecast by month
- Resource forecast by department
- Late appraisals by department
- Late appraisals by month
- Appraiser activity
- Appraisals with appraiser
- Appraisal completion by department
- Agreed Personal Development Plans learning/development needs
- Medical educators
- Medical educators Continuing Professional Development
- Medical Leadership

The contract with L2P is due to expire in November 2026.

3.4 Quality Assurance measures

Current quality assurance processes and measures are outlined below:

- Appraisee feedback on the overall process and their appraiser.

- EXCELLENCE quality assurance tool. Every appraiser has two appraisals quality assured per appraisal year This equates to approximately 100 appraisals being quality assured per year. The Clinical Lead for Appraisal and Revalidation and Medical Appraisal Coordinator completes this audit. The results of the audit are shared with the appraisers with individual profiles that highlight areas of strength and improvement.

- Monthly revalidation meetings between the coordinator and the Responsible Officer

- Responsible Officer occasionally facilitates at the Responsible Officer network meetings, in partnership with NHS England and the General Medical Council. This ensures sharing of best practice and new process development.

- Annual Training events for medical appraisers and all medical staff who wish to learn more about local process

- Medical Appraisal 1:1 session for all medical new starters to Northern Lincolnshire and Goole NHS Foundation Trust although primarily aimed at new starters from abroad.

- Annual revalidation report

- Statement of compliance signed by the Chief Executive Officer, which is then submitted to NHS England

- External audit which will was conducted by MIAD Healthcare in 2022.

3.5 Appraisal Data

3.5.1 Annual Organisational Audit report (AOA)

The Annual Organisational Audit report is an element of the Framework of Quality Assurance (FQA), and this is a standardised reporting mechanism for all Responsible Officers (Responsible Officer) to complete and return to their higher-level Responsible Officer.

Name of organisation: Northern Lincolnshire and Goole NHS Trust	**Consultants**	**Specialty Doctors, Associate Specialists, Specialists (SAS)**	**Temporary contact holders (all fixed term contract holders)**	**Trustwide**
Total number of doctors with a prescribed connection as of 31 March 2023	**178**	**164**	**134**	**476**

Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	170	113	91	347
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	8	51	43	102
Total number of agreed exceptions	8	51	43	102

The headline results for the above is that there are no doctors who did not have an appraisal without an agreed exception. This is a positive result, especially given that the Responsible Officer has a 17% increase, which equates to 60 additional doctors, in the number of doctors that have a prescribed connection to Northern Lincolnshire and Goole NHS Foundation Trust since April 2020

This is the first time Northern Lincolnshire and Goole NHS Foundation Trust has achieved this which was the result of having a dedicated support infrastructure for clinicians to have their appraisal. This primarily consists of the Revalidation and Medical Appraisal Coordinator (Band 5) and the Appraisal Lead for Appraisal (1 Programmed Activity per week) and fully established cohort of trained Medical Appraisers (55 In total), and a cloud-based document management system called “L2P” which had the Appraisal 2020 format.

As a team, the coordinator and appraisal lead engaged with and continually stayed in contact with clinicians who may be experiencing delays to their appraisal. This means providing bespoke 1:1 support, guidance, and understanding for those who are experiencing difficulties which may cause delays to appraisal.

This approach, a combination of a resolute support team and electronic document management system is the primary driver for the above results which are a Northern Lincolnshire and Goole NHS Foundation Trust first.

As a result of the above Annual Organisational Audit results, Northern Lincolnshire and Goole NHS Foundation Trust can demonstrate not only standard compliance with regulations relating to the Medical Profession and other key pieces of legislation (Medical Act 1983) and key national guidance (Good Medical Practice for example), but that the journey of continued improvement over time is a successful endeavour. The results above will allow Northern Lincolnshire and Goole NHS Foundation Trust to continue in its pursuit of quality improvement for the medical appraisal process and its services provided by the Trust, provide necessary assurance to the higher-level Responsible Officer of NHS England and function as evidence Care Quality Commission inspections.

A breakdown of the exceptions granted is as follows:

- 9 doctors had long term sickness during their appraisal period

- 4 on maternity leave/adoption leave
- 2 on “other leave” (long term caring responsibilities, compassionate, personal/family reasons etc.)
- 1 doctor was on career break and subsequently resigned from post in April 2023
- 1 doctor has returned to practice very recently following retirement 2 years ago.

Those above (with exception to the doctor who has resigned) are being continually supported 1:1 and are being encouraged to have appraisal when they are fully phased back into work and feel more settled.

- 85 doctors were new arrivals to the UK and the NHS and obtained their primary medical qualification outside the UK. Last year this was 83.

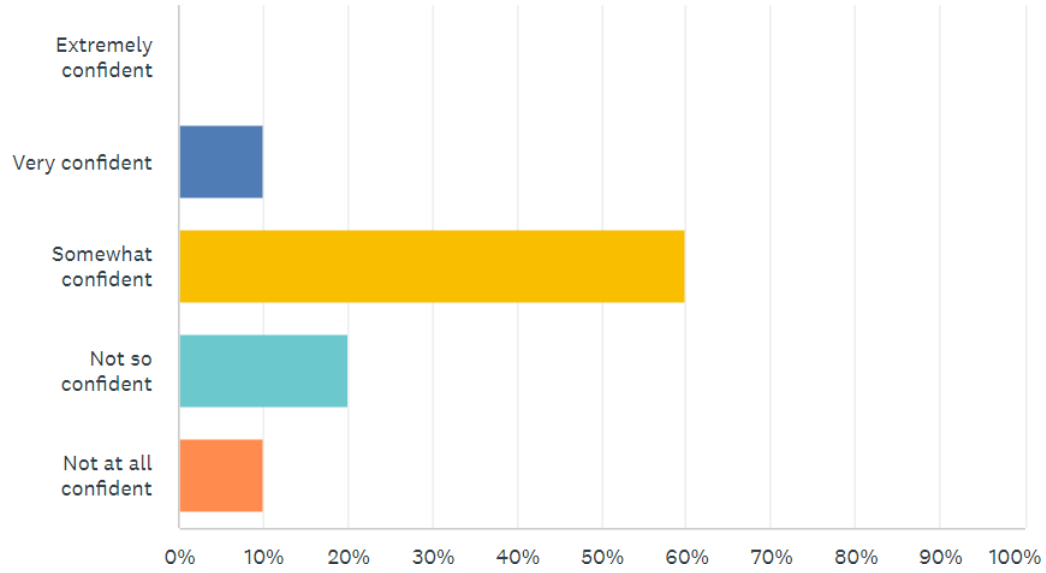
  New doctors to the UK and NHS do have a delay to their first appraisal which range up to 12 months from their start date. The reason for this is because a doctor has to bring a significant amount of supporting information and evidence which matches their scope of work, demonstrates that they are safe, demonstrates engagement with professional standards, demonstrates continued improvement within their service area (e.g., participating in audits) and ultimately the supporting information and the discussions around it will contribute to lifelong professional development.

  Furthermore, appraisal is the now the vehicle of reflective practice, and this is usually a new key skill that doctors new to UK practice must learn in preparation for appraisal. This is not an easy skill to “pick-up,” and it is a skill that continually evolves through the career of a clinician so therefore new starters to the trust are given ample time to not only settle into their new life in the UK but to acquire the soft skills required for their role, such as the ability to reflect, as well as gaining the necessary evidence to reflect on (such as feedback).

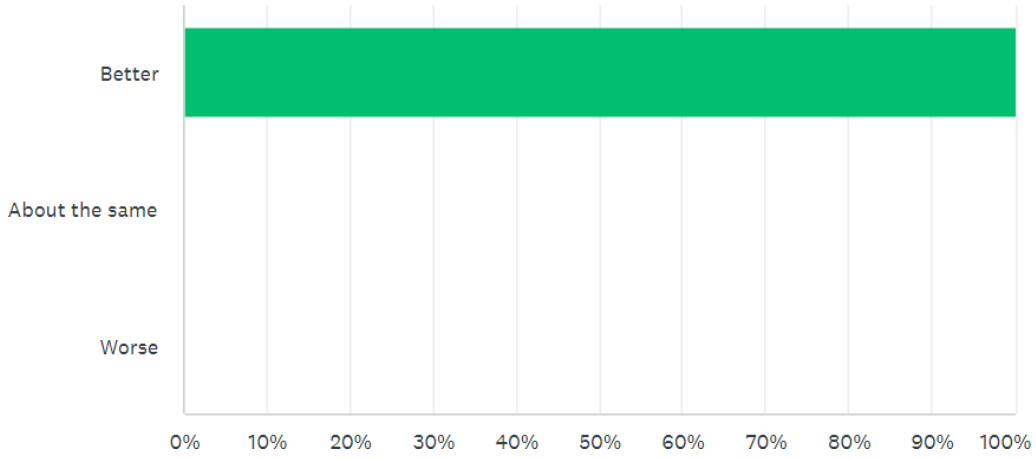
  These doctors are engaged by the coordinator to have a 1:1 medical appraisal support session which aims to induct the doctors into the medical appraisal process and therefore can begin work on their portfolio which constitutes as process engagement. Feedback from the new starters demonstrates how effective this approach is:

3.5.2 Data and feedback from 1:1 new medical starter session for appraisal

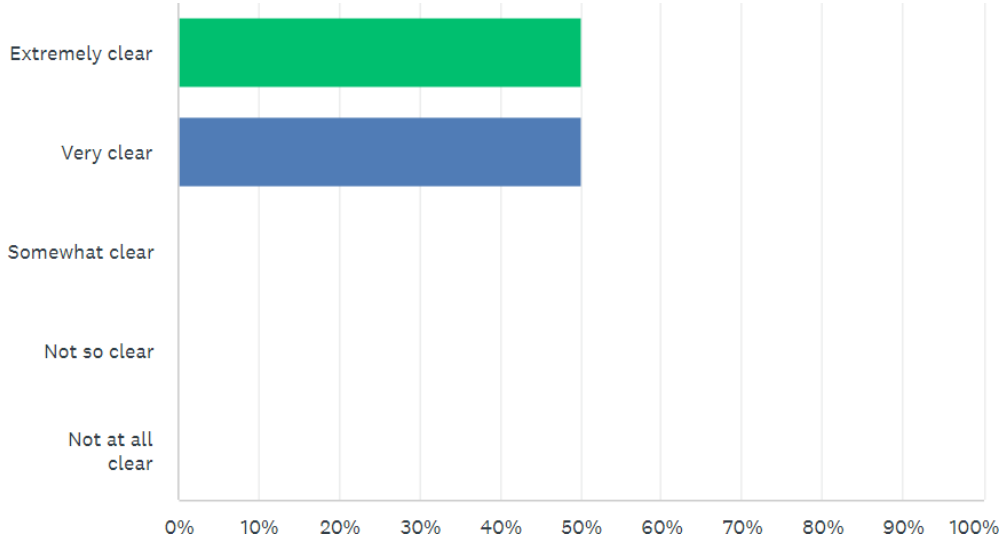
How confident were you about appraisal requirements BEFORE your 1:1 session?



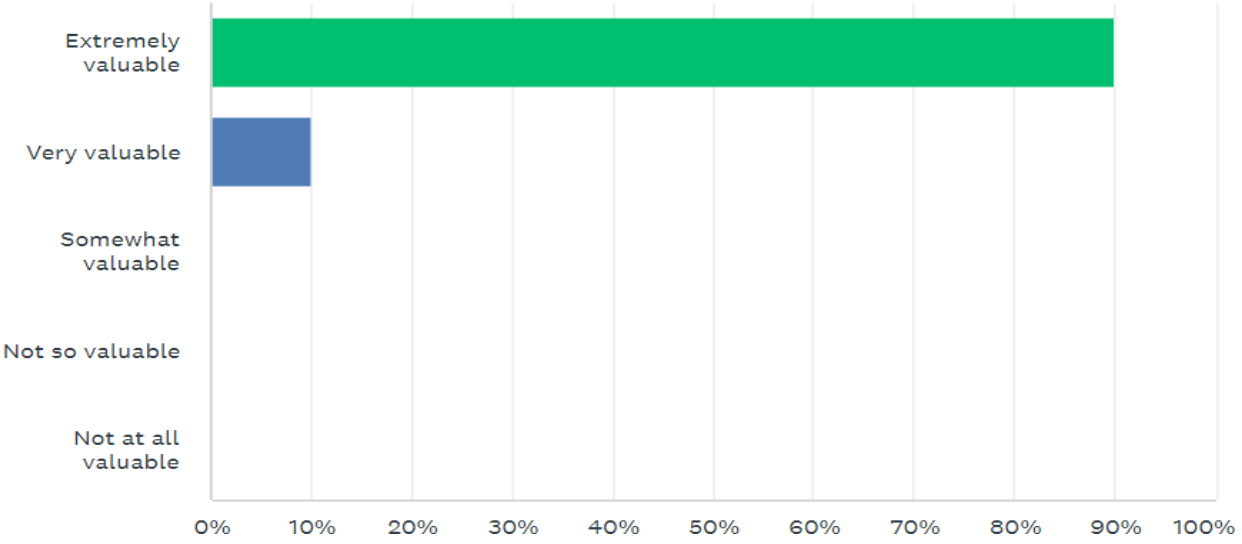
After the session, how do you now feel about the appraisal process?



Do you understand what is now required from you for your appraisal?



How valuable was this session in terms of your understanding of appraisal and revalidation?



Please enter your comments about the session here. Please include what was good about the session, and if any, improvements.

"The 1:1 session with Rachael was great. Now, I have a better understanding of General Medical Council's appraisal and revalidation. Rachael is amazing, she is knowledgeable and very supportive. Coming from a different country where appraisal is completely different from NHS, I have no idea of the process of the General Medical Council's appraisal and revalidation. I had an appraisal from a previous trust last year but was no given the same type of support hence I had no idea what to put in my appraisal form. However, after this session with Rachael I am now more confident in doing my appraisal this year. Thank you. Please continue the good work."

"Being a first appraisal, I was very afraid about it but now I am confident that it's a step to improve ourselves. Thank you so much"

"Rachael was so thorough with her explanation of what needs to be done for the appraisal and went through each section in a very clear manner. It was a very useful session and I believe that it would be such a valuable session for any doctor who is new to the NHS. Thank you"

"I felt that Rachael really wanted to help me understand the process, she completely understood my struggles and showed me ways to tackle the issues ahead. Her being clear in what was needed of me made me more confident and less fearful in completing the appraisal. I value her input very much and would seek her help again if needed. I will highly recommend her to my colleagues having the same trouble."

3.5.3 Medical and Dental Staff Appraisal Compliance

Since 1st July 2022, the coordinator submits weekly data to the Workforce Intelligence and Systems which is then uploaded to Workforce Information systems on Power Business Intelligence.

The same data is also submitted to the Human Resource business partners for the Performance Review and Improvement meetings, and this ensures reporting consistency.

Staff Development	PADR Rate	Mar 2023	83.0%	85.0%	Alert			Boar
	Medical Staff PADR Rate	Mar 2023	97.0%	85.0%	Highlight			Boar
	Combined AfC and Medical Staff PADR Rate	Mar 2023	82.2%	85.0%	Alert			Boar

Figure 6 excerpt from workforce IPR scorecard (reported April 2023)

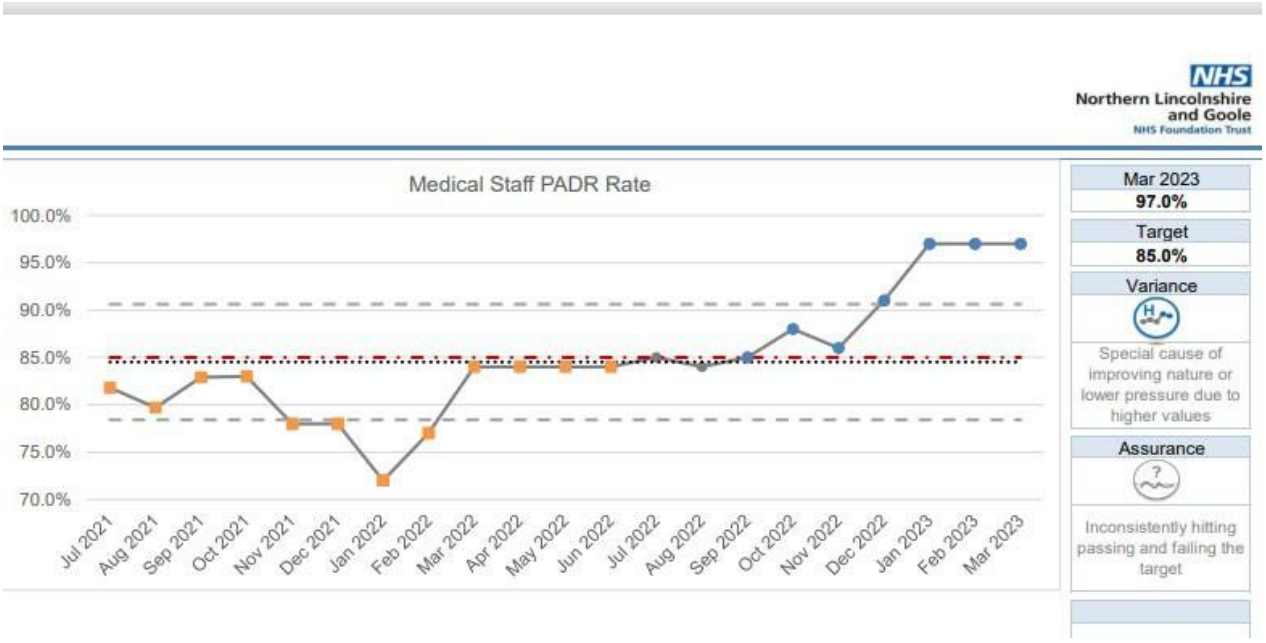


Figure 7 SPC chart medical PADR compliance (as of April 2023)

The positive Annual Organisational Audits results are shown above are also reflected by the Trust's internal reporting systems as demonstrated in the Integrated Performance Reporting Workforce report.

4. Recommendations of Revalidation to the General Medical Council

4.1 Revalidation submission data

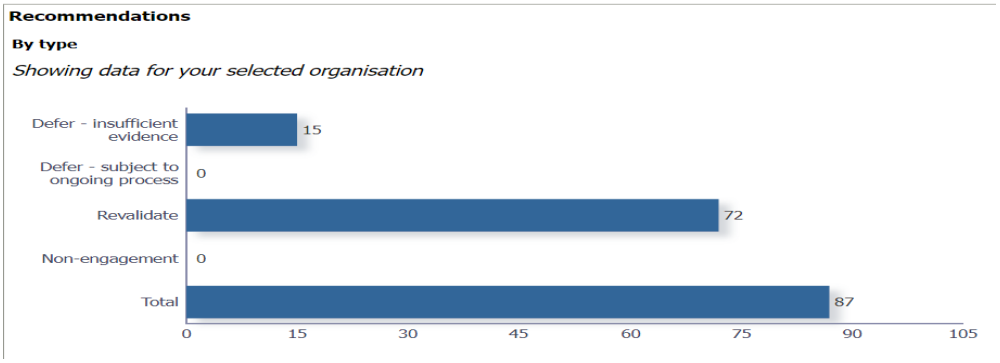


Figure 8 Data from General Medical Council Connect Northern Lincolnshire and Goole NHS Foundation Trust Dashboard

Between April 2022 and March 2023, 72 doctors were revalidated. A doctor revalidates once every 5 years. There were no non -engagement submissions made to the General Medical Council by Northern Lincolnshire and Goole NHS Foundation Trust.

There were fifteen deferrals. It is important to note that deferral does not mean that a doctor has failed to revalidate.

Deferring is a neutral act which grants a time extension for the doctor to complete the necessary requirements to be revalidated – annual appraisals and 360 feedback completed in the last 5 years. The fifteen deferrals outlined above were all made because the doctors had insufficient evidence – primarily this was due to the lack of completion of 360 feedback from colleagues and patients with a reflective piece of work on the feedback results.

Out of the 15, 14 doctors subsequently revalidated. The remaining one doctor is under notice to revalidate, and it is expected that this doctor will revalidate in the next 12 months.

5 Medical Governance

5.1 Local Medical Governance arrangements for medical appraisal

The Responsible Officer for the period 1st April 2022 – 31st March 2023 (Dr Kate Wood, Chief Medical Officer) was appointed by the Trust Board in 2018 in line with statutory requirements. The Chief Medical Officer is supported by the Clinical Lead for Appraisal and a band 5 Coordinator who manage 480 doctors to engage with processes that underpin revalidation.

Progress and compliance with the regulations is monitored by:

- A well-established Recommendation of Revalidation procedure whereby all revalidation decisions are recorded and stored in the relevant Chief Medical Officer files on the H Drive.

- Weekly compliance data to Workforce Information System team (Integrated Performance Reporting) and to the Human Resource business partners for Performance Review and Improvement Meetings within the divisions.

- Submission of the Annual Organisation Audit report to NHS England's Higher-Level Responsible Officer.

- Comprehensive dashboards within L2P to access and review data

- Formal audits using EXCELLENCE once a year. It should be noted that the internal EXCELLENCE audit for this report has been omitted as MIAD Healthcare conducted an external review and audit of the Trust's appraisal systems.

5.2 Monitoring conduct and performance.

Medical staff performance and conduct is managed through regular supervision, through annual appraisal and participating in regular audits, case reviews, Structured Judgment Reviews, all but to name a few, as part of quality improvements processes which are captured via the medical appraisal.

During appraisal discussions the doctor is encouraged to discuss aspirations and challenges and to review the progress of Personal Development Plan objectives. The doctor is also required to reflect meaningfully on when things have gone wrong and demonstrate how changes and learning needs have been identified and actioned.
We also train appraisers to challenge doctors in relation to participating in quality improvement activities, especially if there is a deficiency in this area.

Separately, the "Doctor's in Difficulty" (DiD) group has been operational since April 2018. The purpose of the Doctors in Difficulty group is to ensure those required to attend are sighted on issues and concerns in relation to "Doctors in Difficulty." Doctors are classified as being in difficulty if they meet one or more of the criteria below.

- Known through internal referrals to/from the General Medical Council and NHS Resolution and/or have restrictions on clinical practice

- Going through a Maintaining High Professional Standards investigations

- On or recently returned from long term sickness absence

- Recent sickness absence relating to stress, anxiety and/or other mental health issues

- Have had 4+ sickness episodes in over 12 months (rolling)

- Involved in a confirmed serious incident

- Training issues

- "Other" – this covers a range of issues that would not sit in the above categories, for example, employment tribunals.

The attendees of the group, which has senior Human Resource representation, gives an opportunity to check whether the doctors mentioned above are receiving the required support from the operational divisions and the Human Resource Business Partners, and challenge where there is a deficiency in pastoral support and/or general support altogether (such as return to work).

Additional advice is sought from the Practitioner Performance Advice Service (part of NHS Resolution) as soon as a serious concern arises. The General Medical Council's employer liaison adviser is contacted as appropriate. Any serious concern is registered with the Chief Executive, Chief Medical Officer and Director of People and Organisational Development.

5.3 Responding to Concerns

The Trust has a specific Maintaining High Professional Standards Policy/Procedure (MHPS) which supports in dealing with responding to concerns. In addition, the Doctors in Difficulty Group ensure those required are sighted on issues and concerns known through recruitment of doctors with restrictions on their practice, internal referrals to/from the General Medical Council and NHS Resolution or those that have previously or are due to commence employment at Northern Lincolnshire and Goole NHS Foundation Trust
.
Our Trust Board is sighted on all cases going through the formal Maintaining High Professional Standards process, for example the number of suspensions and this is provided by the People Directorate.

5.4 Transfer of Information between Responsible Officer s

When a doctor joins Northern Lincolnshire and Goole NHS Foundation Trust and has come from another UK healthcare organisation whether this is another NHS Trust, Locum agency or training, then the coordinator invokes the Medical Practice Information Transfer process (MPIT).

The coordinator will formally contact the doctor's previous designated body with a Medical Practice Information Transfer form, which is prepopulated with the doctor's name, General Medical Council number and Northern Lincolnshire and Goole NHS Foundation Trust 's Responsible Officer details, and requests that the designated body and its Responsible Officer, or authorised delegate, fills in the form.

The Medical Practice Information Transfer form requests the following information.

- Date when Doctor left previous organisation
- Date of last Annual Review of Competencies Panel OR appraisal

- To inform the new Responsible Officer any of additional information or concerns relating to the doctor's practice

Occasionally, a doctor's previous Responsible Officer requests to have a conversation with the Responsible Officer of Northern Lincolnshire and Goole NHS Foundation Trust and this is swiftly organised.

If information of note is shared with the Responsible Officer of Northern Lincolnshire and Goole NHS Foundation Trust regarding a doctor's practice, there is collaboration between the Responsible Officer , Associate Director of Strategic Medical Workforce, Divisional Medical Directors, and the Clinical Lead for the employing specialty, to support and if necessary, supervise the new doctor.

6. Employment checks

Systems to ensure that appropriate pre-employment background checks are undertaken to confirm doctors who are starting with the Trust, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties, are covered by the Recruitment and Selection Policy and the "Recruitment and Selection – A Best Practice Guide."

For Agency Locum doctors who are identified as potential candidates to fill a shift which is live on the Locum Management System, the CV of a potential candidate is sent to the Clinical Leads to review that the qualification, skills, and training competencies of the candidate are suitable for the shift.

7. Conclusion

7.1 Review of actions from last year's annual revalidation report

To support the new reporting dashboard using the Business Intelligence reporting suite for medical appraisal reporting

Update: Weekly reporting is embedded

To review the Medical Appraisal Procedure document which is due for review in February 2023.

Update: Extension was granted to review date as the document is awaiting approval from Joint Local Negotiating Committee**.**

Continue to work with General Medical Council in terms of workshops being hosted at Northern Lincolnshire and Goole NHS Foundation Trust

Update: The coordinator has an excellent relation with the General Medical Council Outreach Regional Advisor who delivers General Medical Council workshops relating to medical ethical and legal areas of Consent, End of Life, Fitness to Practice, Confidentiality, Leadership and Management, Raising Concerns. These workshops continue to be exceedingly popular and approximately around 20-30 doctors attend each workshop.
Even more popular was the Professional Behaviours and Patient Safety workshop which is new course jointly delivered by the General Medical

Council and Nursing and Midwifery Council and organised by the coordinator. This was delivered in April 2023. The programme aimed to.

- Define and identify unprofessional behaviours in practice
- Understand the harmful impact of these behaviours on patient safety
- Develop individual and practice skills to challenge unprofessional behaviours

Doctors of all grades, nurses and allied health professionals attended this course, and it was the biggest cohort of professionals that the General Medical Council and Nursing and Midwifery Council have delivered the course to. There was 95 attendees and future sessions are being planned due to the enthusiasm for the course.

Assist the Medical Leadership programme by ensuring that all new leaders and doctors who undertake the programme complete the medical leadership module on L2P.

Update – The appraisal lead and cohort of senior medical staff who have undertaken the Northern Lincolnshire and Goole NHS Foundation Trust Medical Leadership and Management course have the medical leadership module on their appraisal. Feedback was undertaken.

- 75% of respondents agreed that the medical leadership module on L2P reinforced learning from Medical Leadership and Management course.
- 75% respondents agreed that reflecting on their leadership skills via appraisal will help their personal and professional development as a medical leader
- 100% of respondents agreed that reflecting on their medical leader skills and abilities will help improve patient care
- 75% respondents agreed that reflecting on their medical leader skills and abilities will contribute to service improvements
- 100% of respondents agreed that all doctors, regardless of grade or seniority, should reflect on their medical leadership skills and abilities.

Going forward, all doctors will be required to reflect on their leadership abilities via appraisal. Before Trust-wide implementation will begin, the appraisal lead has identified that some of the core leadership standards that doctors require to reflect on can be interpreted as abstract and therefore difficult to reflect. By September 2023, the coordinator and Appraisal Lead will develop a crib sheet/guidance for doctors on completing the medical leadership module.

Continue to train and retrain medical appraisers. The budget to pay medical appraisers has since transferred from the operational groups to the Medical Director's Office. Within this budget, there is capacity for 55 appraisers and therefore there are currently seven vacancies.

Update- Full establishment of Medical Appraisers with a reserve list.

From April 2023, no doctor will have a scheduled appraisal during the months of January, February, and March. This will require step-by-step implementation to ensure doctors are given notice of their new appraisal month. There is a project plan in place as well as a

communication strategy to ensure smooth operation. The Medical Director's Senior Management Team are regularly kept updated regarding this.

Update: fully implemented. Doctors are no longer routinely allocated an appraisal in January, February, or March. This will help ensure doctors have annual appraisal within each appraisal year (runs from April to March) and will leave the months January, February, and March appraisal activity free which will allow clinicians to focus on patient activity**.**

MIAD Healthcare external review for quality assurance purposes of the revalidation service at Northern Lincolnshire and Goole NHS Foundation Trust .

Update: Completed. Report and action plan appended to report in separate bundles.

Annual Revalidation Report Appendix 1 – MIAD Report Annual
Revalidation Report Appendix 2 – MIAD action plan

7.2 Current issues and new actions

Increase in number of doctors connecting to Northern Lincolnshire and Goole NHS Foundation Trust

The number of doctors connected to Northern Lincolnshire and Goole NHS Foundation Trust has increased annually every year since 2014. This increases number of resources required to ensure all doctors can engage and comply with appraisal and revalidation. This includes increase in number of software licences and increase in number of appraisers however a demand and capacity review will need to take place this year to ensure that the Trust has the required number of appraisers to ensure facilitation of annual appraisal and revalidation for the growing medical workforce. The demand and capacity review will take place in September 2023.

General Medical Council becoming multi-professional regulator

Anaesthesia Associate and Physician Associate will come under regulation of the General Medical Council and will be required to revalidate. It is expected more information on this will be published by the General Medical Council by Spring 2024. The impact on Northern Lincolnshire and Goole NHS Foundation Trust is not yet known however the Coordinator will keep abreast of developments by regularly reviewing communications and publications from the General Medical Council and Department of Health and Social Care.

Good Medical Practice update

Good Medical Practice is currently under review and being updated by the General Medical Council. It is expected more information will be published later this year by the General Medical Council and the impact on revalidation and appraisal is not yet known.

Widening Professional Behaviours and Patient Safety workshop

The Professional Behaviours and Patient Safety workshop was an excellent success. Further workshops will be arranged for doctors and nurses to attend and will be class based.

Wider implementation of Medical Leadership module on L2P

Aim for all doctors, regardless of grade or seniority, to reflect on their leadership abilities during their appraisal. Before wider implementation, guidance will need to be produced for doctors on completing the Medical Leadership Module on L2P.

MIAD Action Plan

Complete actions on the MIAD action plan by December 31st, 2023. Action Plan is appended with this report in separate bundle (*Annual Revalidation Report Appendix 2 – MIAD action plan)* The action plan will be added to next year's annual report to show closure as many of the actions are due to be completed by December 31st, 2023

Implementation of reflective practice workshops

Doctors are required to reflect on their scope of practice and the supporting information they bring to appraisal to demonstrate that they are fit to practice across their scope of work. Supporting information includes but not limited to continued professional development evidence, evidence of quality improvement activities, feedback, and clinical governance information such as incidents, never events, complaints. To aid this, implement General Medical Council training resources to define reflection; show how reflection is central to both personal learning and improving patient safety; reviewing 'what, so what, and now what' framework for reflection; and how to support an effective reflective discussion.

Medical Appraisal Procedure document review

Ratified policy document by September 2023 and uploaded to the Trust Intranet.

7.3 Action from the Board

To ask the Board to accept the report, noting it will be shared with the higher-level Responsible Officer at NHS England and Improvement.

The Board, through the Chief Executive, are required to sign the 'Statement of Compliance' at the end of the report confirming that the organisation is compliant with the Responsible Officer regulations.

The approved annual report and signed statement of compliance will be submitted to NHS England by the Responsible Officer's office.

Feedback and recommendations from the Board are also welcomed.

8. Statement of compliance

The Board of Northern Lincolnshire and Goole NHS Foundation Trust have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

Chief Executive

Official name of designated body:
Northern Lincolnshire and Goole NHS Foundation Trust

Name: **Signed:**

Role: **Date:**

Annual Revalidation Report 2023 – Appendix 1

External Quality Assurance of Appraisal and Revalidation Evaluation Report for

Northern Lincolnshire & Goole NHS Foundation Trust

Date: October 2022

Consultants: Liz Brewer, Dr Joanne Byfleet, Pam Strange & Nicky Heyworth
Miad

Miad Healthcare

Contents

1. Introduction and Scope

Medical revalidation was launched in 2012 to strengthen the way in which doctors are regulated, with the aim of improving the quality and safety of all aspects of patient care and thereby, increasing public trust and confidence in the medical system. The requirements for revalidation became legal and statute to practice in the United Kingdom from December 2012. The keystone to revalidation is the annual appraisal, which is defined as a professional process of constructive dialogue in which the doctor being Appraised (the Appraisee) has a formal structured opportunity to reflect on their work and to consider how their effectiveness may be improved.

Doctors who are registered and licensed by the General Medical Council (GMC), are required to undergo annual appraisals during a 5 year revalidation cycle. The effectiveness of the annual appraisal process contributes significantly to the Responsible Officer (RO) revalidation recommendations to the GMC for each Medical Practitioner.

A Framework of Quality Assurance (FQA) was issued by NHS England to ensure that Responsible Officers (RO's) meet the statutory regulations (Medical Performance, RO Regulations 2010 (amendment 2013)). It is recommended that an external quality assurance review occurs periodically to provide evidence that systems and processes are in place.

Northern Lincolnshire & Goole NHS Foundation Trust (the Trust) provide a range of hospital-based and community services to a population of more than 400,000 people across North and North East Lincolnshire and East Riding of Yorkshire. Operating from three hospital sites, the Trust has approximately 850 inpatient and critical care beds across 44 wards, 120,000 inpatient episodes, and delivered over 360,000 outpatient appointments. The Trust employs around 6,500 members of staff.

In June 2022, the Responsible Officer wished to establish a clear overview of all aspects of Medical Appraisal and Revalidation within the Trust and Miad Healthcare was commissioned to conduct an external review of their appraisal and revalidation system. Miad Healthcare is an external organisation with knowledge of revalidation and skills to assess systems and processes to provide support and make recommendations in line with NHS England Core Revalidation Standards, 2014. This report details the findings of the review.

Note of review –the review of the doctors' supporting information in their portfolios covered their work during phases two and three of the pandemic national lockdown**.** Professor Stephen Powis, National Medical Director issued two (2) key Medical Appraisal and Revalidation documents to Responsible Officers and Medical Directors. The first (19th March 2020) advised on the temporary suspension of appraisals and providing guidance on revalidation deferral if required. The second, published on 3rd September 2020, made recommendation that a flexible approach is taken to the resumption of the appraisal process, starting on 1st October 2020 to achieve normal levels of activity by 1st April 2021. The letter also described the 'Appraisal 2020' format, a re-balanced approach that focuses on a doctor's professional development and well-being and simplifies expectations around paperwork. All of this additional guidance has been taken into consideration and is reflected in this review.

Miad Healthcare would like to thank all participants for their co-operation and assistance in giving up their time to complete this review during a very busy and challenging period.

Purpose of External Verification

- To provide a benchmark and basis on which to further enhance the quality of appraisal and revalidation processes at Northern Lincolnshire & Goole NHS Foundation Trust
- To provide signposts to further develop the infrastructure to support revalidation and appraisal
- To provide steers to strengthen links with Clinical Governance
- To provide feedback and recommendations

This external review provides an indication of the quality of the appraisal process as part of revalidation; this includes acknowledgements of good practice, identifies potential areas for development and lists recommendations and suggestions to provide a quality appraisal service which will support the RO's decision making. Additionally, the policy review will help to identify any required amendments to the key policies relating to the implementation and conduct of medical appraisal and revalidation within the Trust. All of the documentation that has been produced by the organisation to evidence compliance with core-revalidation standards and which supports this review, can be found in Appendix F.

Scope of Engagement

This comprised of:

- Interviews were conducted with the Responsible Officer, the Associate Director Strategic Medical Workforce and the Appraisal and Revalidation Co-Ordinator. (Appendix B (i-iii))
- Interviews were conducted with the Lead Appraiser and five (5) of the Medical Appraisers. (Appendix C (i-vi))
- A review of forty-four (44) of the most recent appraisals for the randomly selected Appraisees that had been carried out in the last 18 months. These were reviewed remotely, and relevant criteria mapped against the FQA standards. (Appendix D & E)
- A review of the Medical Appraisal and Revalidation policy and procedure and the Responding to Concerns policy and procedure documents were mapped against the Core-Revalidation Standards, NHS England 2014 (Appendix A (I & ii))
- A review of Appraisee feedback survey (Appendix F)
- Review of additional evidence which supports the Core Revalidation Standards (NHS England FQA, 2014) (Appendix G)

The interviews were conducted either over a remote platform or by telephone.

The review followed strict guidelines with regard to data protection

2. The Designated Body and Key Staff

Designated Body: The Trust was identified as a Designated Body (DB) in 2012. The Chief Medical Officer is also the Responsible Officer (RO). The Trust Board receives a detailed annual report on the status of medical appraisal and revalidation. At the time of the review, there were four hundred and forty eight (448) doctors connected to the DB, who are registered with the General Medical Council (GMC), and who are required to be re-licensed every five (5) years. There are forty eight (48) trained medical Appraisers, available to complete the annual cycle of appraisal required for the revalidation of doctors with a prescribed connection to the DB.
The DB prepared and presented the Annual Report 2020/21 to the Trust Board

Compliance Rate and Engagement in the process: Whilst many NHS Trusts took the decision to suspend medical appraisal in March 2020 in line with the guidance issued by the national Medical Director, due to the pandemic, the RO took the decision to allow individual doctors to decide for themselves whether to continue with their annual medical appraisal. There was no significant impact on the Trust in the early stages of the pandemic and a decision not to stop elective activity if all safety factors were in place was taken. The Trust has emerged on the other side of the pandemic as one of the best in the country for waiting list activity.
There are four hundred and forty eight (448) doctors with a prescribed connection to the DB all of whom are engaged in medical appraisal for revalidation.

The Annual Report shows that during the period 21/22 eighty-seven (87) doctors were recommended for revalidation, twenty- four (24) were deferred and one (1) was subject to an on-going process (MHPS). There were no episodes of non-engagement.

Eighty-three (83) doctors were new arrivals to the UK and the NHS and obtained their primary medical qualification outside the UK. New doctors to the UK and NHS do have a delay to their first appraisal, which ranges from 6 months up to 12 months from their start date.

Key Staff

Responsible Officer (RO): The RO is a Consultant Anaesthetist and Chief Medical Officer, who has been in post as a consultant since 2006. Prior to that she was a trainee at the Trust, she was appointed Acting Medical Director in October 2017 and her post became substantive in April 2019 (although became the Responsible Officer (RO) whilst in the acting role). She underwent the NHS England Responsible Officer (RO) training, delivered by Miad Healthcare, and attends the RO network meetings to keep up to date and share information.

The RO is supported by the Trust Board in her RO role and has access to sufficient resources to ensure that the DB is managed effectively. She also has a dedicated Lead Appraiser, who is very experienced, five (5) senior Appraisers and a good medical appraisal and revalidation administrative infrastructure managed by the Appraisal and Revalidation Co-Ordinator and overseen by the Associate Director – Strategic Medical Workforce. The RO has monthly meetings with the Appraisal and Revalidation Co-Ordinator and fortnightly contact with the Lead Appraiser. There is a focus on recruiting Appraisers to the DB who are enthusiastic and wanting to take on the role. The RO therefore considers that the current recruitment process is a good one, where doctors wishing to become an Appraiser attend the training day in the first instance.

The DB has medical appraisal and revalidation policies in place. These are developed and amended by the Lead Appraiser and the Appraisal and Revalidation Co-Ordinator in the first instance before receiving committee approval.

The RO supports the GMC recommendations for the re-balanced approach to medical appraisal and the DB has agreed to embrace the June 2022 Medical Appraisal Guidance issued by the Academy of Medical Royal Colleges in full. She considers medical appraisal should focus more on reflection and learning but recognises that the onus is on the Appraiser to ensure their summary output is detailed and clear on what has been achieved and what is needed in professional development. She has observed that the outputs are of variable quality and whilst feedback is given to individual Appraisers there will need to be more support and input to achieve a consistently high standard.

The RO established the Doctors in Difficulty group which she chairs and includes the Associate Director – Strategic Medical Workforce and HR representation. This group is the Responsible Officer's Advisory Group (ROAG), established to monitor all doctors who are undergoing GMC/MHPS investigation, doctors who have long or regular short term sickness problems, recruitment issues, usually international doctors settling into the new working and personal life and 'noise in the system' i.e. where there is the potential for problems if a post has not been made substantive, or where a doctor is being highlighted in more complaints/ SI's than could be anticipated. This ensures that all doctors on the radar are monitored, timescales are met, and appropriate support or rehabilitation is given to individuals, linking directly to appraisal.

The RO confirmed that there is no lay representation either on the Doctors in Difficulty group or for Revalidation and she considers the appointment of a Lay Representative would be highly beneficial, contributing challenge to the process and providing assurance to the Trust Board.

The RO wants to engender in the Appraisers a professional, multi-speciality approach to appraisal where individuals take responsibility for their action, both for themselves and the doctors that are connected to the DB. The right tools are needed to effect this type of change and the quarterly meetings need to be focused on learning and development to improve the summary output and the development of the PDP in particular.

There is a good system in place and recognition that improvements have been implemented that have removed the DB from the NHSE and GMC spotlight but there is still work to be done to achieve the overall high and consistent approach to medical appraisal that she, the DB, the Trust and the public require.

Improvement Opportunities:
Review of Appraiser training to ensure outputs are of a consistently high standard in content and detail.
Consideration of Lay representation for the Doctors in Difficulty group and for Revalidation.

Medical Appraisal and Revalidation Co-Ordinator **:** the Co-Ordinator joined the Trust in 2014 to support and develop the medical appraisal and revalidation system. She works full time on Appraisal and Revalidation supporting the RO and Lead Appraiser,

Appraisers and Appraisees. The Co-ordinator is line managed and appraised by the Associate Director – Strategic Medical Workforce. The Co-Ordinator has overall control of the process and is well supported by her line manager, the Lead Appraiser and the RO. When she is on leave, cover is provided by a member of the Chief Medical Officer's Directorate who has access to and understanding of the L2P system and GMC Connect. The Co-Ordinator has fortnightly meetings with the RO and open access to her if needed.

When the Co-Ordinator joined the RO's office, Appraisal for Revalidation was in its early inception and there was no training for managers, she therefore followed the guidance to set up the system, commissioned and implemented the L2P Appraisal Management system and was achieving all the targets required by NHSE by 2015. She assists in the development and amendment of the medical appraisal and revalidation policies which are based on the NHSE framework. When updates are completed, the policy goes to the Consultant Negotiation Body for their consideration before being ratified by the approved committee or Board. Policies are accessed via the Trust intranet and the L2P system.

There is an established process for each new doctor connecting to the DB, where they are transferring from another DB or are international doctors and are completely new to the UK, the Trust and appraisal. They all have a 1:1 with the Co-Ordinator initially. She goes through the process with them and establishes their previous experience, gets the detail from their previous organisation and GMC Connect. She then sets them up on the L2P system and if the Appraisee is not familiar with the system, she provides support and training. If the doctor is new to working in the UK, there is a delay of about eight (8) months prior to starting their appraisal cycle so that they can get settled and up to speed with the process and GMC requirements. Once the Appraisee has been set up on the system and processed the Co-Ordinator allocates them to an Appraiser. She will update the Appraiser via e-mail or the WhatsApp group to advise them of the new Appraisee. The Appraisee is allocated to the Appraiser for a 3 year cycle, unless a conflict of interest is established in which case the Appraisee will be re-allocated.

The MPIT form is utilised to gain information from the previous Trust or other organisations with which the doctor works. The Co-Ordinator always gets a response to the MPIT form completion as she just keeps chasing until she achieves her goal. She has an established working relationship with the locum agencies and has a good response from them. The communication between the independent sector hospitals and the Trust is very good and there will be RO to RO discussion if concerns arise. There is excellent communication between the managers.

The Co-Ordinator has direct access to clinical governance information, incidents and complaints. Appraisees understand that this information is required and are reasonably good at getting letters of good standing from their other areas of practice. An audit was conducted 18 months ago around doctor's scope of practice, to check whether they were including all areas of work and only a couple of doctors had not included some areas of work, which was oversight rather than deliberate.

The Appraisers are recruited internally, and the Co-Ordinator and Lead Appraiser are responsible for running the annual training day that is held off site. The day is run in 2 halves. The morning sessions include appraisal and revalidation guidance and updates, appraisal discussion and summary outputs; the afternoon looks at probity, serious incident discussion and key topics and is attended by both new and established Appraisers which enables discussion. There is a budget allocation for 50 Appraisers and there are currently 6 vacancies. The training day is advertised via the newsletter along with the confirmation that the DB is actively looking to recruit Appraisers. The Co-Ordinator is responsible for the documentation relating to new Appraisers. They have a job description which is included in their job plan, and she confirms the Appraiser's Clinical Leads agreement with them prior to them becoming an Appraiser. Having the Clinical Lead's involvement is very helpful. There is a governance form that is completed to assess the Appraiser's suitability.
The Co-Ordinator reads the output summary following completion of the appraisal. She considers that the quality could be improved. Whilst most Appraisers provide detailed outputs a small group provide limited output, it can be quite variable. The Excellence Audit has identified areas for improvement in the past and there needs to be a focus on improving outputs for Appraisee and RO clarity.

In relation to the Revalidation process, there is a monthly or fortnightly meeting between the RO and the Co-Ordinator, and they review every doctor who is under notice for revalidation well ahead of the revalidation date. In preparation for the meetings the Lead Appraiser and Co-Ordinator review the annual appraisal outputs for the 5 years using a revalidation checklist to ensure that all aspects of the doctor's scope of work has been covered, including the MSF. The RO and the Co-Ordinator review the checklist and e-portfolio together and the RO will add her notes to the process. The RO will then make a decision as to whether to recommend revalidation or whether a deferral is required whilst further information is gathered. Either way the doctor will be informed of the outcome and if there are concerns around a deferral the GMC ELA will be involved.

The Co-Ordinator prepares the initial draft of the AOA and the Annual Report, which she then shares with the RO, and they review it together checking the accuracy of the detail, the RO then adds her commentary to the Annual Report and presents it to the Trust Board. The process is mature and tightly managed.

Improvement Opportunities:

The quality of the Appraisers output is variable and could be improved. Whilst most Appraisers provide detailed outputs, a small group provide limited output.

The Associate Director – Strategic Medical Workforce (the AD): line manages the Appraisal and Revalidation Co-Ordinator and completes her appraisal. The AD is strategically involved in Medical Appraisal and has regular 1:1 meetings with the Appraisal and Revalidation Co-Ordinator to discuss any issues that require support. The Lead Appraiser and the Medical Director (RO) are also available to the Co-Ordinator for advice and guidance. There is a member of the wider Chief Medical Officer's Directorate who has a good understanding of Medical Appraisal, who steps into the Co-Ordinator's role as required, for maternity and annual leave, and the AD can support if needed. The Co-Ordinator is a fulltime dedicated role and has strategic support as required and therefore does not require additional resource to manage the process. The Co-Ordinator is extremely competent, has a wide range of knowledge and manages the process efficiently and effectively. The AD has oversight of the associated policies which are developed and updated by the Co-Ordinator with input from the Lead Appraiser. The Medical Appraisal policy is due for review in February and the process has already commenced to ensure it is ratified in good time.

3. Infrastructure

The Trust DB has in place a knowledgeable and stable medical appraisal and revalidation leadership team, who have developed a sound structure and process to support medical appraisal. There are regular meetings between the team members and all elements of appraisal are reviewed. Two audits in recent years have identified key areas for improvement. This section briefly reviews the key aspects of communication that support appraisal.

Communication and Support: The Appraiser group have access to a range of communication strategies - the L2P system, a newsletter and a WhatsApp group, all of which can be utilised to provide information and updates. Pre-pandemic there were quarterly Appraiser network meetings which were postponed during the pandemic. The Appraisal and Revalidation Co-Ordinator has planned to re-start the meetings which will be appreciated by many who have indicated the need for them.

Appraisers receive anonymised feedback which is generally positive and shows the value Appraisees place on their appraisal discussion and support.

Appraisees are supported in the process by the Co-Ordinator who is particularly sensitive and supportive of the needs of the international doctors recruited to the Trust.

Appraisal and Revalidation System - access, security and confidentiality: the DB uses the electronic L2P system, which was specifically procured to securely generate and record the Appraisee's documentation in preparation for the appraisal discussion with the Appraiser, who also records their comments on the appraisal and the revalidation readiness. The system holds all of the appraisal documentation for all doctors connected to the DB.

Access to the system is limited to maintain security and confidentiality. Information Governance and confidentiality awareness is part of the mandatory training programme and doctors should therefore be aware that all their supporting information used for appraisal must be anonymised to ensure that all personal or organisational identifiers are removed to protect individuals from identification.

Identified issues: during the portfolio review it was identified that there was a lack of familiarity with a few Appraisees and Appraisers with the L2P system.

Sometimes comments made by the Appraiser were not relevant for the section attached or the Appraisee has recorded information in the incorrect section. There was also occasional evidence of the Appraiser supporting an Appraisee on the most effective way to use the L2P system. Another example of clear evidence is where an Appraiser is orientating the Appraisee to the medical appraisal process in the UK and providing guidance on expectations going forwards. A review needs to take place to ensure all Appraisers and Appraisees are familiar with and orientated to the system.

The Co-Ordinator has identified that the L2P system will allocate the Appraisee to the same Appraiser on completion of the three (3) year cycle. This is a software problem that is being reviewed. In the meantime, the Co-Ordinator re-allocates as needed.

Meeting structure: there is an established and appropriate programme of meetings between the key staff within the DB, details of which are referenced in each section. The Appraiser quarterly network group is being re-established. There is a Doctors in Difficulty group chaired by the RO.

Sharing information: there are established information sharing networks for appraisal update, GMC and NHSE information via the meeting structure or the Co-Ordinator e-mails information to Appraisers. There is also an information update on the L2P system.

Policies: detailed review of the Medical Appraisal and Revalidation policy and procedure and the Raising Concerns policy and procedure documents has taken place. These two key policy statements cover the majority of the required detail to fulfil their purpose and have been ratified by the Workforce Transformation Committee and the Trust Management Board respectively. There are some points for addition or clarity required to ensure completeness. These recommendations and suggestions, including links to key guidance are contained within Appendix A (i & ii). Some examples of additional guidance include:

Medical Appraisal and Revalidation Policy:

- clarify who is responsible for ensuring new doctors are connected to the Trust and what information is transferred between organisations for starters and leavers.
- reference to the Medical Practice Information Transfer form or process needs to be included
- reference to GMP will need to be updated to the most recent version published in November 2020
- an equality impact analysis should be developed for this policy
- the benefits of professional development need to be made more explicit for both the individual doctor and the organisation

Responding to Concerns Policy:

- reference to 'Being Fair' and the 'Just Culture' guide in the decision-making process should be considered
- the mechanism for seeking advice from the GMC ELA should be updated to include HR and legal advisors
- maintaining documentation is not specifically referred to. 'A practical guide for responding to concerns about medical practice' contains some useful information about documentation.

4. Appraiser Support and Development:

Appraisers for the DB are recruited internally. They are initially self-selecting rather than being actively recruited. Consultants who express an interest in becoming an Appraiser attend the annual appraisal Training held by the DB where they gain further insight and training. This also provides the opportunity for them to discuss the role with other established Appraisers. If they are still interested, they discuss taking on the role with their Clinical Lead to ensure they are making the right decision. The Clinical Lead will then support the application and the Lead Appraiser will make the final decision. If accepted as an Appraiser, the role is added to their job plan, and they will be supported initially by the Lead or a senior Appraiser.

The Lead Appraiser has ensured that all Appraisers have been allocated one PA per week (4 hours) to complete appraisals. There are sufficient Appraisers within the DB to complete the appraisals required.

Recruitment to the Appraiser role used to be difficult but having adopted this process, it is now good. There are between 40 -50 applications of interest for the annual course, for which they must apply for study leave. It is held externally to the Trust. The doctors therefore need to be reasonably committed to supporting the appraisal process and it means that the DB gains an enthusiastic, self-selected body of Appraisers.

Lead Appraiser: is a Consultant and Clinical Lead for Emergency Medicine and has been the Lead Appraiser for the Trust since 2012. He completed his Appraiser training with the Region in Manchester He was interviewed for the post of Lead Appraiser and has a job description for the role which is included in his job plan. He was very involved in setting up the original governance framework for medical appraisal within the DB. He maintains his knowledge in medical appraisal by attending network meetings, updates from the GMC and NHSE and he in turn passes the information to the Appraisers.

The Lead Appraiser works closely with the RO and has confidence in the appraisal system. He meets with the Appraisal and Revalidation Co-Ordinator weekly, either remotely or face to face. They continuously monitor the position of medical appraisals. When a doctor is due to revalidate, they review the cycle of appraisals and use a proforma to check the content and ensure that everything has been achieved. This includes input from the clinical governance system to independently ensure that the Appraisee has included all complaints, serious incidents and mandatory training requirements prior to forwarding to the RO to consider making

recommendation to the GMC for revalidation. He and the Appraisal and Revalidation Co-Ordinator have regular meetings with the RO. The Lead Appraiser feels well supported in his role, as a team they have worked together for a long time and have developed a strong communication system.

There is an 'open door' policy of access to the Lead Appraiser. Appraisers can always contact him for advice on a potentially difficult Appraisee, not supplying enough supporting information, if there is slippage, or to discuss how certain situations can be handled. He is committed to supporting Appraisers early to avoid them becoming overly concerned. There are also five other senior Appraisers across the Trust that are available to provide support. The quarterly lunchtime Appraiser Update meetings are being re-instated following the pandemic and this is another source of support and opportunity to network. Appraisers are informed of any policy changes, national and local changes through the newsletter and now the update sessions again.

The Lead Appraiser and the Co-Ordinator take joint responsibility in ensuring that policies are kept up to date.

The doctors with a prescribed link to the DB have supported the GMC's recommended re-balanced approach to medical appraisal. It has been well accepted in the Trust, doctors like it, as it is more focussed on quality rather than quantity. Appraisers are having to write more in their summary outputs, and this will take a time for Appraisers to develop greater challenge during the appraisal discussion, rather than taking things on face value, as there may be less supporting information. The challenge for the DB is to achieve consistency across all appraisal outputs. He knows that some Appraisers do not challenge enough, and it is his intention to develop these skills through sharing examples of high quality outputs that show rigorous challenge and support has occurred within the appraisal discussion.

Appraisers are guided to escalate any issues around difficult or unusual appraisals or concerns about a doctor's practice or well-being for initial discussion to either himself or one of the other senior Appraisers. Consideration is then given to the specific situation and if the difficulty is around engagement, or difficulty in arranging an appraisal meeting in the required time frame, then a solution will be found, if possible, prior to escalation to the RO. If the concern is about practice, then the case will be clearly presented for escalation to the RO. It is for the RO to decide if further action or investigation is required.

There is still a challenge in getting some senior doctors, close to retirement, to engage in the appraisal process. The Lead Appraiser considers it very important to include preparation for retirement in the appraisal discussion early to get doctors thinking about less clinical sessions and more education or management responsibility that they can continue if they wish post clinical retirement. He is planning to discuss with the Appraiser group how this can be developed and implemented. There needs to be a clear and consistent approach that is seen to add value.

The main change going forward, that the Lead Appraiser would like to see, is greater proportional representation across the Appraiser group. Not all specialties have Appraiser representation, and it would be helpful to achieve this across the two sites. Appraisers work across specialties but with some smaller more specific clinical specialities, there is not always the knowledge of the doctor's skill development requirements. Whilst working across specialties reduces bias there is a need for speciality specific knowledge.

Improvement opportunities

Development of Appraiser summary outputs to show a consistent approach to documenting the appraisal discussion, including reflection, challenge and support in line with the Academy of Medical Royal Colleges, Medical Appraisers Guide, June 2022

Develop consistent Appraiser challenge within the appraisal discussion using shared example of high quality outputs

Strive to fully engage in appraisal of some senior doctors, close to retirement

Include preparation for retirement in the appraisal discussion early to get doctors thinking about less clinical sessions and more education or management responsibility that they can continue if they wish post clinical retirement. Clear and consistent approach to ensure added value.

Increase proportional representation across the Appraiser group to include all specialties.

Appraisers: five (5) Appraisers kindly gave their time to provide an overview of their experience of being an Appraiser with the Trust and to make suggestions where improvements could be made to support the quality and consistency of medical appraisal. The summary notes of the interviews can be found in section C of the Appendix, on which the following overview is based.

The Appraisers had all undergone medical appraisal training and attended the annual update day. They also included their Appraiser role in their own scope of practice. They consider that the Trust sees the medical appraisal process as important, and they feel well supported by and have easy access to the Lead Appraiser and the Co-Ordinator. Additionally, they require sufficient time allocated to the process. There were some comments around the additional support required by international doctors in their initial appraisal. They feel that the L2P system works well and that there is a good framework to support all the elements of appraisal, including the relevant policies.

The Co-Ordinator allocates the Appraisee initially and informs the Appraiser accordingly. The Appraisee makes contact with the Appraiser and the arrangements for the appraisal discussion are made and it is agreed that the portfolio will be available to the Appraiser two weeks (2) prior to the meeting. If there is a lack of supporting information the Appraiser will either, ask for additional information to be supplied or defer the appraisal meeting until the situation has been resolved. They considered that the reflective activity of some Appraisees was less which meant it is important that it is included in the discussion and more documentation is needed from the Appraiser.

The Appraisers appraise across specialties and still have a mix of remote and face to face discussions depending on the situation. The Appraiser is changed after the three (3) year cycle.

All the Appraisers interviewed were confident in raising any concerns they may have about an Appraisee with the Lead Appraiser in the first instance.

The Appraisers are supportive of the re-balanced approach to medical appraisal, considering it to be a more focussed on the learning and development needs of the Appraisee. The June 2022 guidance was circulated to all Appraisers.

They receive anonymised feedback from their Appraisees which they include in their own supporting information. An example of one Appraisee's view is below:

'I have been allocated several over the years and usually well in advance. It does feel a bit strange as the last 2 Appraisers have been in Rehab medicine - could not really get more removed from ED or UCS. However, they have looked in detail at my portfolio and done their homework.'

Improvement opportunities:

Re-establish the Appraiser quarterly meetings and include topics covering GMC Fitness to Practice issues, support in sign posting well-being issues identified through appraisal discussion, shared case studies and experience of difficult appraisals.

Additional support provided to Trust Grade/Career Grade doctors who can struggle to populate their portfolios with the correct supporting information. They often miss out on QIA and their information can be thin. This group also include international doctors who have not got previous experience of medical appraisal and the knowledge base is just not there.

Guidelines around the development of a PDP, to ensure that sufficient detail and goals are included to know what outcome is expected and how the doctor can truly evidence the achievement of that goal.

Guidance that includes recommendations for specialist clinical audit or QIA would be beneficial and applied to all Appraisees.

5. Appraise feedback Survey

Quality of Medical Appraisal Experience Survey Outcome

To obtain information on the quality of the medical appraisal experience within the DB, fourteen (14) questions were developed and approved by the Appraisal and Revalidation Co-Ordinator. The link was then sent to doctors connected to the DB of which seventy-three (73) Appraisees responded. The anonymised data has been reviewed and the survey outcome and freehand comments are described as follows.

There was a range of medical appraisal experience in the respondent group. 51% had undergone more than five (5) appraisals, 17% between three (3) – five (5) appraisals and 32% had completed between one (1) and two (2) appraisals.

Those that had transferred from another DB, 65% had stated that they found the transfer process easy, whilst 35% stated that they had not transferred with one (1) comment that the process was too complicated. 77% of the Appraisees asked felt supported in getting set up and using the new, for them, system. The remaining 23% either did not need support or responded that it was not applicable to them. 96% of Appraisees agreed there was a contact point for them if needed, with comments that the contact point was easy to approach and very helpful. 4% answered no to the question, one (1) made use of the intranet guidance.

100% of Appraisees agreed that an Appraiser has been allocated to them quickly, of which 78% of Appraisees made contact by e-mail, 14% by phone with 8% being supported by the Appraisal and Revalidation Co-Ordinator.

Responses to questions around the appraisal discussion meetings revealed that 100% of Appraisees found their Appraiser to be approachable and supportive, 96% of whom said the Appraiser set clear expectations of times to receive the portfolio, setting an Appraisal date and achieving sign off. 56% of appraisals were held virtually, 56% face to face and 5% over the phone as a result of IT problems on the day.

When asked if the appraisal discussions were supportive and clear 100% of Appraisees agreed that had been their experience, 96% confirmed that the Appraiser had been helpful in setting their PDP. Of the remaining 4%, for one (1) Appraisee it was their last appraisal before retirement, the remainder were confident in developing their own but agree they could discuss if needed.

100% of Appraisees agreed they transferred to a new Appraiser after three (3) cycles; 100% agreed they gave feedback to their Appraiser with few comments that they found it difficult to know what to say. 96% of Appraisees had not experienced a conflict of interest with their Appraiser, whilst 4% or three (3) respondents indicated they had experienced a conflict of interest but gave no reason as to why or how it was resolved.

Some quotes from the freehand commentary include:

'Contact point is easy to approach and very helpful'

'NONE from colleagues but if you know where to get support it is there. 3 years here 2nd appraisal overdue'

'Contact was easy and swift'

'Very supportive. Excellent!!'

'Helpful advice before the meeting and supportive during the meeting'

'Very supportive and helped me a lot as it was my first appraisal'

'Being my first job and appraisal. The process went smooth (sic), and I was facilitated very well and appropriately'

6. Medical Appraisal Portfolio Review - Detailed Findings

- **Methodology –** The Miad Healthcare reviewer signed an NDA and was provided with administrative access to the L2P medical appraisal system. A review sample of forty-four (44) completed and signed off most recent medical appraisal for the randomly selected Appraisees that had been carried out in the last 18 months. These were reviewed remotely, and relevant criteria mapped against the FQA standards. (Appendix D & E). All Appraisees were asked if they agreed to having their portfolio reviewed and two (2) requested exclusion from the process.

The portfolios were reviewed against the Miad Healthcare's assessment of input tool (Appendix D) and the NHSE Excellence QA Tool to assess Appraiser output. (Appendix E).

The portfolio section completed by the Appraisee were reviewed to answer the following questions (inputs of appraisal): -

- What are Appraisees submitting as supporting information and is it relevant to the appraisal?
- How are Appraisees using their supporting information to demonstrate their competence in the four domains of Good Medical Practice (GMP)?
- Within the sample – what is the quality of reflection of the Appraisee? There is great emphasis on reflection, and how the doctor might apply their reflections through their practice, through their thinking, and their learning.
- Is there a connection between the Appraisee's input and the Appraiser's output: is there continuity across the PDP, and summaries of reflection and discussion?
- What is the quality of the summary of appraisal discussions like in this sample (Appraiser output)?
- Was the appraisal summary written in such a way that there was evidence of a supportive appraisal meeting?
- Did the Appraiser reference the supporting information in their summary to evidence the discussions?
- What is the level of challenge like with regard to the quality of supporting information – has the Appraiser helped the Appraisee to set objectives around including reflection on supporting information, addressing gaps in supporting information as required by the GMC?

The Appraiser summary section was matched against the specific element (twenty in total) to quality assure the output documentation described under three (3) headings:

- Overall
- Planning ahead
- Reviewing

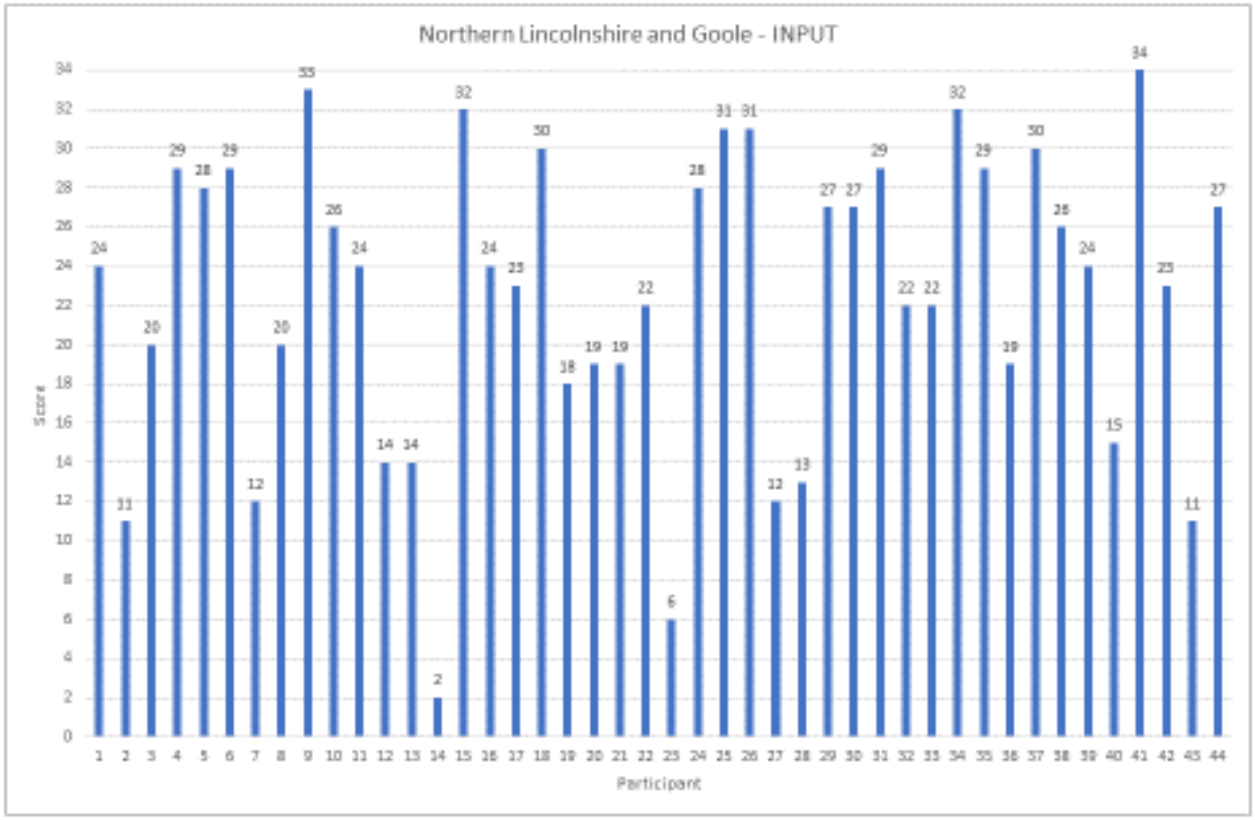
The scoring applied to each for Appraisee (input) and Appraiser (output) is as follows:

Input	**Output**
0 = Information not present	0=No (absent from summary)
1= Some detail	1=Partially (room for improvement)
2 = Good	2=Yes (well done)

FINDINGS - INPUTS

The report will first present the findings of Appraisee Inputs, before looking at the quality of Appraiser Outputs.

The charts (Annex 1, questions 1-17 and Appendix D: Questions/Criteria) and supporting text below are the results of the forty-four (44) portfolios reviewed against criteria mapped with the FQA standards and using the Excellence tool.



The highest attainable score in the above graph is 34

The highest potential score attainable is thirty four (34), each element is scored 0-2:

0 - no supporting information provided, 1 - further supporting information/ detail required, 2 - good

Forty-four (44) appraisal portfolios contained within the L2P Toolkit completed over the previous eighteen (18) months were randomly selected for review. Each Appraisee had been given the opportunity to opt out of the review. Each of the portfolios were reviewed to assess the quality of the input by the Appraisee and the quality of the output documented by the Appraiser.

The above graph depicts the total level of inputs seen in each portfolio, the individual element inputs are graphically described in the accompanying document Annex 1, questions 1-17. The highest attainable score for the Appraisee inputs is 34. The score variation for this review ranged between thirty-four (34) and two (2) with one (1) Appraisee scoring thirty-four (34).

- twenty-three (23) Appraisees (52%) achieved scores of twenty four (24) and over
- twelve (12) Appraisees (27%) scored 15-23
- seven (7) Appraisees (16%) scored 6-14
- two Appraisees (5%) scored 0-5

Whilst over half of the Appraisee portfolios reviewed achieved scores in the upper quartile, nine (9) Appraisees (20%) were awarded scores well below that which would normally be expected. The very low scoring inputs were not picked up and supported by the Appraiser. Further breakdown is provided under each category reviewed and where the review has identified areas that could be improved upon, these have been detailed below.

Scope of Practice Annex 1 (question 1)

Review of this element showed that 91% of the Appraisees comprehensively described their scope of practice to a good standard, including their private or other practice, achieving a score of two (2), this is a high compliance rate, the remaining 9% needed to document more detail. Only two (2) portfolios included letters of good standing from their other places of work.

There could be greater clarity around hours or sessions worked in each role contained within the scope of practice, those who covered it well, uploaded their job plan.

Supporting Information Annex 1 (question 2)

Supporting information was reviewed, first by checking all six of the GMC recommended pieces of information were present or referred to (Continuing Professional Development (CPD), Quality Improvement Activity (QIA), patient and colleague feedback, complaints & compliments and significant events). It is accepted that not every piece of supporting information is provided every year in full, but good practice dictates that all six types of supporting information should be discussed and addressed annually through the PDP if absent. Detailing the scope provides a reference point for this section and ensures that the supporting information covers all aspects of the Appraisees work, for example, teaching, managerial, committee and regulatory responsibilities in the UK, EU and Globally.

The overarching review of all supporting information showed that 45% of Appraisees had provided sufficient information, 30% needed to provide greater detail and 5% had not provided any detail and these related to the international doctors having their first appraisal.

The inclusion and content of the other supporting information elements (patient and colleague feedback, complaints & compliments and significant events) are commented on under their respective headings below.

Of concern, many of the portfolios contained mainly colleague and occasionally patient identifiable data. These included colleague names, e-mail addresses and patient names and addresses on compliment cards or ID number on surgical lists.
Appraisees need to be reminded of the importance of maintaining anonymity for patients and colleagues as described in the GMC document Guidance on supporting information for appraisal and revalidation. This issue was not documented as being picked up by the Appraisers.

Continuing Professional Development (CPD) Annex 1 (question 3)

The GMC requires all doctors to keep their knowledge and skills up to date and tailored to the specific needs and interests of their whole scope of work.

This element has been considered in the context of the pandemic. The review timescale, sits within the second and third national lockdowns. This meant that the ability for doctors to access the normally available CPD activity of conferences, training and development sessions was curtailed.

61% of Appraisees had attached sufficient supporting information in relation to the CPD in line with rebalanced appraisal expectations, 30% of Appraisees needed to provide greater detail and 5% did not supply any supporting information.
Many of the portfolios gave the impression of more than enough CPD but recorded it as zero and the Appraiser has not included anything different in their summary which resulted in lower scores for the 30% range.

Reflection of Continuing Professional Development (CPD) (Annex 1 (question 4)
The GMC requires that doctors reflect on a selection, not all, of their CPD. Clear examples directly relating to their scope of practice need to be identified, reflected upon and areas for improvement and areas of strength considered and discussed at the appraisal meeting. This in turn should contribute to the PDP development.
The reflective activity of the portfolios reviewed revealed that 52% of the Appraisees had completed this element well, giving a clear indication of how CPD supported their practice. 23% needed to provide further detail and 25% did not provide any written reflection on their CPD. Where reflection was missing this had not been captured by the Appraiser.
Of note, one (1) Appraisee had included an excellent reflection diary.

Quality Improvement Annex 1 (question 5)
The GMC requires Appraisees to have participated in quality improvement activity that is relevant to all aspects of their practice at least once in their revalidation cycle. In relation to QIA, 48% of Appraisees covered this element well, and there are some excellent examples where sharing of examples and improvement outcomes are very clear. 25% needed to provide greater detail and 27% provided no commentary at all.
There appears to be some confusion from Appraisees as to what evidence should fit into this category. There were some local clinical audits, but little clarity on the Appraisees involvement and no reflection or comment by Appraisee or Appraiser. Some logbooks included but with for example, no reflective activity on complication rates, and some teaching sessions included without any context

of an area to improve care and outcomes. It was therefore unclear as to whether the item was being included as QIA.

Reflection of Quality Improvement Annex 1 (question 6)

43% of Appraisees reflected well on their QIA, 16% needed to have detailed more and 41% provided no written reflection. Had reflection been included for the latter 57%, either by the Appraisee or in the Appraiser output following the appraisal discussion this would have clarified the purpose and outcome of the QIA and thereby increased the overall scoring as evidence of a good standard of QIA across the organisation.

Significant Events Annex 1 (questions 7 & 8)

It is expected that in preparation for every appraisal, every doctor declares and reflects on every serious incident in which they have been involved, since their last appraisal. The appraisal discussion should focus on those serious incidents that led to a change in practice or demonstrates the Appraisee's insight and learning. Each Appraisee has to declare as to whether or not they have been involved in a serious incident. 75% of Appraisees declared that they had included any SI's in which they had been involved. 14% needed to supply further information and 18% did not document any involvement.

The overall standard of documented reflection of those Appraisees who had been involved in a serious incident was generally defensive, giving excuses,' it was admin who filed the notes incorrectly' or 'not me- just was consultant responsible' rather than having an open attitude to learning and change**.** Alternatively, the Appraisers should have facilitated the reflective discussion to support greater insight

Appraisees having not declared involvement in a serious incident, did not take the opportunity to learn, and check or change their practice, from other incidents that had occurred in their directorate or via the wider clinical governance frameworks. This should be seen as a missed opportunity to be pro-active in their practice and it is recommended, that all Appraisees should be encouraged to consider this opportunity to be pro-active in improving patient or staff safety, as described in the Patient Safety Strategy 2019 guidance.

Patient Feedback Annex 1 (questions 9 & 10)

It is accepted that the period of time during which the portfolio review took place was subject to lockdowns and limitations and this has reflected on the access to patient feedback. Less out-patient contacts, re-allocation of staff to different areas and shielding or sickness have presented a big challenge for this element. Out of the forty-four portfolios reviewed, 73% of Appraisees were scored two (2) as they had either included some patient feedback, or it was stated that the multi-source feedback (MSF) was not due. Some reflection had been included which was of average quality and mainly included generic statements rather than any specific learning outcome, but the majority had not included reflection.

Whilst recognition must be given to the circumstances affecting this element, checks should be in place to ensure that informal patient feedback is included and reflected upon in those years of the cycle that do not include MSF. This is a GMC recommendation.

Colleague Feedback Annex 1 (question 11 &12)

75% of Appraisees included some colleague feedback or stated that it was not the MSF year and were therefore scored a two (2). As in Patient feedback the reflective activity was very limited with the use of generic statements. Informal feedback from colleagues should be included and reflected upon in those years that MSF is not included.

Complaints Annex 1 (questions 13 & 14)

As with serious incidents the Appraisee is asked to declare any complaints in which they have been involved, to which there was 77% response rate. 21% stated that they had not been involved in any complaints. The reflective activity for those involved in complaints was much better than in previous elements, with 73% of Appraisees having reflected on the complaints in which they had been involved. Whilst there were still generic statements used, there were more specific learning outcomes documented.

Those Appraisees who did not declare direct involvement in a complaint could have taken the opportunity to review a complaint that had occurred within their speciality/ directorate and briefly describe any changes they have made to their own practice or for the team as a learning outcome.

Compliments Appendix 1 (questions 15 & 16)

Compliments are the sixth type of supporting information doctors will use to demonstrate that they are continuing to meet the principles and values set out in Good Medical Practice. They help to identify areas of good practice, strengths and what a doctor does well and should be viewed as affirmation that the Appraisee is 'getting it right'.

Out of this group, 52 % of Appraisees included compliments relating to their specific area of work, but only 18% provided some limited reflection.

Doctor's Achievement of GMC Attributes Annex 1 (17)

The Appraisee is required to consider their achievement of the GMC attributes in the pre-appraisal section of the appraisal input form. Referencing their supporting information and how it demonstrates they are meeting the requirements of GMP is a fundamental element of appraisal for the Appraisee.

This element achieved a low rate of compliance, 32% of Appraisees completed this section to a reasonable standard. 57% of Appraisees did not document any details and 11% included some generic statements. **It is the case however, that at the time of the review and going forward this element** will be integrated into the overall appraisal rather than as a separate element to be completed, as described in the Academy of Royal Colleges – Medical Appraisal Guide 2022.

Improvement Opportunities

Scope of practice - greater clarity around hours or sessions worked in each role contained within the scope of practice, recommend Appraisees include their job plan in their supporting information.
Include letters of good standing from Appraisees other places of work.

Supporting Information - Appraisees need to be reminded of the importance of maintaining anonymity for patients and colleagues as described in the GMC document Guidance on supporting information for appraisal and revalidation.

CPD - portfolios gave the impression of more than enough CPD but recorded it as zero and the Appraiser has not included anything different in their summary which resulted in lower scores for the 30% range described.

QIA – range of evidence that fits into this category, as included in the AMRC 2022 guidance, to be shared with Appraisees so they are aware of the full range of options.

SE's - Appraisees having not declared involvement in a serious incident should take the opportunity to learn, and check or change their practice, from other incidents that had occurred in their directorate or via the wider clinical governance frameworks. This is an opportunity to be pro-active in their practice as described in the Patient Safety Strategy 2019 guidance.

Patient and colleague feedback – encourage the collection and inclusion of informal feedback which is reflected upon for those years of the cycle that do not include MSF. This is a GMC recommendation.

Complaints - Appraisees not declaring direct involvement in a complaint could take the opportunity to review a complaint that had occurred within their speciality/ directorate and briefly describe any changes they have made to their own practice or for the team as a learning outcome

Reflective activity overall – Appraisees need to ensure that they complete reflective activity for each of the six (6) elements as set out in the AMRC 2022 guidance.

Quality of the Appraiser Outputs

Summary of Appraisal

The appraisal summary is a key document used by the Responsible Officer to inform them for their revalidation recommendations. Through correlation with the supporting information submitted in the pre appraisal form, it should demonstrate that the Appraisee has satisfied the four domains of Good Medical Practice[1];

Domain 1 - Knowledge, skills, performance

Domain 2 - Safety and quality

Domain 3 - Communication, partnership and teamwork

Domain 4 - Maintaining trust

A total of forty-four (44) appraisal portfolios were reviewed, and this section describes the findings of the Appraiser outputs; namely the appraisal and domain summary output report and the Personal Development Plan (PDP).

The NHS England Excellence QA tool was used, comprising of ten (10) questions with a score criteria of

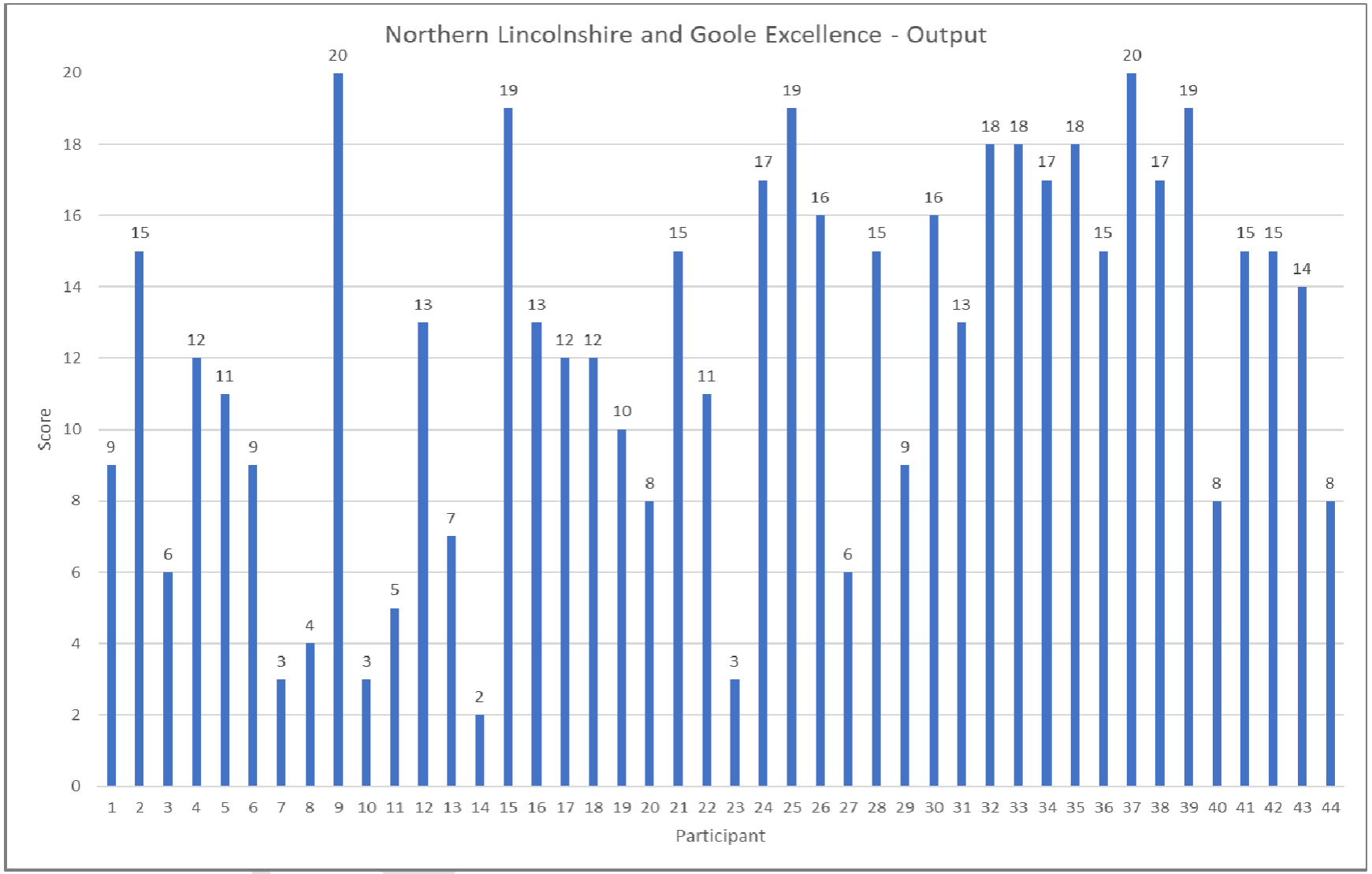
0 = Absent, 1 or 3 = Room for improvement, 2 or 4 = Well done

The questions are organised in three (3) specific categories:

- Overall
- Reviewing
- Planning ahead

The detailed summary with learning opportunities is detailed as follows.

[1] *Good Medical Practice, General Medical Council. March 2013*



The highest attainable score in the above graph is 20

The above graph depicts the score of the Appraiser outputs from each portfolio reviewed. The reviewer was able to select thirty-eight (38) different Appraisers and scored the outputs using the pre-set criteria. The maximum score achievable was 20/20.

- 5% of the Appraisers (2) achieved a score of 20/20

- 39% of Appraisers (17) were scored between fifteen - nineteen (15-19), of which nine (9) Appraisers scored seventeen and above
- 23% (10) scored between fourteen – ten (14-10)
- 23% (10) scored between nine - five (9-5)
- 11% of Appraisers (5) scored between zero and four (0-4)

The five (5) very low scoring outputs are of great concern and therefore warrant further explanation. The reviewer has provided some additional observations on the content of the output summary, and these are some of the reasons why the scoring was so low:

Very little documentation - Generic statement "Dr X is an enthusiastic hard working conscientious consulter".
Sense Appraiser is doing brief reference not appraisal. "Dr X has...goals in mind to work according to GMC guidelines as always" Little else written by Appraiser

PDP just copies paragraph about aspirations to continue working at the Trust. Appraiser states "The GMC have revalidated him, so this is a very good omen" (?) rather than summarises evidence for RO to make recommendation. CPD comment does not match Appraisees and just states "We agreed" for entire summary statement.

There is the appearance of Appraiser comments prior to appraisal not updated. Comments come across as judgmental and mis-match between comments in portfolio and summary e.g., on SI - one says good reflection, other raises issues

There is one (1) low scoring portfolio that has covered some content but has focussed on the well-being aspect as there are notes to this effect.

Further generalised detail by element follows:

Overall

Encompass all – this element asks whether the summary comment documented by the Appraiser covers the context, including Appraisee's stage in the revalidation cycle, and reflection on the whole scope of work. 29% of Appraisers covered this to a good standard, 45% needed to provide greater detail and 34% did not include this element in their commentary.

Exclude bias and prejudice – covers whether statements are objective, and evidence based, 50% of Appraisers documented fully their review, 25% needed to provide further detail for clarity and 25% did not include commentary on this element.

Challenge, support and encourage – reviews whether the Appraiser has summarised the focus of the appraisal discussion to include challenge of the supporting information content, supportive and focussed on the doctor's needs. 34% of the Appraisers reviewed had covered this to a high standard in their summary, 39% needed to provide greater detail to provide the RO with evidence of this element being fully considered and 27% did not comment.

Statements – this ensures that the Appraiser has seen and reviewed as necessary the statements made by the Appraisee including health and probity. 89% of Appraisers had completed this to the required standard, with 11% needing to provide greater detail to attain compliance.

Improvement Opportunities

The summary should provide the RO with an overview of the Appraisee and provide assurance through documented evidence that a thorough appraisal discussion has taken place. Whilst it can be seen that there are Appraisers who are fully compliant with this process there are many who need further support and guidance to provide that detail.

An overview of the less detailed summaries show that some are missing completely, and many of the GMC domain content provided by the Appraisee has either not been commented upon, or there is a general vague sentence, compliment or sentence of encouragement not based in evidence from rest of portfolio. Some of the Appraisee's portfolios where this paucity of summary

output had occurred, had been completed to a detailed standard which must be frustrating for the Appraisee when the content of their portfolio is good, but this is not recognised in the summary output.

One Appraiser had just copied and pasted the Appraisees comments with no sense of discussion.

It is recommended that Appraisers receive guidance on the importance of the summary statements and the detail required.

Reviewing

The focus of this element is on quality improvement through review of supporting information, the use of reflection, changes in practice, review of PDP and identification of good practice.

Supporting information, lessons learned, and changes made – 32% of the Appraisers provided detailed documentation covering all aspects, there was good evidence of reflecting on SI or complaints included during the appraisal discussion. 34% provided some information but a more detailed description would have improved the assurance provided. 34% did not provide any meaningful evidence or just included a generic sentence.

Last year's PDP and reflect on each objective – 61% of Appraisers documented the achievement of the previous year's PDP, highlighting reasons for delay or need to carry over, which were mainly due to the constraints of the pandemic. 21% whilst documenting some information needed to be more specific, e.g., stating how many of the PDP items had been achieved or how achievement is linked to the doctor's development. 18% either did not comment or made a very generic statement.

Encourage excellence, celebrate accomplishments and record aspirations – 55% of Appraisers covered this element to a good standard, 27% needed to expand on their commentary to add value to the output and 18% did not comment which will be a disappointment to Appraisees who have included good examples and whilst there may have been discussion it is not reflected in the documentary evidence.

Improvement Opportunities

Fuller analysis and reference to lessons learned and changes to practice made as a result need to be documented.

In general terms, there was rarely any reflection on the PDP other than whether it had been completed or not. There were, however, a few excellent examples where the Appraisee had clearly stated how they had achieved the PDP item and the outcome success both professionally and in terms of patient care, which had been discussed and documented by the Appraiser.

A significant proportion of Appraisees had stated "course – certificate" or "conference – certificate" with many not specifying what course or conference. This may be contributed to by lack of certainty over Covid as to which course would go ahead, but a skilled Appraiser would have drilled down to the learning need and suggested alternative ways to achieve the PDP item if no courses were available. Review of the achievements and aspirations of the Appraisee provides meaning contribution.

Under the revised guidance, Appraisers need to use the appraisal discussion to further support Appraisees to develop their PDP more fully, with a clear link to professional development needs and outcomes that benefit patients and provide documentary evidence that this has happened.

Planning Ahead

Gaps and how they will be addressed – this element has been assessed as being a significant weakness, only 11% of Appraisers output included identified gaps in the Appraisees input and how these could be addressed. 43% noted gaps in the briefest of terms and 46% made no comment. There is significant evidence in the Appraisee input section that highlight key gaps. There is some evidence in the following elements that support the notion that the discussion may have taken place but greater clarity in documentation is needed to explain the pathway to the final agreed PDP.

SMART PDP objectives – 55% of Appraisers were recorded as scoring two (2) in this area where the objectives have a clarity of purpose, 34% required detail to substantiate challenge and discussion with the Appraisee to reach the decision and 11% contained little or no detail, at best being a cut and paste of the Appraisee's aspirations.

Explain new PDP items – is asking for the summary to provide detail on how the PDP objectives are relevant and derive from the supporting information and appraisal discussion. This section does add support to the Appraiser having identified gaps in the Appraisees input, 39% of Appraisers covered this to a good standard, 45% needed to document relevant detail and 16% supplied no information.

Improvement Opportunities

Overall, there is the impression that appraisal discussions are not being frequently used to support the Appraisee to develop their PDP, many are written the same as the Appraisee had written them in the pre-appraisal meeting section and were no "smarter" when transferred across to the agreed PDP. Appraisers must clearly document the summary discussion in order to show the doctor's developments year on year for the revalidation cycle and provide clarity for new Appraisers and the RO.

Incidental findings

Appraiser comments not updated after appraisal meeting – there are instances where the Appraiser has noted questions in some sections, probably prior the appraisal meeting, and not made any further update after the appraisal as to how their question was resolved.

Consideration should be given to mapping whether those Appraisers with poor summaries have been provided with sufficient training. There are a few examples that look more like a chat and a reference rather than an appraisal which may indicate that the Appraiser is not up to date with the current process of appraisal and evidence needed for revalidation.

It is recommended that Appraisers focus on the following:

- Referencing specific evidence from SI and discussions in Appraiser summary
- Making summaries standalone with basics needed for the RO included
- PDP development – training on focusing the Appraisee on why they are looking to do something, what is the learning need (which course/conference will help with that) and how will they know they have successfully developed this with more emphasis on outcome in their practice rather than certificates of attendance

The check lists should be reviewed as they do not always match the documentation or 'not relevant' is picked when it is relevant without explanation

Identified errors – these include PDP marked as complete, but commentary states it has not been completed, and some declarations at the end of the summary are in contradiction to the evidence provided in the e-portfolio. One (1) Appraisee documented something they have been asked to discuss at their appraisal but there is no reference to this or discussion of it by the Appraiser. Key comments are not always captured in the summary statement e.g., a declared serious incident is not referenced in the summary.

7. Summary of Recommendations

1. Appraisees	Supporting Information
	Scope of practice - greater clarity around hours or sessions worked in each role contained within the scope of practice, recommend Appraisees include their job plan in their supporting information. Include letters of good standing from Appraisees other places of work. **Supporting Information** - Appraisees need to be reminded of the importance of maintaining anonymity for patients and colleagues as described in the GMC document Guidance on supporting information for appraisal and revalidation. **CPD** - portfolios gave the impression of more than enough CPD but recorded it as zero and the Appraiser has not included anything different in their summary which resulted in lower scores for the 30% range described. **QIA** – range of evidence that fits into this category, as included in the AMRC 2022 guidance, to be shared with Appraisees so they are aware of the full range of options. **SE's** - Appraisees having not declared involvement in a serious incident should take the opportunity to learn, and check or change their practice, from other incidents that had occurred in their directorate or via the wider clinical governance frameworks. This is an opportunity to be pro-active in their practice as described in the Patient Safety Strategy 2019 guidance. **Patient and colleague feedback** – encourage the collection and inclusion of informal feedback which is reflected upon for those years of the cycle that do not include MSF. This is a GMC recommendation.

	Complaints - Appraisees not declaring direct involvement in a complaint could have taken the opportunity to review a complaint that had occurred within their speciality/ directorate and briefly describe any changes they have made to their own practice or for the team as a learning outcome. **Reflective activity overall** – Appraisees need to ensure that they complete reflective activity for each of the six (6) elements as set out in the AMRC 2022 guidance.
2. Appraisers	**Overall** • Appraisers receive guidance and training on the importance of the summary statements and the detail required to provide assurance to the RO that all elements of the scope of work have been covered, challenge and support has been the focus of the discussion • CPD – include output commentary on CPD discussed but not included by Appraisee • Appraisers need to ensure that all supporting information is anonymised to ensure patient and colleague confidentiality **Reviewing** • Fuller analysis and reference to lessons learned and changes to practice made as a result need to be documented • Appraisers need to bring clarity to the PDP discussion and document clearly what has been achieved, the identified gaps and aspirations of the Appraisee • Appraisers should encourage Appraisees to consider either other serious incidents/complaint outcomes or review their own speciality practice to see if there are areas of patient or staff safety which could be improved

	Planning ahead • Appraisers need to use the appraisal discussion to further support Appraisees to develop their PDP more fully, with a clear link to professional development needs and outcomes that benefit patients and provide documentary evidence that this has happened • Appraisers support Appraisees with reflective practice during the appraisal discussion and document that this has happened **<u>Incidental findings</u>** • Appraisers need to ensure that comments and questions documented prior to the appraisal discussion are updated prior to sign off of the appraisal • Statements and declarations need to accurately reflect both the input and the appraisal discussion
3. Organisation	**Policies** The recommendations and suggestions for the two key medical appraisal and revalidation policies can be found in detail in Appendix A (i & ii) – Comments and actions. • A review needs to take place to ensure all Appraisers and Appraisees are familiar with and orientated to the L2P system
	General infrastructure • The check lists should be reviewed as they do not always match the documentation or 'not relevant' is picked when it is relevant without explanation • Strive to fully engage in medical appraisal of some senior doctors, close to retirement

	• Include preparation for retirement in the appraisal discussion early to get doctors thinking about less clinical sessions and more education or management responsibility that they can continue if they wish post clinical retirement. Clear and consistent approach to ensure added value • Increase proportional representation across the Appraiser group to include all specialties • Consideration of lay representation for the Doctors in Difficulty group and for Revalidation • Re-establish the Appraiser quarterly meetings and include topics covering GMC Fitness to Practice issues, support in sign posting well-being issues identified through appraisal discussion, shared case studies and experience of difficult appraisals • Additional support provided to Trust Grade/Career Grade doctors who can struggle to populate their portfolios with the correct supporting information. This group also include international doctors who have not got previous experience of medical appraisal and the knowledge base is just not there • Guidelines around the development of a PDP, to ensure that sufficient detail and goals are included to know what outcome is expected and how the doctor can truly evidence the achievement of that goal • Guidance that includes recommendations for specialist clinical audit or QIA would be beneficial and applied to all Appraisees

4. Other Key Recommendations from the document review and interviews	**Appraiser Infrastructure** • Development of Appraiser summary outputs to show a consistent approach to documenting the appraisal discussion, including reflection, challenge and support in line with the Academy of Medical Royal Colleges, Medical Appraisers Guide, June 2022 • Consideration should be given to mapping whether those Appraisers with poor summaries have been provided with sufficient training. There are a few examples that look more like a chat and a reference rather than an appraisal which may indicate that the Appraiser is not up to date with the current process of appraisal and evidence needed for revalidation It is recommended that Appraisers focus on the following: • Referencing specific evidence from SI and discussions in Appraiser summary • Making summaries standalone with basics needed for the RO included • PDP development – training on focusing the Appraisee on why they are looking to do something, what is the learning need (which course/conference will help with that) and how will they know they have successfully developed this with more emphasis on outcome in their practice rather than certificates of attendance • Review of Appraiser training to meet the above recommendation • Develop consistent Appraiser challenge within the appraisal discussion using shared example of high quality outputs

Appendix A (i) – Medical Revalidation & Appraisal Policy Review – North Lincolnshire and Goole NHS Foundation Trust

Core Content of Medical Appraisal Policy
The following content will need to be covered in the Designated Body's appraisal policy:

Required Core Content	Comments & Actions
1. Evidence that the policy has been ratified by the Designated Body's Board or equivalent governance or executive group	Policy approved by the Workforce Transformation Committee.
2. Objectives of medical appraisal This must include • professional development • revalidation • organisational development needs	The policy clearly sets out the aims of appraisal and the link to revalidation. Professional development is referred to regarding the Appraiser's role and their suitability and organisational development is referred to as part of the access to appraisal documentation (access statement). Consider making professional development more explicit, for example: 'medical appraisal can be used to enable doctors to consider their own needs in planning their professional development.' Also, consider making the benefits for the organisation clearer, for example: 'medical appraisal can be used to enable doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practice in.'
3. The appraisal system must cover all doctors with a prescribed connection and there should be a clear process for how starters and leavers are managed	The scope of the policy and who it applies to is clearly set out in the introduction.

Required Core Content	Comments & Actions
	There is a clear process that all new starters from overseas have a mini-appraisal after starting and a full appraisal 9-12 months after they start. A timescale for the mini-appraisal may be helpful to include to ensure consistency. It is not clear who is responsible for ensuring new doctors are connected to the Trust and also what information is transferred between organisations for starters and leavers. There is no reference to the Medical Practice Information Transfer form or process.
4. Accountability, management, and reporting arrangements for the appraisal system are clearly set out.	These are clearly set out under Section 3, 'Duties, Roles and Responsibilities.'
5. There is reference to the Medical Profession (RO) Regulations 2010 and the Medical Profession (RO) (Amendment) 2013	These are referred to throughout the document.
6. There is an explanation of how the appraisal system incorporates the standards in the GMC's Good Medical Practice Framework for Appraisal and Revalidation	This is clearly set out in section 7, 'The Medical Appraisal.' The reference to GMP will need to be updated to the most recent version published in November 2020: Good Medical Practice-English (gmc-uk.org)
7. Responsibilities of the following are explicit: • the Designated Body • the Responsible Officer • the Appraiser (and Appraisal Lead, where this role exists)	The duties, roles and responsibilities are set out clearly in section 3. Consider adding a definition of a Designated Body in the introduction, for example:

Required Core Content	Comments & Actions
• the doctor (Appraisee)	'A Designated Body is generally any organisation which employs or contracts with doctors.'
8. There is a description of the medical appraisal process. This should include timescales, deadlines and to whom the outputs of appraisal are sent on completion. Also, that the appraisal outputs are signed off within 28 days of the appraisal meeting by the Appraisee and the Appraiser	This is covered in the policy and also very clearly set out in Appendix A.
9. There is a written protocol for the handling of information for appraisal and revalidation which complies with information governance, confidentiality and data protection requirements and linked to the information governance policy	There is a very detailed section 'Medical Appraisal documentation access statement' which sets this out clearly. The document, 'Information Management for Medical Revalidation in England (2014)" is referred to and this covers governance considerations. This should be added under Section 11, 'References.' Consider adding the reference to the Data Protection Act (2018) which implements the General Data Protection Regulation (GDPR). Although this is referred to it is not listed in the references in Section 11.
10. There is a clear process for RO information being sought for starters and sent for leavers in line with the requirements of the Medical Practice Information Transfer (MPIT) form	The Medical Practice Information Transfer (MPIT form) should be used to seek information for new starters and used to send information for leavers. Consider using the following example for starters: "When a doctor starts employment with the Trust, the RO will require a structured reference from the doctor's previous RO using the Medical Practice Information Transfer (MPIT) form. This is sought by the Revalidation Officer once the doctor has commenced in post."

Required Core Content	Comments & Actions
11. There is a description of the relationship of medical appraisal to the job planning process (Normally NHS & Foundation Trust only)	Consider adding a paragraph to link the appraisal process with that of job planning. For example: "Appraisal aims to support the job planning process by reviewing any service or organisational goals determined at job planning in the Personal Development Plan (PDP). If the appraisal occurs before job planning the PDP can be reviewed at the job planning meeting."
12. Arrangements are set out, if appropriate, for whole practice appraisal and joint appraisal for clinical academics with honorary contracts to comply with the Follett principles	The Follett principles are not referred to in this policy; if clinical academics are employed then reference to the Follett principles should be added.
13. There is a clear description of the six key areas of Supporting Information that form part of appraisal. This is in line with the GMC document 'Supporting Information for appraisal and revalidation' GMC November 2020	• The GMC document 'Supporting information for Appraisal and Revalidation' is referred to throughout the policy but consider listing the six key elements under section 8.2.8 'Supporting Information for Appraisals.' • The current reference in the policy (2012) will need updating to reflect the latest version released in 2020. Guidance on supporting information for appraisal and revalidation (gmc-uk.org)
14. There is a clear process for obtaining feedback from Appraisees about the medical appraisal system	Although Appraisee feedback is referred to in the policy it is not clear how feedback from Appraisees is sought – is this part of the L2P system or sent separately by the Revalidation Officer?

Required Core Content	Comments & Actions
15. Principles of equality and fairness are described in the policy	• Doctors are required to remain compliant with the Trust's equality and diversity training and reference to the Equality Act 2010. • An equality impact analysis should be developed for this policy.
16. There is a clear process for collecting data for a missed appraisal audit and that this audit forms part of the annual board report	An audit of missed (without agreement) appraisals should be included in the Annual Board Report. The inclusion of this audit in the annual report should be referred to in the policy and the format of the annual report, in line with Annex D, Annual Board Report, A Framework of Quality Assurance for Responsible Officers and Revalidation (updated July 2022).

17. There are clear arrangements for allocation of doctors to Appraisers, including: i. No appraisals are carried out by an Appraiser who is not trained to undertake the role ii. Who allocates Appraisees to Appraisers iii. How appraisals are scheduled iv. No Appraiser for more than three consecutive years in every revalidation cycle v. Whether doctors have a choice of Appraiser and the situations where choice is limited or removed vi. Appeals relating to allocation vii. Conflicts of interest and ensuring objectivity – the description should cover common situations where a conflict may exist between doctor and Appraiser. These are: • an Appraiser and doctor sharing close business or financial interests; • Reciprocal appraisal - where two doctors Appraise each other; • An Appraiser appraising a doctor who acts as their line manager in the same or in a different organisation. • a Responsible Officer or a doctor's direct employer acting as Appraiser viii. financial arrangements - (an Appraiser should not receive direct payment from a doctor for performing the appraisal.	i. This is clearly referred to throughout the policy. ii. Although there is a section on allocation of Appraisees to Appraisers (7.2.5), it is not clear who is responsible for the allocation through L2P. iii. The appraisal year is clear and also how they are scheduled. iv. The same Appraiser for no more than 3 consecutive appraisals is set out clearly. v. The Trust allocates Appraisers to Appraisees (although not clear who, see point ii.) and there is a clear process for Appraisees to request a different Appraiser. vi. The appeal process regarding Appraiser allocation is clear in the policy and also set out at Appendix B. vii. This is covered in detail in Appendix B with a form for appealing against the allocation of a specific Appraiser. viii. This is set out in Appendix B.

Required Core Content	Comments & Actions
18. How specific situations will be dealt with, including: i. illness, secondment, absence, suspension ii. Missed or incomplete appraisals, including engaging disciplinary procedures where this is appropriate and how the Appraisee is communicated with iii. there is a clear process for when significant concern or patient safety issue arises during an appraisal iv. the process for complaints about the Appraiser or the appraisal system	i. Deferment of appraisal is set out clearly in Appendix C with the requirement to complete a postponement application. Suspension / exclusion is not specifically referred to as a reason for postponement. ii. The process for non-engagement in appraisal is set out clearly in Appendix D plus a flow-chart. Management of non-engagement is also set out in the main policy (8.2.6), highlighting the link to pay progression. iii. The section, 'Interrupting an appraisal' sets this out clearly. iv. This is set out clearly in Appendix E. It was not clear where Figure 1 was in the policy regarding putting complaints in writing.
19. There is a description of indemnity arrangements for medical Appraisers	This is clearly set out, plus the potential requirement of additional professional insurance.
20. There is a process in place for the RO to ensure that key items of information (such as significant events, complaints, clinical outcome data) are included in the appraisal portfolio and discussed at the appraisal meeting so that development needs are identified (this may form part of the clinical governance policy)	The process is set out in the Appendix A flow chart, with information being provided to the Appraisee by the Revalidation Assistant.

Required Core Content	Comments & Actions
21. Selection, training and support of medical Appraisers, including; i. description of the selection process for medical Appraisers in line with national guidance ii. required competencies iii. probationary period or early review of skills iv. role description and person specification for medical Appraisers v. description of the training and development of medical Appraisers vi. arrangements for access to leadership, support and ongoing development vii. arrangements for performance review, including feedback on performance in the role viii. description of how Appraisee feedback is given to Appraisers ix. There is reference to NHS England 'Quality Assurance of Medical Appraisers', latest version	i. There is reference to Appraisers being recruited by the RO but not specifically how they are selected / recruited. Reference is made to Quality Assurance of Medical Appraisers: Engagement, training and assurance of medical Appraisers in England, version 5 (NHS Revalidation Support Team, (2014)) which sets out processes for Appraiser recruitment. ii. Appraiser competencies are not specifically referred to; consider adding reference to the competency framework for medical Appraisers: competency-framework-for-medical-Appraisers-appendix-3.pdf (england.nhs.uk) iii. A probationary period is for Appraisers is not set out in the policy, but consideration should be given to this period for new Appraisers. iv. Role descriptions for the Appraisal Clinical Lead and the senior Appraiser role are clear set out at Appendix F but not for the Appraiser role which should be added. v. Training is referred to but consider reference to the 'Training Specification for Medical Appraisers in England,' RST (V2 2012): Training Specification (RST) vi. Leadership, support and development of Appraisers are clearly encompassed in the Appraiser Clinical lead role and the senior Appraiser role and in section 5, 'Leadership of Medical Appraisal.' vii. The methods of assuring the quality of Appraisers are clearly set out in the policy.

Required Core Content	Comments & Actions
	viii. Monitoring the performance of medical Appraisers through Appraisee feedback is set out in the role descriptions for the Appraisal Clinical Lead but it is not clear how often this is given to Appraisers and in what format. ix. Reference is made to 'Quality Assurance of Medical Appraisers.'

Required Core Content	Comments & Actions
22. There is a process for quality assuring a minimum of 20%, or at least two (whichever is the greater number) of each Appraiser's appraisal summaries and PDPs per year using an audit tool. The outcomes should be recorded in the annual report.	Quality Assurance is set out in section 8.2.2 although it is not clear how the appraisals are rated or what percentage are reviewed. Consider adding which quality tool is to be used, for example, PROGRESS, EXCELLENCE. Please see link for more detail: qa-appraisal-guidance-notes-v1.pdf (england.nhs.uk)
23. There is a system for monitoring the fitness to practice of doctors whether or not it is a doctor with whom the Designated Body has a prescribed connection. i. Relevant information (including clinical outcomes, reports of external reviews of service, etc.) is collected to monitor the doctor's fitness to practice and is shared with the doctor for their portfolio ii. Relevant information is shared with other organisations in which a doctor works where necessary iii. There is a system for linking complaints, significant events / clinical incidents / SUIs to individual doctors iv. Where a doctor is subject to conditions being imposed by, or undertakings agreed with the GMC, the RO monitors compliance with those conditions or undertakings v. There is a process whereby the RO identifies any issues arising from clinical data, such as variations in individual performance, and ensures that the DB takes steps to address such issues vi. The quality of the data used to monitor individuals and teams is reviewed	i. The RO accessing information from Clinical Governance systems is referred to, but clinical outcomes are not specifically referred to. Reference to this could be added at section 7.2.2 under appraisal inputs and content. ii. This is covered in the 'sharing information with other persons' section of the documentation access statement. iii. This is clearly set out in Appendix A and the information provided to the doctor by the Revalidation Officer. iv. This is not covered in the policy and should be added to include, for example, when a new doctor starts to ensure that GMC investigations, conditions or restrictions are all clear and any action needed is understood. v. There is no specific process for this in the policy (also see point I., above); consideration should be given to adding this. vi. Governance data (complaints, claims and SUIs) is available to the doctor but it is unclear if this is benchmarked, and individual's standards improved if necessary. However, this information is reviewed by the Appraiser. vii. The GMC Employer Liaison Advisor (ELA) is referred to in relation to non-engagement in appraisal.

Required Core Content	Comments & Actions
vii. Where appropriate, ensuring that advice is taken from the GMC, ELAs, PPA, etc.	Consider adding reference to the Practitioner Performance Advisory (PPA) (previously NCAS) service for discussion if serious issues are raised (cross-referenced to the Concerns Policy). For example: "In a minority of cases, the RO may become aware of concerns or difficulties in relation to a doctor's practice. These concerns may come to light through appraisal or clinical governance processes and may relate to one or more issues around conduct, performance or health. For a small number of individuals who may struggle to meet the requirements of revalidation, it will be important for the RO to have appropriate and effective routes for support in place including discussion with the PPA or the Trust's GMC ELA."
24. It is clear in the policy that the appraisal portfolio must not contain personally identifiable information or data.	This is set out clearly in the 'Appraisal Documentation Access Statement.'

Appendix A (ii) - Responding to Concerns - North Lincolnshire and Goole NHS Foundation Trust

Core Content of Responding to Concerns

A policy for responding to concerns, which complies with the Responsible Officer regulations, has been ratified by the Designated Body's board (or an equivalent governance or executive group).

Required Core Content	Comments
1. There is a responding to concerns policy in place which is ratified by the Designated Body's board (or equivalent)	This has been approved by the Trust Management Board.
2. There are formal procedures in place for colleagues to raise concerns	There are examples of how concerns may come to light, and formal procedures for raising concerns are clear.
3. There is a clear process, if appropriate, to manage concerns informally initially. For example, reference to 'Being Fair' (NHS Resolution (2019)) and 'Just Culture' (NHS Improvement) flow chart	An informal route is decided by the case manager when a concern has been raised in line with MHPS. Reference to 'Being Fair' in the decision-making process should be considered, as should reference to the 'Just Culture' guide. NHS Resolution Being Fair Just Culture Guide
4. There is a process established for initiating and managing investigations of capability, conduct, health and fitness to practice concerns which complies with national guidance (NHS Resolution; Practitioner Performance Advice)	This is clearly set out in Section 4, 'When a Concern Arises.' Reference to NCAS will need to be updated with Practitioner Performance Advice (PPA). NHS Resolution are already referred to.
5. There is reference to case investigators and case managers being appropriately trained and qualified	Reference is made to case investigators and case managers being appropriately trained and qualified. Consider adding reference to the training being provided by NHS Resolution.

Required Core Content	Comments
6. There is an agreed mechanism for assessing the level of concern that takes into account the risk to patients	Patient safety and risk are referred to throughout the document and levels of concern described. There is no clear mechanism to help support professional judgement, and reference to a risk assessment matrix should be considered, such as that in 'A practical guide for Responding to concerns about medical practice' (NHS England, March 2019). A Practical Guide For Responding to Concerns
7. There is a process of ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practice are considered	These are all covered in the policy.
8. There is a mechanism to seek advice from expert resources, including: • GMC Employer Liaison Advisers (ELA), • NHS Resolution (NHSR); • GDC (if applicable): • Practitioner Performance Advice (PPA); • Legal advisers, • HR • Occupational health	The policy includes seeking advice from NHS Resolution, although the PPA is not mentioned. The policy includes referral to the GMC & the GDC, but does not refer to seeking advice from the GMC ELA and should be updated to include this. Neither legal advisors nor HR are referred to in the policy. Although there is a section on health, Occupational Health are not referred to in the policy and consideration should be given to their inclusion.
9. The objective of taking any steps necessary to protect patients is clear	The need to protect patients is made clear throughout the policy.

Required Core Content	Comments
10. Where appropriate, referring a doctor (or dentist) to the GMC (or GDC) is made clear	This is made clear throughout, and the policy refers to both doctors and dentists.
11. There is a clear process when a doctor (or dentist) should be excluded or have conditions or restrictions placed on their practice using best practice, for example, NHS Resolution guidance (April 2022): Exclusions - NHS Resolution	Restricting practice and excluding doctors and dentists is clearly set out in Section 7 'Restriction of Practice and Exclusion from Work.' Consider reference to NHS Resolution 'exclusions' decisions flowchart: Managing exclusions NHS Resolution https://resolution.nhs.uk/wp-content/uploads/2022/04/Exclusions-flowchart-to-ensure-compliance-with-good-practice-final.pdf
12. There is a process to ensuring that a doctor (or dentist) who is subject to exclusion or restrictions on their practice is kept informed about progress and that the doctor's comments are taken into account where appropriate	This is clearly set out and also includes the role of the Non-Executive Director in the exclusion.
13. There is a clear process for sharing relevant information relating to a doctor's fitness to practice with other parties, in particular the new RO should the doctor change their prescribed connection	Sharing information with a new RO is set out clearly in the policy.
14. There is a clear process for appropriate records to be maintained by the RO of all fitness to practice information	Maintaining documentation is not specifically referred to. 'A practical guide for responding to concerns about medical practice' contains some useful information about documentation.

Required Core Content	Comments
	A Practical Guide For Responding to Concerns
15. There are clear measures described to address concerns, including but not limited to: a) requiring the doctor to undergo training or retraining b) offering rehabilitation services c) addressing any systemic issues within the Designated Body which may contribute to the concerns identified	a) Training and retraining are covered with input from NHS Resolution if necessary. b) Rehabilitation is referred to under the 'health' section but not in detail – this may be covered in the Trust's sickness absence policy. c) Systemic issues are referred to in the policy when reviewing a concern. Reference could be made here to the 'Just Culture' guide and 'Being Fair' which help organisations consider and explore system failures. NHS Resolution Being Fair Just Culture Guide
16. There is a clear process to ensure that any necessary further monitoring of the doctor's conduct, performance or fitness to practice is carried out	Monitoring of doctors / dentists on return from exclusion or restriction is referred to in the policy. The 'improvement note' (Appendix B) makes reference to further monitoring. There is reference to NHS Resolution assisting the Trust in drawing up action plans in capability cases. Consider making a link back to the appraisal process to support, monitor and develop the practitioner post-investigation and also appointing a mentor if considered necessary.

Appendix B (i)

Summary notes of the interview conducted with Dr Kate Wood, Chief Medical Officer and Responsible Officer by Pam Strange of Miad Healthcare on Friday 18th November 2022 via Teams.

Dr Wood is a Consultant Anaesthetist working in North Lincolnshire and Goole NHS Trust since 2006 and before that she was a trainee with the Trust. She was appointed Acting Medical Director in October 2017 and her post became substantive in April 2019 (she also became the Responsible Officer (RO) during the period of acting medical director). She underwent the NHS England Responsible Officer (RO) training delivered by Miad Healthcare and attends the RO network meetings to keep up to date, these have been patchy since the pandemic but are getting back up to speed.

Dr Wood considers that she is supported by the Trust Board in her RO role and has access to sufficient resources to ensure that the DB is managed effectively. She also has a dedicated Lead Appraiser, who is very experienced, and a good medical appraisal administrative infrastructure managed by the Appraisal and Revalidation Co-Ordinator and overseen by the Associate Director – Strategic Medical Workforce.

Dr Wood is focussed on recruiting Appraisers to the DB who are enthusiastic and wanting to take on the role, she therefore considers that the current recruitment process is a good one. doctors who are interested in becoming Appraisers attend the annual training update which also helps them understand their responsibilities. They then discuss their intention to apply to be an Appraiser with their Clinical Director, to be sure they have the right skill set and, if supported by the CD, they apply to the Lead Appraiser. This way new Appraisers are clear on their remit before taking on the role. There are sufficient applicants, the DB is four Appraisers short currently, but the annual training is due to be held. Dr Wood is keen to develop the interests of all the doctors across the Trust, she appreciates that everyone has their own skill set and they need to be supported to find the right fit for them and by having the training first helps with that process and also benefits their own appraisal experience.

The DB policies are developed by the Lead Appraiser and the Appraisal and Revalidation Co-Ordinator in the first instance. Appraisers are made aware of changes and updates via the training day and the newsletter.

Dr Wood considers that the GMC recommendations to the re-balanced approach to medical appraisal is progress and the DB has agreed to embrace the June 2022 Medical Appraisal Guidance issued by the Academy of Medical Royal Colleges in full. During the pandemic she had discussions early with the medical workforce, explaining the reduced scrutiny applied to appraisal and the stance that was taken was that if Appraisees wanted to continue with their appraisal then that was possible. In the early stages of the pandemic there was not a massive impact on the Trust from covid cases that came later. Therefore, the Trust did not stop elective activity as long as all safety factors were in place and the Trust has emerged on the other side of the pandemic as one of the best in the country for waiting list activity. At the time the Trust was in special measures with a low CQC rating, but with support the pandemic provided the Trust with an opportunity to transform some of the services, recognise different skill sets in staff and build relationships. From the perspective of re-balanced appraisal, this was well accepted by doctors in the Trust, the feedback was positive. Medical appraisal should focus more on reflection and learning.

Dr Wood states that the Appraiser outputs are variable, some provide full documentation, covering all aspects and reflecting the thoughts and ideas of the discussion, others a few lines and this is of worry to her. Where there is limited output, individuals receive feedback, there must be standardisation. Dr Wood wanted this QA carried out so that there was an external view of what needs to be achieved as well as the perception of individuals. Then a plan can be developed to improve. She knows there is work to do. Whilst feedback is provided to Appraisers on individual outputs via the Appraisal and Revalidation Co-Ordinator it is not always followed through by the Appraiser and it is Dr Wood's plan to ensure that either the Lead Appraiser or herself, depending on the circumstances, feedback to individuals. Dr Wood is attending the Appraisal Training Day to talk about her role, provide clarity on what is required by an RO in an Appraiser output to provide revalidation recommendation and to establish what training and support is needed. The key element is the shift for the Appraiser to provide more detailed documentation on reflection and the whole appraisal discussion. This has not been in place before and Appraiser's need support and training to achieve this fully along with support to discuss and sign post aspects of well-being. Dr Wood is very aware that there is a potential for issues to arise if insight into the new process is not greatly improved and standardisation not achieved.

In relation to concerns raised about individual doctors, Dr Wood established the Doctors in Difficulty group which she chairs and includes the Associate Director – Strategic Medical Workforce and HR representation. They work from an excel spreadsheet which contains all the detail of doctors who are undergoing GMC/MHPS investigation, doctors who have long or regular short term sickness

problems, recruitment issues usually international doctors settling into the new working, and personal life and 'noise in the system' i.e. where there is the potential for problem that has not been made substantive, or where a doctor is being highlighted in more complaints/ SI's than could be anticipated. This ensures that all doctors on the radar are monitored, timescales are met, and appropriate support or rehabilitation is given to individuals. This links to appraisal.

The Appraisal and Revalidation Co-Ordinator runs checks on all SI's and complaints in which doctors are involved, so that if the doctor has not included them in their portfolio the Appraiser can bring it to the discussion and reflect on the outcome. Dr Wood does not want Appraiser's to get into the discussion of why the Appraisee forgot to include a complaint or SI, rather focus on taking responsibility, the learning and change made to practice.

Dr Wood wants to engender in the Appraisers a professional, multi-disciplinary approach to appraisal where individuals take responsibility for their action, both for themselves and the doctors that are connected to the DB. The right tools are needed to effect this type of change and the quarterly meetings need to be focused on learning and development to improve the summary output and the development of the PDP in particular.

Dr Wood raised the point that there was no lay representation either on the Doctors in Difficulty group or for Revalidation and she considered the appointment of a Lay Representative would be highly beneficial, contributing to the process and providing assurance to the Trust Board.

Dr Wood knows that improvements have been implemented that has removed the DB from the NHSE and GMC spotlight but there is still work to be done to achieve the overall high and consistent approach to medical appraisal that she, the DB, the Trust and the public require.

Appendix B(ii)

Summary notes of the interview conducted with Rachael Norfolk by Pam Strange, Miad Healthcare on Friday 16th September 2022 via Zoom

Rachael is the Appraisal and Revalidation Co-Ordinator for the Trust, having joined in 2014 she is part of the original team. She works full time on Appraisal and Revalidation supporting the RO, Lead Appraiser and senior Appraisers. There are 440 Appraisees and 48 Appraisers. Rachael is line managed and Appraised by the Associate Director – Strategic Medical Workforce, who is rarely directly involved in the day to day management, but there is a member of her team who has access to the L2P system and GMC Connect and provides cover for annual leave and sickness or maternity leave. Whilst it is quite a large remit, Rachael has never felt overwhelmed, and she prefers to have overall control of the process. When she joined the RO's office, Appraisal for Revalidation was in its early inception, there was no training for managers, she therefore followed the guidance to set up the system, commissioned and implemented the L2P Appraisal Management system and was achieving all the targets required by NHSE by 2015. She has monthly meetings with the RO and open access to her if needed. Rachael feels well supported in her role.

Rachael oversees the development and amendment of the policies which are based on the NHSE framework. When updates are completed, the policy goes to the Consultant Negotiation Body for their consideration before being approved by the Transformation Workforce Committee. Policies are accessed via the Trust intranet and the L2P system.

Rachael has set up a process for each Appraisee connecting to the DB. Whether they are transferring from another DB or completely new to the process they all have a 1:1 with Rachael initially. She goes through the process with them and establishes their previous experience, gets the detail from their previous organisation and GMC Connect. She then sets them up on the L2P system and if the Appraisee is not familiar with the system, she provides support and training. If the doctor is new to working in the UK, there is a delay of about 8 months prior to starting their appraisal process so that they can get settled and up to speed with the process and GMC requirements.

Rachael uses the MPIT form to gain information from previous Trust or other organisations the doctor works with, she has never not had a response as she just keeps chasing until she achieves her goal, and she has a good response from locum agencies. She has easy access to clinical governance information, incidents and complaints. Appraisees understand that this information is required and are reasonably good at getting letters of good standing from their other areas of practice. An audit was conducted 18 months ago

around doctor's scope of practice, to check whether they were including all areas of work and only a couple of doctors had not included some areas of work which was oversight rather than deliberate. The communication between the independent sector hospitals and the Trust is very good and there will be RO to RO discussion if concerns arise. There is also excellent communication between the managers. Once the Appraisee has been set up on the system and processed then Rachael hands them over to the Appraisers, who are very supportive. She will update Appraisers via e-mail or the WhatsApp group.

The Appraisers are recruited internally and informally, doctors expressing an interest in becoming an Appraiser are asked to attend the annual Appraiser workshop that is run internally and off site. The day is run in 2 halves, the morning sessions include appraisal and revalidation guidance and updates, appraisal discussion and summary outputs; the afternoon looks at probity, serious incident discussion and key topics and is attended by both new and established Appraisers which enables discussion. If it something potential new Appraisers still want to do, and their Clinical Leads approve then they will become an Appraiser and are supported by the Lead or a Senior Appraiser. There is a budget for 50 Appraisers and there are currently 6 vacancies. The Newsletter is used to advertise the workshop and the fact that the DB is actively looking for Appraisers. Rachael is responsible for the documentation relating to new Appraisers, they have a job description, it is included in their job plan, and she checks with the Clinical Lead that all is agreed, having their involvement is very helpful. There is a governance form that is completed to assess suitability.

Rachael allocates the Appraisee to the Appraiser for a 3 year cycle. The L2P system automatically allocates the Appraisee to the same Appraiser after 3 cycles and this needs changing by the software manufacturer. Rachael reads the output summary following completion of the appraisal, she considers that the quality could be improved, whilst most Appraisers provide detailed outputs a small group provide limited output, it can be quite variable. She has not pushed any back to the Appraisers, but the Excellence Audit has identified areas for improvement in the past and there needs to be a focus on improving outputs for Appraisee and RO clarity. Any concerns are escalated to the RO.

Appraisers communicate via the Newsletter; the WhatsApp Group and Rachael is trying to re-establish the quarterly network meetings following the pandemic where they did not happen.

Appraisers receive anonymised feedback which is generally positive and shows the value Appraisees place on their appraisal discussion and support.

In relation to the Revalidation process, there is a two weekly meeting between the RO and Rachael, and they review every doctor who is under notice for revalidation well ahead of the revalidation date. Rachael prepares for the meetings by reviewing the annual appraisal outputs for the 5 year cycle using a revalidation checklist to ensure that all aspects of the doctor's scope of work has been

covered including the MSF. The RO and Rachael the review together and the RO will add her notes to the process. The RO will then make a decision as to whether to recommend revalidation or whether a deferral is required whilst further information is gathered. Either way the doctor will be informed of the outcome and if there are concerns around a deferral the GMC ELA will be involved. Rachael prepares the initial draft of the AOA and the Annual Report, which she then shares with the RO, and they review it together checking the accuracy of the detail, the RO then adds her commentary to the Annual Report and presents it to the Trust Board. Overall, the process is mature and tightly managed.

Appendix B (iii)

Summary notes of the interview conducted with Jane Heaton, Associate Director – Strategic Medical Workforce by Pam Strange, Miad Healthcare on Tuesday 27th September 2022 via Zoom

Jane is the Associate Director – Strategic Medical Workforce, she line manages the Appraisal and Revalidation Co-Ordinator and completes her appraisal. Jane is strategically involved in Medical Appraisal and has regular 1:1 meetings with the Appraisal and Revalidation Manager to discuss any issues that require support. The Clinical Lead for Medical Appraisal and the Medical Director (RO) are also available to the Manager for advice and guidance.

There is a member of the wider Chief Medical Officer's Directorate Team who has a good understanding of Medical Appraisal, who steps into the Medical Appraisal and Revalidation Co-Ordinator's role as required, for maternity and annual leave and Jane can support if needed. The Manager is a full time dedicated role and has strategic support as required and therefore does not require additional support to manage the process. Jane considers the Appraisal and Revalidation Co-Ordinator is extremely competent, has a wide range of knowledge and manages the process efficiently and effectively.

Jane oversees the policy process for Medical Appraisal, the Appraisal and Revalidation Co-Ordinator reviews and amends the policies as required, and then sends to Jane for oversight prior to the policy being reviewed by the Trust's internal governance process, which includes review by the Joint LNC and ratification by the Trust Management Board. The Medical Appraisal policy is due for review in February and the process has already commenced to ensure it is ratified in good time.

Appendix C (i)

Summary notes of the interview conducted with Dr Ajay Chawla, ED Consultant and Lead Appraiser by Pam Strange, Miad Healthcare on Monday 3rd October 2022 via zoom.

Dr Chawla is a Consultant and Clinical Lead for Emergency Medicine and has been the Lead Appraiser for the Trust since 2012. He completed his Appraiser training with the Region in Manchester He was interviewed for the post of Lead Appraiser; he has a job description for the role which is included in his job plan. He was very involved in setting up the original governance framework for medical appraisal within the DB.

He has ensured that all Appraisers have been allocated one PA per week (4 hours) to complete appraisals. There are sufficient Appraisers within the DB to complete the appraisals required. The Appraisers are initially self-selecting rather than being actively recruited. If they express an interest in becoming an Appraiser, they attend the annual Appraisal Training held by the DB where they gain further insight and training. This also provides the opportunity for them to discuss the role with other established Appraisers. If they are still interested, they discuss taking on the role with their Clinical Lead to ensure they are making the right decision. The Clinical Lead will then support the application and Dr Chawla will make the final decision. If accepted as an Appraiser, the role is added to their job plan.

Recruitment to the Appraiser role used to be difficult, but having adopted this process it is now good, there are between 40 -50 applications of interest for the annual course, for which they have to apply for study leave and it is held externally to the Trust. The doctors therefore need to be reasonably committed to supporting the appraisal process and it means that the DB gains an enthusiastic, self-selected body of Appraisers.

Dr Chawla maintains his knowledge in medical appraisal by attending network meetings, updates from the GMC and NHSE and he in turn passes the information to the Appraisers.

Dr Chawla works closely with the RO and has confidence in the appraisal system that works well. He meets with the Appraisal and Revalidation Co-Ordinator weekly, either remotely or face to face. They continuously monitor the position of medical appraisals.

When a doctor is due to revalidate, they review the cycle of appraisals and use a proforma to check the content and ensure that everything has been achieved, this includes input from the clinical governance system to independently ensure that the Appraisee has included all complaints, serious incidents and mandatory training requirements prior to forwarding to the RO to consider making recommendation to the GMC for revalidation. He and the Appraisal and Revalidation Co-Ordinator have regular meetings with the RO.

Dr Chawla feels well supported in his Lead Appraiser role, as a team they have worked together for a long time and have developed a strong communication system.

As Lead Appraiser, Dr Chawla has an 'open door' policy, Appraisers can always contact him for advice on a potentially difficult Appraisee, not supplying enough supporting information or there is slippage, or to discuss how certain situations can be handled. He is committed to supporting Appraisers early to avoid them becoming overly concerned. There are also five other senior Appraisers across the Trust that are available to support. The quarterly lunchtime Appraiser Update meetings are being re-instated following the pandemic and this is another source of support and network. Appraisers are informed of any policy changes, national and local changes through the newsletter and now the update sessions again.

Dr Chawla and the Appraisal and Revalidation Co-Ordinator take joint responsibility in ensuring that policies are kept up to date.

Dr Chawla knows that the GMC's recommended re-balanced approach to medical appraisal has been well accepted in the Trust, doctors like it, as it is more focussed on quality rather than quantity. Appraisers are having to write more in their summary outputs, and this will take a little time to develop greater challenge during the appraisal discussion, rather than taking things on face value, as there may be less supporting information. The challenge for the DB is to achieve consistency across all appraisal outputs. He knows that some Appraisers do not challenge enough, and it is his intention to develop these skills through sharing examples of high quality outputs that show rigorous challenge and support has occurred within the appraisal discussion.

Appraisers are guided to escalate any issues around difficult or unusual appraisals or concerns about a doctor's practice or well-being for initial discussion to either himself or one of the other senior Appraisers. Consideration is then given to the specific situation

and if the difficulty is around engagement, or difficulty in arranging an appraisal meeting in the required time frame then a solution will be found if possible, prior to escalation to the RO. If the concern is about practice, then the case will be clearly presented for escalation to the RO. It is for the RO to decide if further action or investigation is required.

Appraisers receive feedback from those whom they Appraise which is on the whole good, with some constructive comments.

There is still a challenge in getting some senior doctors, close to retirement, to engage in the appraisal process. Dr Chawla considers it very important to include preparation for retirement in the appraisal discussion early to get doctors thinking about less clinical sessions and more education or management responsibility that they can continue if they wish post clinical retirement. He is planning to discuss with the Appraiser group how this can be developed and implemented. There needs to be a clear and consistent approach that is seen to add value.

The changes going forward that Dr Chawla would like to see is greater proportional representation across the Appraiser group. Not all specialties have Appraiser representation, and it would be helpful to achieve this across the two sites. Appraisers work across specialties but with some smaller more specific clinical specialities, there is not always the knowledge of the doctor's skill development requirements. Whilst working across specialties reduces bias there is a need for speciality specific knowledge.

Appendix C (ii)

Summary notes of the interview conducted with Dr Khan, Consultant in Emergency Medicine by Pam Strange, Miad Healthcare on Monday 12th September 2022 via the telephone.

Dr Khan is a Consultant in Emergency Medicine, he joined the NHS as an international doctor ten years ago and has been an Appraiser for one year. He underwent a one day training workshop, run by the Appraisal Lead and the Appraisal and Revalidation Co-Ordinator. It covers a range of topics including handling difficult appraisals, portfolio content and group exercises. A great deal of information is provided. Dr Khan also draws on his own appraisal experience having had four different Appraisers. He includes his Appraiser role in his own scope of practice for development purposes and because he learns a great deal from his involvement which he uses as reflective learning.

The Appraiser recruitment process within the Trust is that annually there is an advertised one day Appraiser workshop. This is attended by anyone at Consultant or SAS level who is interested in becoming an Appraiser along with Appraisers already appraising. If doctors are still interested in becoming an Appraiser, then they express their interest to the Appraisal Lead and are asked to discuss this with their Clinical Director to ensure that he/she considers them appropriate for the appraisal role and that their time can be released from the service. There is a job description of duties issued. Appraisers have 0.25 of a PA in their job plan (1 hr per week). New Appraisees or overseas doctors take longer to be introduced and coached through the system and sometimes that takes longer than the allocated time. Dr Khan considers that the Trust places a great deal of importance on Medical Appraisal.

Appraisees are allocated by the Appraisal and Revalidation Co-Ordinator, who e-mails the Appraiser and if it is a new Appraisee there is a check for a conflict of interest. If this is the case, then the Appraisee is re- allocated. The Appraisee will then contact the Appraiser and the meeting is agreed along with the time scale to access the portfolio. If the Appraisee does not make contact the Appraisal and Revalidation Manager will chase them up. Dr Khan conducts appraisal meetings either face to face (if on the same site) or remotely if needed. He completes one (1) appraisal a month. Appraisees come from a range of specialities.

Other than the core areas, Dr Khan particularly looks for letters of good standing or MPIT input of the Appraisee work in other organisations, reflection on the previous PDP and development of the next PDP. He considers that reflective activity is often missing or

poor and this he discusses with the Appraisee and supports them to look at the wider aspect and think what can change both in clinical practice, team and the organisational context.

Dr Khan considers that the re-balanced approach to appraisal is better and is especially helpful to be able to cover the well-being aspect, particularly in the case of overseas doctors who may be struggling or have not been able to get back to see their families due to Covid-19.

Dr Khan is aware of the policies relating to Medical Appraisal and is very familiar with the L2P system as he uses it for his own appraisal as well as his Appraisees. He feels well supported in the process and will access the Lead Appraiser for support and guidance as needed. There is always a swift response either from the Lead Appraiser or the Appraisal and Revalidation Manager. So far has not had to escalate any concerns to the Lead Appraiser or RO but is confident in the process if needed. He gets Appraisee feedback on a six monthly basis and feedback from the RO.

There is a newsletter for Appraisers and Dr Khan would like to see more workshops including the GMC covering Fitness to Practice issues and more support in sign posting well-being issues identified through appraisal discussion.

Appendix C (iii)

Summary notes of the interview conducted with Dr Namita Singh, Consultant Anaesthetist by Pam Strange, Miad Healthcare on Thursday 3rd November 2022 via the telephone.

Dr Singh is a Consultant Anaesthetist and has been with the Trust for nineteen years. She was an Appraiser pre 2012 where the appraisals were not as detailed as they are currently. Dr Singh attended an Appraiser training course when medical appraisal for revalidation started and has gathered and shared appraisal information since, she also attends the Trust's annual appraisal training. She receives appraisal updates via the Appraisal and Revalidation newsletter and runs lunchtime sessions for new Appraisees within her department. There used to be quarterly update sessions for Appraisers, but these had to be restricted during the pandemic. The RO and the Appraisal and Revalidation Co-Ordinator send ad hoc information as needed.

Appraisal work is included in Dr Singh's job plan and is included in her own appraisal scope of practice and CPD.

Appraisees are allocated to Dr Singh by the Appraisal and Revalidation Co-Ordinator for a three year cycle. All the information is uploaded on the L2P system and is available well in advance of the appraisal meeting date. For the first appraisal with a new Appraisee approaches Dr Singh via the system or an e-mail, most of them approach two months before the appraisal date. They discuss the process, set a meeting date and Dr Singh asks for the portfolio to be available to her two weeks before the meeting to give her enough time to review the supporting information and decide whether there are any gaps, if this is the case she will either ask the Appraisee to bring additional information to the meeting or, on occasion, defers the appraisal meeting until further information has been uploaded to the portfolio.
On completion of the appraisal discussion Dr Singh will write up her outputs and get the documentation completed and signed off within two weeks. There are good systems in place to support the process and it generally works very well.

Dr Singh considers the re-balanced approach to medical appraisal is a positive one, it is more focussed on the doctor's development needs and their professional and personal well-being. She is pleased that the DB has nominated to continue with this approach. The new guidance was circulated to all Appraisers.

If Dr Singh needs to discuss or has concerns about an Appraisee, she will bring it to the attention of the Lead Appraiser and the Appraisal and Revalidation Co-Ordinator in the first instance and they will decide together what further action is required, depending on the circumstances. If there is a requirement for extra support or there needs to be a delay then the Appraisal and Revalidation Manger will guide the Appraisee, if it is more of a clinical or personal concern the Lead Appraiser will recommend a course of action or escalation to the RO by Dr Singh with the involvement of the Appraisee.

Dr Singh receives anonymised feedback from the Appraisees she works with via the Revalidation office.

Dr Singh feels well supported as an Appraiser, there is sufficient time allocated to carry out appraisal in her job plan. She has around eight Appraisees annually, across specialities, and does have some challenging Appraisees in her current cohort. She expects to take up to 8 hours from start to finish for a new Appraisee, especially if it is the first appraisal for an international doctor and they require additional support. After that it tends to be three to four hours.

Dr Singh would like to see the lunchtime Appraiser update sessions re-instated, she found these very useful, and it is helpful to network with other Appraisers.

Appendix C (iv)

Summary notes of the interview conducted with Dr Banerjee, Consultant in Medicine and Stroke care by Pam Strange, Miad Healthcare on Thursday 3rd November 2022 via the telephone.

Dr Banerjee is a Consultant in Medicine and Stroke services and has been an Appraiser for ten years. He underwent training for appraisal when medical revalidation commenced and until recently has attended the yearly update for Appraisers run by the Trust. He keeps up to date via the newsletter, via information from the RO's office and by talking with colleagues. He Appraises across specialties. He has a job description for his Appraiser role, and it is in his job plan. Dr Banerjee includes his Appraiser role in his own scope of work for his appraisal and includes the feedback as supporting information and for reflection.

Once an Appraisee is allocated to Dr Banerjee, he waits for them to make contact as he knows they are then ready for the appraisal discussion. He always tries to give an appointment within two weeks unless requested otherwise by the Appraisee. He asks that he has access to the portfolio at least one week prior to the appraisal meeting and spends time going through the supporting information. If he identifies gaps, he will contact the Appraisee and ask them to bring the additional information to the meeting for review. Dr Banerjee prefers face to face meetings wherever possible as this generally leads to a better discussion and the Appraisee can share additional information. They are also able to see what he is writing at the time. He prefers to get the appraisal written up and signed off on the same day. Dr Banerjee does nine or ten appraisals a year and on average spends about three hours on each of them in total.

Dr Banerjee considers that the abridged version of the appraisal process adopted during the pandemic was appropriate but now needs to become more detailed again and he is very clear with an Appraisee when he requires greater detail in supporting information.

He has not had to escalate any concerns about a doctor to the RO but would do so if needed. He would first speak with the Appraisee to ensure they understood what was going to happen and initially speak with the Appraisal Lead and the Appraisee's line manager then escalate to the RO for action.

Dr Banerjee feels supported in his Appraiser role, the Lead Appraiser and Rachael are very approachable and the L2P system ensures that the process is clear and focussed, with Appraisee details across the year. The appraisal content is clear and accessible and easy to use. He feels that the process is just about right.

Dr Banerjee would value an Appraiser group meeting to catch up, share cases and information, which could be held remotely and held six months after the annual Appraiser training day.

Appendix C (v)

Summary notes of the interview conducted with Dr Hebbar Consultant in Paediatrics, by Pam Strange, Miad Healthcare on Monday 10th October 2022 via Zoom

Dr Hebbar is a Consultant Paediatrician and Appraiser with the Trust. She completed the training day and discussed her role as an Appraiser with her Clinical Director who supported her in taking on the Appraiser role. She has a job description and has allocated time included in her job plan. She includes her Appraiser role in her own scope of practice and includes the feedback she receives in the supporting information. Dr Hebbar stays up to date by receiving information via the Lead Appraiser, the RO and Appraisal newsletter. She is aware of the policies and guidance related to medical appraisal.

Appraisees are allocated to her initially by the Appraisal and Revalidation Co-Ordinator for a three year cycle. She has a minimum of six allocated to her over the year. Appraisees approach her after the initial contact and arrangements are made for the appraisal meeting with the Appraisee's portfolio being made available to her at least two weeks before the meeting. If an Appraisee is slow in coming forward Dr Hebbar will send them a reminder e-mail.

Dr Hebbar considers the changes that have been recommended for medical appraisal being more focussed and including the aspects of a doctor's well-being are far better and she has embraced the 2020 guidance. She does recognise that whilst the well-being aspect is very important it can also be very personal, and care has to be taken as to how that is documented and how the doctor can be sign-posted for support. Some of the Appraisee's do not supply sufficient supporting information and Dr Hebbar will ask for more information before the appraisal meeting can go ahead. It is the same with reflection and she will always discuss the need for good reflection with the Appraisee and ask them to reflect with her elements of the supporting information, CPD, SI or complaints.

Whilst Dr Hebbar has not needed to escalate a concern, but if needed she would discuss the issue with the Lead Appraiser in the first instance and then escalate to the RO if needed. She has experienced some delays in an Appraisee engaging, not complying with the timescales or expecting her to make contact. If an initial reminder e-mail does not get the desired response the Appraisal and Revalidation Co-Ordinator will intervene or the Lead Appraiser if necessary. This does not happen very often.

Dr Hebbar feels well supported by the Appraisal Team and gets a prompt response to any queries she may have from the Appraisal and Revalidation Co-Ordinator. The system is good and works well.

From her experience, Dr Hebbar would like to see additional support provided to Trust Grade/Career Grade doctors who can struggle to populate their portfolios with the correct supporting information. They often miss out on QIA and their information can be thin. This group also include international doctors who have not got previous experience of medical appraisal and the knowledge base is just not there. There is a Trust training programme to support them, but they still come with low expectation of what is expected of them by the Trust and the GMC. In some cases, Dr Hebbar has needed to coach the Appraisee as to what they need to include and how much detail they need to supply. This makes the process longer and more challenging.

In addition, Dr Hebbar would like to include in the Appraiser network meetings the sharing of case studies so that Appraisers can learn from each other and discuss and reflect on difficult appraisals

Appendix C (vi)

Summary notes of the interview conducted with Dr Pai, Consultant Radiologist, by Pam Strange, Miad Healthcare on Monday 3rd October 2022 via Teams

Dr Pai is a Consultant Radiologist and has been an Appraiser with the Trust for around nine years. He originally underwent a two day training course when he expressed his intention to become an Appraiser. The role is included in his job plan, and he Appraises nine Appraisees a year. He keeps up to date via the Trust RO office newsletter and the Lead Appraiser and is aware of the policies relating to medial appraisal and revalidation. Dr Pai attends an Appraiser Refresher course every two years. He includes his Appraiser role in his own scope of practice.

Appraisees are allocated to him via the L2P system, and they make contact with him in order to discuss the timings of appraisal meetings. Dr Pai Appraises across specialties. He requests access to the portfolio two weeks prior to the meeting so that he can read through it and make notes in preparation. If the Appraisee is from another speciality, he will read their specialist college guidelines to ensure he is completely up to speed. He will also check out the complaint, serious incident data and whether the Appraisee is up to date with their mandatory training. If he considers that there is not enough supporting information presented, he will send the Appraisee an e-mail stating what needs to be done to continue with the appraisal meeting. The information required can sometimes be quite basic, the Appraisee may not have elaborated on their CPD or QIA for example. It is quicker to be clear on what is expected then no time is wasted. He will explore reflective activity in the appraisal discussion, particularly on which experiences did not go well especially around complaints and serious incidents and what the Appraisee has learnt. He also focusses on what has gone well for the Appraisee and will review feedback (MSF and informal) carefully. Dr Pai finds the standard of PDP development variable; it often requires more focus and does not always include speciality development work which is also of benefit to the doctor's development. Dr Pai reflects all of these findings in his output summary.

Dr Pai supports the GMC recommendations on the re-balanced approach to appraisal and does not wish to return to the pre-Covid appraisal system.

Dr Pai feels supported and informed in his Appraiser role and he considers he has sufficient time allocated to him to perform the role well. The system works well, and the Appraisal and Revalidation Co-Ordinator is very helpful and flexible in her approach. To date he has not found it necessary to escalate a doctor in difficulty. He will discuss any concerns he may have with the Lead Appraiser and the RO. The challenges are usually around getting Trust Grade doctors to engage fully especially if they are international doctors who have not experienced appraisal before. It is also a challenge when Trust Grade doctors have sat exams and have not been successful, it can be really hard to keep them motivated and moving forward.

Dr Pai receives feedback collated over the year and he values any suggestions for improvement and general comments. These are included in his own supporting information for reflection and learning.

Dr Pai is looking forward to the Appraiser Group re-convening in October after it stopped during the pandemic. He finds it a very useful forum for keeping up to date, discussing challenging cases and sharing experience.

Dr Pai feels it would be helpful to have some guidelines around the development of a PDP, to ensure that sufficient detail and goals are included to know what outcome is expected and how the doctor can truly evidence the achievement of that goal. Sometimes he feels Appraisees opt for easy elements and Trust - wide guidance that includes recommendations for specialist clinical audit or QIA would be beneficial and applied to all Appraisees.

APPENDIX D Criteria for appraisal portfolio INPUT review (Miad Healthcare)	
1.	Scope of work: Has full practice been described
2.	Sufficient supporting evidence from all roles/ places of work
3.	CPD - Is it compliant with GMC requirements
4.	Is there evidence of reflection by Appraisee
5.	Is QA activity compliant with GMC requirements
6.	Evidence of reflection on QA by Appraisee
7.	Review of SI has been included
8.	Evidence of reflection/learning on Supporting information
9.	Patient feedback exercise has been completed
10.	Evidence of reflection on patient feedback is included
11.	Colleague feedback exercise has been completed
12.	Evidence of reflection on colleague feedback is included
13.	Review of complaints is included
14.	Evidence of reflection on complaints
15.	Review of compliments is included
16.	Evidence of reflection on compliments
17.	The Dr's achievement of the GMC attributes is discussed in the pre-appraisal section by the Appraisee

APPENDIX E – Excellence QA Tool – NHS England

EXCELLENCE QA Tool: Improving and quality assuring appraisal output documentation Appraiser: Quality Assured by: Date:							**Score** 0=No (absent from summary) 1=Partially (room for improvement) 2=Yes (well done)
Do the summary of appraisal, sign off statements and the Personal Development Plan (PDP):		**Score**	**Comments**	**Score**	**Comments**	**Score**	**Comments**
		Appraisal 1 RO name:		**Appraisal 2** RO name:		**Appraisal 3** RO name:	
Overall	***E**ncompass all?* DOES THE SUMMARY COMMENT ON CONTEXT, INCLUDING STAGE OF REVALIDATION CYCLE, AND REFLECTION ON THE WHOLE OF THE SCOPE OF WORK?						
	***EX**clude bias and prejudice?* ARE ALL STATEMENTS OBJECTIVE, FREE FROM BIAS AND PREJUDICE AND BASED ON EVIDENCE? IS IT A TYPED, PROFESSIONAL DOCUMENT?						
	***C**hallenge, support and encourage?* DOES THE SUMMARY DEMONSTRATE THAT THE APPRAISAL WAS CHALLENGING, SUPPORTIVE AND FOCUSSED ON THE NEEDS OF THE DOCTOR?						

	***E**xplain why any statements (including health and probity) have not been agreed?* DOES APPROPRIATE COMMENTARY EXPLAIN ANY 'NO' OR 'DISAGREE' ANSWERS?	(Score 2 if N/A)					
Reviewing	***L**ook at supporting information, lessons learned and changes made?* DOES THE SUMMARY DRIVE QUALITY IMPROVEMENTS BY REFLECTING WHAT HAS BEEN LEARNED AND WHAT NEEDS TO BE CHANGED AS A RESULT?						
	***L**ook at last year's PDP and reflect on each objective?* IF ANY OBJECTIVES HAVE NOT BEEN ACHIEVED, HAVE THE REASONS BEEN DISCUSSED AND DOCUMENTED?						
	***E**ncourage excellence, celebrate accomplishments and record aspirations?* DOES THE SUMMARY CAPTURE EXAMPLES OF GOOD PRACTICE AND RECORD ASPIRATIONS (SOME OF WHICH MAY HAVE A TIMESCALE OVER ONE YEAR)?						
Plannin	***N**ote any gaps/no gaps in the requirements for revalidation and how*						

	they will be addressed? WHAT SUPPORTING INFORMATION IS OUTSTANDING FOR EACH ROLE?						
	Contain SMART PDP Objectives? *Are they* **SPECIFIC, MEASURABLE, ACHIEVABLE, RELEVANT AND TIMELY?** DO THEY CHALLENGE THE DOCTOR TO MAKE QUALITY IMPROVEMENTS?						
	Explain the new PDP items? DOES THE SUMMARY SHOW HOW THE PDP OBJECTIVES ARE RELEVANT AND DERIVE FROM THE SUPPORTING INFORMATION AND APPRAISAL DISCUSSION?						
Overall Comments Total							

APPENDIX F

Appraisee Questionnaire

1. Establish how many Appraisals the Appraisee has had
2. If you transferred from another DB, did you find the transfer easy? If not, why not
3. Were you supported in the transfer i.e., was the transfer process clear/ if the system is different did you get support in using it?
4. Is there a contact point you can go to for day to day advice? (System and process)
5. Was an Appraiser allocated to you quickly?
6. How did you make contact with the Appraiser?
7. Was the Appraiser approachable and supportive?
8. Does the Appraiser set clear expectations of times to receive your portfolio, your Appraisal date and sign off?
9. Are your Appraisal discussions face to face? If not, how does it happen?
10. Are the Appraisal discussions supportive and clear?
11. Do you find the Appraiser helpful in setting your PDP?
12. Do you automatically get a new Appraiser after 3 cycles?
13. Do you feel comfortable providing Appraiser feedback? How does this happen?
14. Has there ever been a conflict of interest and how was this handled?

APPENDIX G – Cross mapping Revalidation documents against Core Revalidation Standard

	QA Documents	Standards covered	Document viewed by Miad Healthcare
1	Annual Board Report	1.10	Seen
2	Latest Organisational Audit (AOA) and associated action plans	1,4	Cancelled for period
3	Certificates for RO training	1.7	Seen
4	CPD certificates relating to the RO Role and records for RO network meeting attendance	1.7	Seen
5	Medical Practice Transfer of Information Form (MPIT)	1.8, 3.1, 4.1	Seen
6	Appraisal and Revalidation Policy	1.9, 2.1, 2.3.1, 2.3.2, 2.3.3, 2.3.4, 2.5, 2.6	Seen and reviewed
7	Managing Concerns Policy (may also be responding to concerns or covered by a Maintaining High Professional Standards Policy)	1.9	Seen and reviewed
8	Clinical Governance Policy	1.11, 3.1	Seen
9	Performance Management / Review Policy		Seen
10	Latest CQC Report	1.11	Seen
11	Latest Trust Development Authority (TDA) Report (NHS Trusts only)	1.11	No longer required
12	Latest Monitor Report (Foundation Trusts only)	1.11	No longer required
13	Information Governance Policy	2.1	Seen under review for update
14	Evidence of Appraiser ongoing CPD development and meetings	2.7	Evidenced in interview
15	HR Recruitment process for checking identity, GMC restrictions, reference requests, right to work in the UK, Medical Practice Information Transfer form etc.	4.1	Seen
16	Equality Impact assessment tool.		Seen

Appendix H– Statement of responsibility

We (Miad Healthcare) cannot accept responsibility for the accuracy of the above information, which remains the responsibility of management. We have not independently verified the sources or accuracy of the information or sought to establish this by reference to other evidence.

Consequently, this Review is based on the information we have received from management and therefore can only be as accurate as the information provided to us prior to its production.

On Behalf of (Miad Healthcare)

Signed: ……..

Date: ……..

On Behalf of (client name)

Signed: ……..

Date: ……..

Name of the Action Plan	**External Quality Assurance of Medical Appraisal and Revalidation at NLaG – Action Plan**
Director Lead	Dr Kate Wood – Chief Medical Officer
Contact Officer/Author	Rachael Norfolk – Revalidation and Appraisal Coordinator
Clinical Lead	**Mr Ajay Chawla – Clinical Lead for Appraisal**
Purpose of the Action Plan	Implement recommendations from external quality assurance audit which was conducted by MIAD Healthcare.
Background Information and/or Supporting Document(s) (if applicable)	***External Quality Assurance of Appraisal and Revalidation Evaluation Report for Northern Lincolnshire & Goole NHS Foundation Trust*** ***Date: October 2022*** ***Consultants: Liz Brewer, Dr Joanne Byfleet, Pam Strange & Nicky Heyworth*** ***Miad***
Reporting/ Governance Oversight	CMOD SMT (bi-monthly) Briefing report to 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)	Nil identified.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Nil identified.

o.	Recommendation (What are the key learning points / what changes need to be made)	Action to be Taken (How the changes will be made)	Risk	Lead & Oversight (For ensuring each action happens)	Timescale for Completion / Date Completed	Evidence of Completion (sources of verification)	Progress notes	RAG Status
1. Appraisees Scope of Practice								
a)	There needs to be greater clarity around hours or sessions worked in each role contained within the scope of practice.	- Provide guidance for all doctors on scope of work from Royal colleges, GMC and NHS England. - Incorporate in appraiser training - Incorporate into the personal 1:1 appraisal support session - Liaise with L2P regarding potential developments	Low	**Rachael Norfolk and Ajay Chawla**	**December 31st 2023**	Established guidance disseminated to all medical staff (i.e. Hub page) Programme agenda for appraiser training L2P updates	Scope of work is discussed at 1:1 medical appraisal support sessions. Rachael Norfolk advises doctor to ensure all roles are covered. Clarified that private work isn't just private healthcare work, may also include work for charity or any other non-nhs work that requires a licence. **This topic was also discussed at the appraiser network on 5/5/2023**	

b)	SAS and Consultants to upload Job Plan to the appraisal as supporting information	- include in newsletter/comms - Include in appraiser training - Include in personal 1:1 support session * encourage uploading of job plan but be clear that this not mandatory	Low	**Rachael Norfolk/Ajay Chawla**	**December 31st 2023**	**Job plans uploaded to appraisal – audit would be required to confirm if this is being done.**	**This was discussed and covered at the appraiser network (5/5/2023) and is highlighted at 1:1 appraisal support session (for new starters)** **Included in summer newsletter.** **Outstanding actions – Hub guidance**	
c)	Doctors who do private/non-NHS work (such as private hospitals, charity roles, or any other role outside main employment that requires a licence) to include a letter of good standing from other place of work	- include in newsletter/comms - Include in appraiser training - Include in personal 1:1 support session - NLaG RO/CMO to write to all local private providers that this is usual part of the appraisal process, and are they ok to provide	Low	**Rachael Norfolk/Ajay Chawla**	**December 31st 2023**	**Scope of work covered in the appraiser training programme.** **In 1:1 support session, there are discussions about the importance in ensuring CPD**	**25/04/2023 – this topic has been placed on agenda for next NLaG appraiser network (5/5/2023)** **Letter ready to be sent, waiting on contact list for local private providers** **RN has contacted PP team to ascertain a list**	

		this in a timely manner when requested. - Draft letter for doctors to send through to their private employers				**matches full range of practice.** **Consider audit and reaudit to see if changes are effective**	**of PP work doctors to begin audit.,**	
2.	**Appraisees Supporting Information (evidence uploaded to appraisal form)**							
a)	Appraisees need to be reminded of the important of maintaining anonymity for patients and colleagues as described in the GMC document "*Guidance on Support information for appraisal and revalidation"*	- include in newsletter/comms - Include in appraiser training - Include in personal 1:1 support session - Liaise with L2P	Breech of confidential information.	**Rachael Norfolk/Ajay Chawla**	**December 31st 2023**	**No patient identifiable information is identified by appraiser or RO office at point of sign off.**	**Doctors are required to confirm, with every piece of supporting information uploaded, that there is no patient identifiable information.** **Included in May Newsletter** **Discussed at Appraisal Network (5/5/2023)**	

3. Appraisees Continuing Professional Development (CPD)								
a)	Some portfolios give the impression of more than enough CPD but the number of CPD points are not inputted.	- include in newsletter/comms - Include in appraiser training - Include in personal 1:1 support session - Liaise with L2P to see if the inclusion of CPD points more prominent/mandatory input within form can be.	Low	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**No appraisal will have 0 CPD points**	**In 1:1 support session, doctors are routinely informed of the importance of inputting CPD points.** **When doctors upload evidence, there are boxes at the bottom to input CPD points** **Discussed at appraiser network 5/5/2023 – general agreement that the reflection on the CPD undertaken is more important than the points however point allocation will be encouraged.** **Guidance on Hub to be update.**	

							Appraiser handbook being developed which will cover CPD.	
b)	Where the above occurs, appraisers include in their summary notes that omission of CPD points is an error.	-appraiser training -include in appraiser networks - L2P system allows for referring back where 0 CPD points inputted -	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**No appraisal will have 0 points.**	**The GMC now emphasise quality CPD over quantity ~(i.e they do not mandate a minimum requirement)** **25/04/2023 – this topic has been placed on agenda for next NLaG appraiser network (5/5/2023)**	
4. Appraises Quality Improvement Activity (QIA)								
a)	There is a range of QIA evidence. Academy of Medical Royal College (AMRC) guidance to be shared with appraisees	- Develop dedicated QIA guidance in step with AMRC guidance and disseminate to all doctors - Liaise with QI team	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Established guidance disseminated to all staff.**	**Appraiser handbook in development which will cover QIA.** **Once complete, all staff guidance which will be uploaded onto**	

	so they are aware of full range of options						**L2P resources and hub page.** **The L2P resources tab has links to the Royal college's appraisal web pages**	
5.	**Appraisees Significant Events (SE's)**							
a)	Appraisees who are informed that there are no incidents attached to their name, should take opportunity to learn from incidents that have occurred in their areas of work. This is an opportunity to be pro-active in their practice as described in the Patient Safety Strategy 2019 guidance.	-Work with L2P to emphasise this point – this would go in the QIA section – this could be something that AMRC also advises in their QIA guidance. - developing local comms/guidance	Low	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Increase in number of 'periphery' incidents/events included in appraisal**	**Discussed at appraiser network 05/05/2023.** **Topic is being covered in the newly developed appraiser handbook.** **Included in May newsletter** **When doctors receive emails from CMO office regarding clinical gov info, they are encouraged to include incidents/events that**	

							they are aware of and can learn from.	
6.	**Appraisee Colleague and Patient Feedback (MSF/360 feedback)**							
a)	Encourage the collection and inclusion of informal feedback which is reflected upon for those years of the cycle that do not include MSF/360. This is a GMC recommendation	- **Comms via newsletter** - **Via appraiser networks** - **Via 1:1 support session**	Low	**Rachael Norfolk /Ajay Chawla**	**December 31st 2023**	**Increase of informal feedback in appraisal**	**Discussed at appraiser network** **Covered in Mays Newsletter** **Included in appraiser handbook.** **Update Hub page for info**	
7.	**Appraisee Complaints and Claims**							
a)	Appraises who declare non-involvement in complaints should take opportunity to review complaints that have occurred in their area of	-Work with L2P to emphasise this point – this would go in the QIA section – this could be something that AMRC also advises in their QIA guidance.	Low	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Increase in number of 'periphery' complaints**	**As above for incidents/SUIs**	

	work. This will need reflection and description of changes to practice for quality improvement purposes and learning outcomes.	developing local comms/guidance - appraiser training				**included in appraisal**		
b)	Claims to be routinely included in appraisal which are then to be reflected upon by the appraisee and include any changes to practice as a result as identified in Patient Safety Strategy Guidance.	- Work with Gerard Curran's team to implement. - Use same process for complaints and SIs	Low	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Claims included in appraisal**	**Rachael Norfolk currently liaising with Gerard Curran to establish process like that of the Incident and complaint sharing process** **25/04/2023 – still awaiting confirmation from GC that he has had conversation with Sarah Davy** **30/05/2023 – pending update from GC regarding this.**	
8. Appraisee Reflective Practice								

a)	Appraisees need to ensure that they complete reflective activity for each of the six (6) elements as set out in the AMRC 2022 Guidance.	-disseminate guidance to all doctors -encourage practice via appraiser networks and training Work with L2P consider software updates – i.e. Making the reflective text a mandatory requirement and the appraisal summary box mandatory requirement.	Low	**Rachael Norfolk /Ajay Chawla**	**December 31st 2023**	**Will need to do audit to see if there meaningful reflection**	**When doctors upload supporting information, they are prompted to reflect .** **05/05/2023 – discussed at appraiser network** **Appraiser handbook being developed.** **Appraisal team looking to implement reflective workshops.**	
9. Appraiser and Appraiser Infrastructure								
a)	Appraisers to review guidance and training on the importance of summary statements and the detail required to provide assurance to the RO that all elements of the scope of work	- Develop guidance and disseminate to appraisers - Look at the appraiser training module on summary statements. - Appraiser networks	**medium**	**Rachael Norfolk / Ajay Chawla**	**August 31st 2023**	**Better quality output summaries as identified in 'Excellence' Audit.**	**RN producing 'Appraiser handbook' which will contain examples of high-quality summaries and producing a template which can be used**	

	have been covered and challenged. The summary statements should also demonstrate that support has been the focus of discussion.					**Dissemination of established guidance**		
b)	To include in summary notes of any CPD discussed at appraisal meeting but not uploaded to the appraisal form by appraisee.	- Appraiser training - Consider software update on form on appraiser note section – "hints and tips"	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2034**	**Excellence audit will identify improvement of appraiser oversight of CPD**	**Discussed at appraiser network 05/05/2023**	
c)	Appraisers to ensure that all support information uploaded is anonymised (where relevant), particularly patient and colleague feedback.	- Via appraiser networks - L2P form already prompts doctor to check supporting information before upload (there is a mandatory tick box)	**Medium**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**No breeches of confidential information**	**Doctors are required to confirm, with every piece of supporting information uploaded, that there is no patient identifiable information.**	

d)	Fuller analysis and reference to lessons learned and changes to practice made as a result need to be documented by the appraiser in summary notes	- Encourage via appraiser training - Disseminate the "reflective practitioner" - Encourage via appraiser net work - - consider a "hints and tips" software update but this will need buy in from supplier	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Excellence audit will reflect that appraiser summary encourages changes and improvements because of identified improvements**	**Development of appraiser handbook to help guide appraisers in developing summaries that take note of "lessons learned".**	
e)	Appraisers to bring clarity to the PDP discussion and document clearly what has been achieved, identify gaps and aspirations of the appraisee.	-liaise with L2P with appraiser hints and tips - appraiser training -comms via appraiser networks	**Low**	**Rachael Norfolk / Ajay Chawla**	**31st December 2023**	**EXCELLENCE audit will show improvement in PDP quality.**	**Appraiser handbook is being developed.** **This was discussed at NLAG appraiser network 05/05/2023**	
f)	Appraisers to encourage appraisees to consider other incidents/evens/complaints/outcomes/reviews in their own speciality	liaise with L2P with appraiser hints and tips - appraiser training -comms via appraiser networks	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Increase in number of 'periphery' incidents/event**	**Appraiser handbook is being developed.** **This was discussed at NLAG appraiser network 05/05/2023**	

	practice to see if their areas of patient or staff safety which could be improved upon.					**s included in appraisal**		
g)	Appraisers need to use the appraisal discussion to further support appraisees to develop their PDP more fully, with a clear link to professional development needs and outcomes that benefit patients and provide documentary evidence that this has happened.	- liaise with L2P with appraiser hints and tips - appraiser training -comms via appraiser networks	**Low**	**Rachael Norfolk / Ajay Chawla**	**31ST December 2023**	**Increase in quality of PDPs as identified by EXCELLENCE audit.**	**Appraiser handbook is being developed.** **This was discussed at NLAG appraiser network 05/05/2023** **Appraiser training also covered the development of PDP in depth/**	
h)	Appraisers support appraisees with reflective practice during the appraisal discussion and document that this happened.	- liaise with L2P with appraiser hints and tips - appraiser training -comms via appraiser networks	**Low**	**Rachael Norfolk /Ajay Chawla**	**December 31st 2023**	**Will need to do audit to see if there meaningful reflection being discussed as evidenced in**	**When doctors upload supporting information, they are prompted to reflect.** **Appraiser handbook is being developed.**	

		- Disseminate AMRC "Facilitating ref lection A guide for supervisors"				**appraiser summary**	**This was discussed at NLAG appraiser network 05/05/2023** **Reflective practitioner uploaded to L2P resources page which can be accessed by all doctors**	
i)	Appraisers need to ensure comments and questions documented prior to appraisal discussion are updated prior to final submission	**-**appraiser training -comms via appraiser network - At RO sign off, refer back appraisals that have pre-meeting comments.	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**No pre-meeting comments/question will be in appraisal summary**	**Appraiser handbook is being developed.** **This was discussed at NLAG appraiser network 05/05/2023**	
j)	Statements and declarations need to accurately reflect both the input and the appraisal discussion	- appraiser training -comms via appraiser networks	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**EXCELLENCE audit will demonstrate that inputs and outputs are matched**	**Appraiser handbook is being developed.** **This was discussed at NLAG appraiser network 05/05/2023**	

k)	Development of Appraiser summary outputs guidance/examples to show a consistent approach to documenting the appraisal discussions, including reflection, challenge and support in line with AMRC Medical Appraisers Guide.	Produce guidance and examples for dissemination Considering adding this to the CMOD hub. Upload onto L2P resource section.	**Medium**	**Rachael Norfolk / Ajay Chawla**	**August 31st 2023**	**EXCELLENCE audit will show quality summary which reflect the discussion which include reflect challenge and support discussions.** **Established guidance disseminated.**	**producing 'Appraiser handbook' which will contain examples of high quality summaries and producing a template which can be used**	
l)	Consideration should be given to mapping whether those Appraisers with poor summaries have been provided with sufficient training. There are examples in the audit conducted that look more like a chat which may indicate that the	- RN and AC to deep dive into results (- Consider putting those appraisers onto 3rd party appraiser training.	**Medium .**	**Rachael Norfolk / Ajay Chawla**	**August 31sr 2023**	**Audit results of specific low scoring appraisers.** **Improved performance demonstrated**	**Doctors have attended 1:1 with Ajay for training.** **Will audit (planned for august) so measure improvement via the appraisal summaries.**	

	Appraiser is not up to the date with current process of appraisal and evidence needed for revalidation					**by Excellence audit**		
m)	Making summaries standalone with basics needed for the Responsible Officer included	- Look at revalidation requirements and consider incorporating this into the appraiser summary/checklist	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**EXCELLENCE audit**	**Appraiser handbook being developed which will include good examples of appraisal summaries.**	
n)	PDP development – training on focusing the appraisee on why they are looking to do something, what is the learning need (which course/conference will help with that) and how will they know they have successfully developed this with more emphasis on outcome in their practice rather than just	- Create guidance on PDP development - Look at online webinars/workshops for dissemination (the Open University have this) - Comms via newsletter	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**EXCELLENCE audit will show increase in SMART PDP**	**Appraiser handbook is being developed.** **This was discussed at NLAG appraiser network 05/05/2023** **PDP module at appraiser training event**	

	certificates of attendance.							
o)	Review of the appraiser training programme to meet the recommendations set out in this action plan	Summarise recommendations for appraiser lead and senior appraisers to include in next training session	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Renewed training programme**	**List of recommendations generated for training facilitators, awaiting meeting to update programme.** **25/04/2023 Training completed and feedback collated which is extremely positive**	
p)	Develop guidance in relation to Appraiser challenge within the appraisal discussion using shared example of high quality outputs.	- source examples of high-quality inputs for dissemination - incorporate a module around appraiser challenge into the	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Excellence Audit.**	**Appraiser handbook being developed** **The challenging discussion was included at appraiser training**	

		training and network sessions						
12. Organisation- General Infrastructure								
a)	The appraisal checklists should be reviewed as they do not always match the documentation or 'not relevant' is picked when it is relevant without explanation.	- Will need to liaise with L2P regarding checklist as the appraisal form is updated to the new "shorter" version. - With the above considered, incorporate this recommendation into appraiser network sessions and training.	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Summary discussions to reflect inputs which will be picked up via audit (Excellence or ASPAT)**	**Checklist is include in new appraisal format which act as useful prompt for doctors in case they omit any supporting information.**	
b)	Strive to fully engage in medical appraisal of some senior doctors, close to retirement.	- Would need to know which senior doctors are considering retirement as not all	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Would need to specifically pick of those appraisals of doctors who are fully**		

		doctors fully retired (i.e retire and return)				**retiring to see what the engagement is like.**		
c)	Include preparation for retirement in the appraisal discussion early to get doctors thinking about less clinical sessions and more education or management responsibility so that they can continue if they wish post-clinical retirement. Clear and consistent approach to ensure added value.	- Consider liaising with People directorate to see how this may be included in their retirement workshops - Look at any guidance regarding this recommendation and look to disseminate on CMOD hub and appraiser network	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Would need to specifically pick of those appraisals of doctors who are fully retiring to see what the engagement is like.**		
d)	Increase proportional representation across the Appraiser group to include all specialties.	- Would need to look at numbers across specialties however someone specialties have less than 5 doctors. Consider	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Can provide information in annual report regarding**		

		proportional representation across the divisions as oppose to specialities.				**appraiser speciality.**		
e)	Consider lay presentation for the doctors in difficulty group	Consideration was given; however, this is not a formal meeting and just use of soft intelligence to ensure that the CMO has oversight particularly to ensure that the right support in terms of health and wellbeing is wrapped around the individual. Consideration will be given to a discussion with the CMO as to whether this should be put on a formal footing and if so a lay person would form part of the TOR.	**Low**	**Jane Heaton**	**Discussion with CMO before end of March 2023.**	**N/A**		
F)	Consider lay representation for the Revalidation meetings.	There is guidance on lay representation by AMRC and there is best practice which can be picked up from other organisations regarding	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Lay representation at revalidation meeting**		

		recruitment. Will need to develop a case for this						
G)	Re-establish the appraiser quarterly meetings and include topics covering GMC fitness to practice issues, support in sign posting well-being issue identified through the appraisal discussion, shared case studies and experience of difficult appraisals.	**These have been re-established. Considering covering the topics starting with next scheduled meeting.**	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**		**Meetings have been re-established**	
h)	Additional support provided Trust Grade/Career Grade doctors who can struggle to populate their portfolios with the correct supporting information. This group	Continue with 1:1 support session provided by CMOD. Continue with Welcome to UK Practice sessions at NLaG	**Low**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Feedback from 1:1 session will highlight support is provided**	**Rachael Norfolk invites all new starters to a 1:1 session.** **GMC workshops upcoming in Feb, March and April.**	

	includes a high number of international medical graduates who have not got previous experience of medical appraisal and the knowledge base is not there.	Look at additional appraisal sessions aimed at international medical graduates.					**25/04/2023 – feedback Is being obtained from these 1:1 sessions which will be included in annual revalidation report and use for QI purposes.**	
i)	Guidelines around the development of a PDP, to ensure that sufficient detail and goals are included to know what outcome is expected and how the doctor can truly evidence the achievement of that goal	Produce guidance that can be disseminated Find examples of high quality PDPs for dissemination on CMOD hub, resource page on L2P and via appraiser training/network.	**Low.**	**Rachael Norfolk / Ajay Chawla**	**December 31st 2023**	**Better quality PDPs as identified in EXCELLENCE audit**	**Appraiser handbook is being developed.** **This was discussed at NLAG appraiser network 05/05/2023** **PDP module included at appraiser training.**	

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Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	1 August 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 20 April 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Audit, Risk & Governance Committee held on 20 April 2023 and approved at its meeting on 20 July 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.

MINUTES

MEETING:	Northern Lincolnshire and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**	
DATE:	**20 April 2023** via MS Teams	
PRESENT:	Simon Parkes	Chair of ARG Committee / Non-Executive Director
	Gill Ponder	Non-Executive Director
	Kate Truscott	Non-Executive Director
IN ATTENDANCE:	Lee Bond	Chief Financial Officer
	Helen Harris	Director of Corporate Governance
	Sally Stevenson	Assistant DoF – Compliance & Counter Fraud
	Robert Pickersgill	Governor
	Chris Boyne	Deputy Director, Internal Audit (Audit Yorkshire)
	Danielle Hodson	Assistant Internal Audit Manager (Audit Yorkshire)
	Nicki Foley	Local Counter Fraud Specialist
	Nicola Parker	Assistant DoF – Planning & Control (For item 5.2)
	Alison Hurley	Assistant Trust Secretary (For item 5.3)
	Ron Gregory	Head of Safety and Statutory Compliance (For item 10.1)
	Sue Meakin	Data Protection Officer (For item 11.2)
	Ivan Pannell	Head of Procurement (For item 11.3)
	Lauren Short	Directorate Admin / PA to CFO (Minutes)

Item 1 04/23 **Apologies for Absence:**

There were no apologies for absence.

Item 2 04/23 **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 04/23 **Minutes of Previous Meetings and Highlight Report**

3.1 The minutes from the public meeting held on 23 February 2023 were agreed as an accurate record.

3.2 The minutes from the private meeting held on 23 February 2023 were agreed as an accurate record.

3.3 The Public Highlight Report from 23 February 2023 had been provided and noted.

Item 4 04/23 **Matters Arising/Review of Action Log**

There were no matters arising that were not included on the agenda or covered in the action log.

Simon Parkes confirmed that all actions were either on the agenda or pending/ closed with the update / evidence provided on the action log.

Item 5 04/23 Annual Governance Issues

5.1 Going Concern Report 2022/23

Lee Bond explained that the going concern report is produced every year as a precursor to preparing the annual accounts with a projection as to whether the Trust finds itself a going concern. Lee Bond stated that the Trust was not going insolvent and Regulators were not saying they were moving services, therefore it was reasonable to conclude the Trust is a going concern.

Lee Bond's recommendation was to prepare the annual accounts on the principle of an on a going concern basis, as it is clear from the evidence provided within the report that the Trust is a going concern for 2022/23.

Members of the Committee agreed with Lee Bond's recommendation, commenting that the principle was sound and highlighted that the Trust needs to be very clear and transparent with the issues it faces.

The Committee approved the view that the annual accounts should be prepared on the basis of the Trust being a going concern. It was agreed to highlight this item to the Trust Board.

5.2 Draft Annual Accounts 2022/23

Simon Parkes welcomed Nicola Parker to the meeting whereby it was explained that the draft annual accounts for 2022/23 had been completed.

Nicola Parker spoke to the report highlighting key points of information and changes which could be seen on pages 1, 2 and 3 of the report.

Simon Parkes on behalf of the Committee thanked Nicola Parker and her team for preparing the annual accounts in such a timely manner and providing the highlight notes and changes to enable the Committee to focus on key points within the accounts. Simon Parkes congratulated Nicola Parker for having such a thorough understanding of the accounts.

Lee Bond referred to the following points within the report:

- Page 19, note 2 and asked why the operating segments were included. Nicola Parker explained that previously the Trust has always had to demonstrate the elements which relate to healthcare but added that it could be taken out. Lee Bond wondered whether this statement could create confusion as to what the other segment is or is it all healthcare if left in.
- Page 22, note 5.3 was referred to whereby it was advised to mention what the figure related to i.e., car parking.
- Page 25, note 8 and referred to an impairment of £13m relating to the new ED departments and Coronation Block, these are large

impairments. Some buildings e.g. The Roost have increased in value which seems to imply that this doesn't relate to market conditions.

- Page 25, note 8 and page 33, note 19 - Lee Bond queried how the figures were linked to which Nicola Parker explained how each figure tied back and Lee Bond was content with the explanation.
- Page 33, Boreholes – it was queried how these had been reported in the accounts and the value. Nicola Parker confirmed that these are shown under assets under construction and included within the £8.6m.

Robert Pickersgill asked about cash and NHSE liquidity support. Nicola Parker confirmed that PDC was available if needed. Creditors are paid within 90 days and the Trust is monitored on this.

Gill Ponder commented that overseas visitor's income had increased significantly from the previous year but wondered whether there would be further opportunities to recover more, and also touched on whether the Trust is maximising the apprenticeship levy or whether there were further opportunities for it. Nicola Parker explained that the apprenticeship levy income is not fully utilised by the Trust. Discussions took place around the apprenticeship levy and how it is a common issue for other NHS Trusts to maximise their levy spend but Kate Truscott realised this is something which could have the potential to be addressed. Gill Ponder advised for this to be referred to the Workforce Committee whether that be through the Finance and Performance (F&P) Committee or via the ARG Committee's highlight report to the Trust Board. It was agreed that Gill Ponder would refer this to the Workforce Committee. Lee Bond confirmed that a paper on the apprenticeship levy had gone to the Trust Board in recent months.

Action: Gill Ponder

Nicola Parker referred back to the overseas visitor's income and informed the Committee of an issue which was raised through an internal audit report of late invoices being raised, with some of the income being from invoices dating back to 2021/22. The overseas visitor's department are currently being monitored to ensure the Trust has assurance of invoices being raised on time.

Simon Parkes thanked Nicola Parker again for her thorough briefing and stated that it was a strong indicator of a strong Finance team to have their accounts finalised in a timely manner and expressed his disappointment of not having an external auditor at present to start auditing the draft accounts.

The Committee shared their contentment with the draft Annual Accounts for 2022/23 being submitted to NHSE.

Nicola Parker left the meeting.

5.3 Annual Governance Statement 2022/23 - Draft

Alison Hurley informed the Committee that the AGS was still at draft stage due to some information still needing to be gathered and confirmation of its contents from the External Auditor, however it had been approved to date by Peter

Reading, Chief Executive, and the Executive Directors. Once the final version is complete, it will be circulated to the Trust Board members.

Helen Harris asked Committee members as to whether they felt anything had been missed or not represented within the statement. The Committee were content, and Lee Bond confirmed that he would work on the financial governance and risks section which would be completed over the next couple of weeks. Sally Stevenson noted minor spelling errors which she would share with Helen Harris offline.

Alison Hurley left the meeting.

5.4 Head of Internal Audit Opinion 2022/23 – Draft

Chris Boyne spoke to the report and shared that the direction of travel was heading towards a significant overall opinion with the caveat of roughly eight audits outstanding which should be completed in June 2023.

Positive progress had also been made in terms of the overdue recommendations recording eight in total to date whereas last year it was significantly higher.

The Committee raised no questions and Simon Parkes was pleased to hear the reduced number of overdue recommendations reported, noting there was still time to further reduce this figure and felt the opinion of significant assurance was fair.

The Internal Auditors were thanked for their work.

Item 6 04/23 External Audit

6.1 Update on Position with External Audit Service Tender

Due to Lee Bond having technical issues, Sally Stevenson provided the update for this item.

The Committee were informed of Lee Bond working with NHSE who were helping to source an external auditor. NHSE had been having discussions with various firms and offering extended accounts submission deadlines, but even this was proving challenging. NHSE were continuing to talk to firms on the Trust's behalf. Lee Bond would contact NHSE for an update in the next week.

Item 7 04/23 Internal Audit (Audit Yorkshire)

7.1 Internal Audit Progress Report

Danielle Hodson informed the Committee of their plans to change the way in which this report is presented for the coming year with it being more concise. The Committee will still receive the full reports via the Audit Committee Sharepoint site.

The Internal Audit Progress Report on the 2022/23 plan showed all audits apart from the Activity Planning review being near to completion with no further changes to the plan.

Danielle Hodson was pleased to update the Committee on the final opinion of the BAF and CQC Action Plan Compliance gaining 'significant assurance', with the other following audits being at draft report stage:

- Long Term Locums
- Medical Staff Job Planning Follow Up
- Leaning from Complaints
- Data Quality Review
- Data Security & Protection Toolkit

Kate Truscott raised her concerns with regard to the job planning for 2021/22 still not being completed and the Trust having already paid for an E-Rostering system which is not being fully utilised for junior doctors and wondered if any progress had been made.

Lee Bond shared these concerns, however he stated that he was not clear on what the action plans particularly on the roll-out of E-Rostering looked like and would pick up with the Execs. It was agreed for Lee Bond to take an action to contact Kate Wood for an update on job planning and feedback to the Committee on what will be discussed at the Joint Board Development Day regarding E-Rostering.

Action: Lee Bond

Robert Pickersgill referred the Health and Wellbeing of Staff on page 11 of the report and was concerned to see an overall opinion of significant assurance when the feedback from staff via the staff survey and the Workforce Committee seem to show that it is not working very effectively. Simon Parkes took on board these comments although the detailed report had previously been discussed at a previous Committee meeting when the audit was completed, with recommendations being made to improve/address issues. Chis Boyne noted that there is always an issue with triangulation but the overall opinion on the audit is based on numerous detailed information. Lee Bond acknowledged the comments and stated that it was a huge priority area for the organisation.

Both Simon Parkes and Gill Ponder had recommended that the Board consider the impact on Trust performance of the ongoing workforce challenges.

7.2 IA Recommendations Follow-Up – Status Report

The paper was taken as read with no further comments due to covering most of the detail of this report in item 5.4 on the agenda which noted the improved position.

7.3 Internal Audit Plan 2023/24 – Final Draft

This plan had been discussed at the previous Committee meeting and had since been shared with the Executive Directors. There was a request to look at theatre utilisation which will commence as soon as possible and the Medical

Gases issue which was under matters arising which will be worked up in the audit plan this year.

Following discussion, the final version of the Internal Audit Plan 2023/24 was approved by the Committee.

The Committee broke at this point for a five minute break.

Item 8 04/23 Counter Fraud

8.1 LCFS Progress Report

Nicki Foley presented the progress report and highlighted the following key points to note:

- Counter Fraud Plus had gained a new organisation into the collaborative; Hull University Teaching Hospitals joined from April 2023.
- Mandatory Training – at the end of March 2023 75% of staff had completed the now mandatory Fraud Awareness training.
- National Fraud Initiative is on-going at the moment with 2,476 data matches; 165 payroll and 2,312 creditor matches, with work underway to review them.
- Investigation Referrals – three new referrals received since the last report, with eight referrals ongoing.

Ron Gregory joined the meeting.

Simon Parkes shared his positive thoughts on the Trust already reaching 75% compliance with regards to the mandatory Fraud Awareness Training which only became mandatory in mid-January 2023, and asked for it to be added to the Highlight report to the Trust Board.

Sally Stevenson informed the Committee that the as a result of the training becoming mandatory it had already had a positive impact as a fraud referral had been received as a result.

The next item was taken out of sequence on the agenda.

Item 9 04/23 Losses and Compensations Report

Lee Bond spoke to the report and noted an improved position from last year's figures. The report shows figures within the following three areas:

- There has been a number of overseas visitors emergency admissions which the Trust have been unable to recover costs for which is disappointing.
- Expired drugs losses during to fridge problems, which Lee Bond noted was very honest of the Trust for reporting as this was not something he has seen reported on within other NHS Trusts.
- Salary overpayments – the latest report shows an improving position with overpayments, but this report also shows that very few overpayments have to be written off and are actually recovered.

Lee Bond reminded colleagues of the PPM audit featuring on this year's internal audit plan which will be welcomed to improve the process for both patients and staff and hopefully drive the numbers down for these types of losses and compensation payments.

Lee Bond left the meeting. The Committee returned to the sequence of the agenda.

8.2 Counter Fraud Operational Plan 2023/24

Nicky Foley informed the Committee of the plan being in line with the government functional standard for counter fraud which came into effect on 1 April 2021, with the fraud risk assessment under pinning the plan. Each risk has its own risk owner within the Trust who takes on the responsibility of managing and following up on their risks.

Simon Parkes referred to the risk owners and questioned how they were chosen. It was confirmed that the risks were studied along with the policy a risk would fall under and therefore the first port of contact being the owner of said policy. After discussions with those individuals they understood the responsibility of the risk sat with them. Nicky Foley confirmed that the risks will be monitored throughout the year and if there were any changes they would be updated accordingly.

Item 10 04/23 Management Reports for Assurance – Items for Approval

10.1 Annual Health and Safety Policy Statement

Simon Parkes welcomed Ron Gregory to the Committee and asked for a brief summary of the policy statement.

Ron Gregory advised that the Annual Health and Safety Policy Statement is mandated to be reviewed every year with the review for this year already taken place noting the following two changes:

- Page 3; developing key performance indicators specific to health and safety.
- Page 4; collaborative working between NLAG and HUTH as Bill Parkinson is now covering both Trusts.

Sue Meakin and Ivan Pannell joined the meeting.

The Audit Committee members were content to recommend the updated Annual Health and Safety Policy Statement to the Trust Board.

Robert Pickersgill asked whether the Trust would be looking to gain any accreditations and Ron Gregory would be looking at one in Estates and Facilities as a test area, however it was noted that the cost to achieve such accreditations was difficult to justify.

Ron Gregory left the meeting.

Item 11 04/23 Management Reports for Assurance

11.1 Document Control Report

Simon Parkes took the report as read and asked Helen Harris to inform the Committee of any further updates if necessary. Helen Harris advised that she would contact the relevant Executive Directors to chase any out of date documents.

Action: Helen Harris

Slow progress was noted, but no escalation required to the Trust Board at this stage.

11.2 IG Steering Group Highlight Report

Simon Parkes welcomed Sue Meakin to the Committee to provide a brief update. It was noted that a total of 720 staff are currently non-compliant with their mandatory IG training, however work is taking place to achieve the required 95% compliance (currently at 88%). A piece of focussed work is happening over the next couple of days.

Sue Meakin highlighted a change in the way DSPT training reporting is being monitored going forward with the 95% being taken away and training being reviewed differently to previous years, looking at training needs analysis, delivery and evaluation elements.

Kate Truscott queried how the confidentiality breaches were processed and reported. Sue Meakin confirmed that all incidents are reported through Ulysees and are filtered to different areas to investigate however, the Information Governance team have an overall review of all incidences in case further work is required.

Gill Ponder asked if reaching the 95% was the only issue preventing the Trust from achieving the IG Toolkit standard, the Trust should ideally be able to hit that target. Sue Meakin stated that they were still working on this for this year, and were hopeful of a compliant DSPT return.

Going forward joint working between HUTH and NLAG will hopefully enable more scope for improvements, however at this moment in time the IG audit report looked to be positive with confirmation of this gained from Chris Boyne.

Simon Parkes agreed to add the IG training compliance to the highlight report to the Trust Board.

Sue Meakin left the meeting.

11.3 Waiving of Standing Orders Report

Simon Parkes welcomed Ivan Pannell to the meeting and asked for the paper to be taken as read. Ivan Pannell noted 52 waivers reported between January to March 2023 which was not unusual for the time of year due to year end and money needing to be spent.

Gill Ponder informed the Committee of the Trust being in receipt of late funds and due to hitting the capital plan target for 2022-23, this meant the late funds were used to purchase items from the capital plan for 2023-24.

The Committee were content with the report noting the time of the year.

Ivan Pannell left the meeting.

11.4 Salary Overpayments Report

The report was taken as read with no further questions from the Committee. Sally Stevenson highlighted that the overall value of salary overpayments for 2022/23 had reduced significantly on the previous year and was in fact the lowest annual value since 2015/16.

11.5 Standards of Business Conduct Policy Declarations

The report was taken as read. Helen Harris noted previous escalation of low compliance to the Trust Board, further comms being issued and actions such as the policy featuring within the Corporate Induction as recommended by the auditors being followed up by Helen Harris in discussion with Simon Nearney.

11.6 LSMS Annual Work Plan 2023/24 – for information

The LSMS Annual Work Plan for 2023-24 was noted by the Committee.

Item 12 04/23 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 Ethics Committee (no meeting taken place)
12.5 Strategic Development Committee
12.6 RATS Committee Annual Summary Report to ARGC

Item 13 04/23 Private Agenda Items

None.

Item 14 04/23 Any Other Business

14.1 SFI / Trust Scheme of Delegation – Approval to Extend

Sally Stevenson informed the Committee of a review needing to take place once the new Group model between NLAG and HUTH takes place and more detail about the joint structure is known once the Group CEO starts in post. Due to the timing of the SFI's and Trust Scheme of Delegation needing to be reviewed,

it was suggested to extending the existing documents to the end of December 2023.

The Committee approved extending the two documents to 31.12.23 and highlight it to the Trust Board.

Item 15 04/23 Matters for Escalation to the Trust Board

- Going Concern Report 2022-23
- Draft Annual Accounts 2022-23
- Draft Annual Governance Statement 2022-23
- Draft of Head of Internal Audit Opinion 2022-23
- Mandatory Training – Fraud Awareness and IG Training
- Annual Health and Safety Policy Statement
- Trust Scheme of Delegation and Power Reserved for the Trust Board / Standing Financial Instructions

Item 16 04/23 Matters to Highlight to other Trust Board Assurance Committees

None.

Item 17 04/23 ARG Committee Workplan – For Information

It was agreed for the EPRR highlight reports to feature on the Finance and Performance Committee agenda due to EPRR sitting under the Chief Operating Officers portfolio and attending that Committee. The ARG Committee will continue to have annual oversight of the EPRR Annual Report including annual oversight of the medical gases testing of contingency plans, etc.

Item 18 04/23 Review of the Meeting

Gill Ponder commented that the detailed walk through of the annual accounts was very helpful.

Simon Parkes noted the remarkable achievement of Nicola Parker and her team having the draft annual accounts completed in a timely manner. Gill Ponder mentioned the Our Star awards coming up and thought it would be good to nominate Nicola Parker. It was agreed for Simon Parkes to discuss this with Lee Bond.

Simon Parkes thanked everyone for attending.

Item 19 04/23 Date and Time of the next meeting

20 July 2023 – 1.00pm –4.00pm via Microsoft Teams.

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Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	01/08/2023	
Director Lead	Adrian Beddow, Associate Director of Communications	
Contact Officer/Author	Charlie Grinhaff	
Title of the Report	**Communications Update**	
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 May and June 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	✓ 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

Communications Team update

August 2023

Kindness • Courage • Respect

Report period: May and June 2023

Contents

Headlines

3,450 Members of the staff Facebook group

226 Ask The Execs questions asked

147 Freedom of Information requests received

95 General Enquiries dealt with

93% Of media enquiries dealt with on deadline

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%+ Freedom of Information requests (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, Emergency Department statistics and more recently patient feedback • Undertaken video training to enable to the team to produce more video content • Carried out a survey of our Foundation Trust Members to help shape member engagement going forward	**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 • Relaunched Ask Peter as Ask the Execs • Brought back the annual staff awards ceremony, Our Stars 2023, receiving a record number of nominations – over 1,000 • Aligned everything we do to the People's Promise – introducing the brand to relevant internal content
What we're working on • How we can work more closely with our local media, providing positive news stories • 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.

Supporting the Trust's priorities

Trust Priority 1 – Our People

Our Stars, the Trust's Annual awards ceremony is back for 2023. Nominations were open for a six-week period during May and June and we received the most on record, more than 1,000.
Shortlisting is taking place during the Summer. The event will be held at The Baths Hall in Scunthorpe on Friday 24 November. Staff have been in touch with the team to express their delight at being nominated with comments including: "very exited and humbled' and "Gosh – me – an unsung hero! Someone is being much too kind."

We continue to support the Trust's Organisational Development team with their regular initiatives including Schwartz rounds. In this period, we also created a video to support the launch of the Leadership programme and raised awareness around Learning at Work Week

Trust Priority 2 – Quality and Safety
We celebrated the Trust coming out of the Recovery Support Programme, formerly special measures regime, with screensavers, an all-staff email, media release, social media posts and a timeline of our journey from 2017 to date.

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Supporting the Trust's priorities

Trust Priority 5 – Collaborative and System working
Continuous planning in collaboration with our Integrated Care Board (ICB) colleagues continues under the Humber Acute Services review.

Trust Priority 6 – Strategic Service and Development

Both Scunthorpe and Grimsby have now received funding in principle for new Community Diagnostic Centres. We worked with colleagues in the ICB on the announcements and resulting media queries

Trust Priority 10 – The NHS Green agenda
We continue to raise awareness about green schemes across the Trust. This included case studies of staff who are successfully recycling in their areas, green campaigns and a focus on clinical waste.

Other work: The Annual Report is near completion

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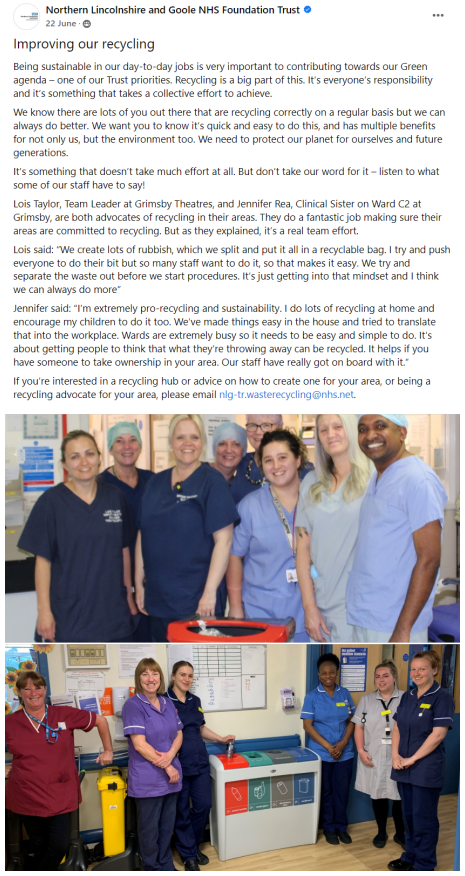


Campaigns and awareness weeks

Campaigns and awareness weeks

In this period, we celebrated Volunteers week, Pride month and National Healthcare Estates and Facilities Day.

The overall reach for the latter was 19,343, with 333 positive reactions, 241 clicks, 1.736 media views and 20 shares

In May we celebrated International Nurses Day and International Day of the Midwife

Campaigns and awareness weeks

Patient experience campaign

We're supporting the Chief Nurse Division with their patient experience campaign. In April 2023, we launched a year-long patient experience campaign and shared the story of Carol, a patient who came to us with Creutzfeldt-Jakob disease (CJD) and spent her final few weeks with us before moving to a hospice. She received excellent care at times, but there were some aspects which could have been better. Carol is the face of this campaign and her daughter, Sarah, is working alongside us and championing these positive changes. At the end of May, we supported the launch of our visiting review, which sought feedback from patients, visitors, the public and staff. We publicised the survey on our external social media channels and website, plus internally. In June, we asked staff for their help in naming the campaign, with the chosen name to be published soon.

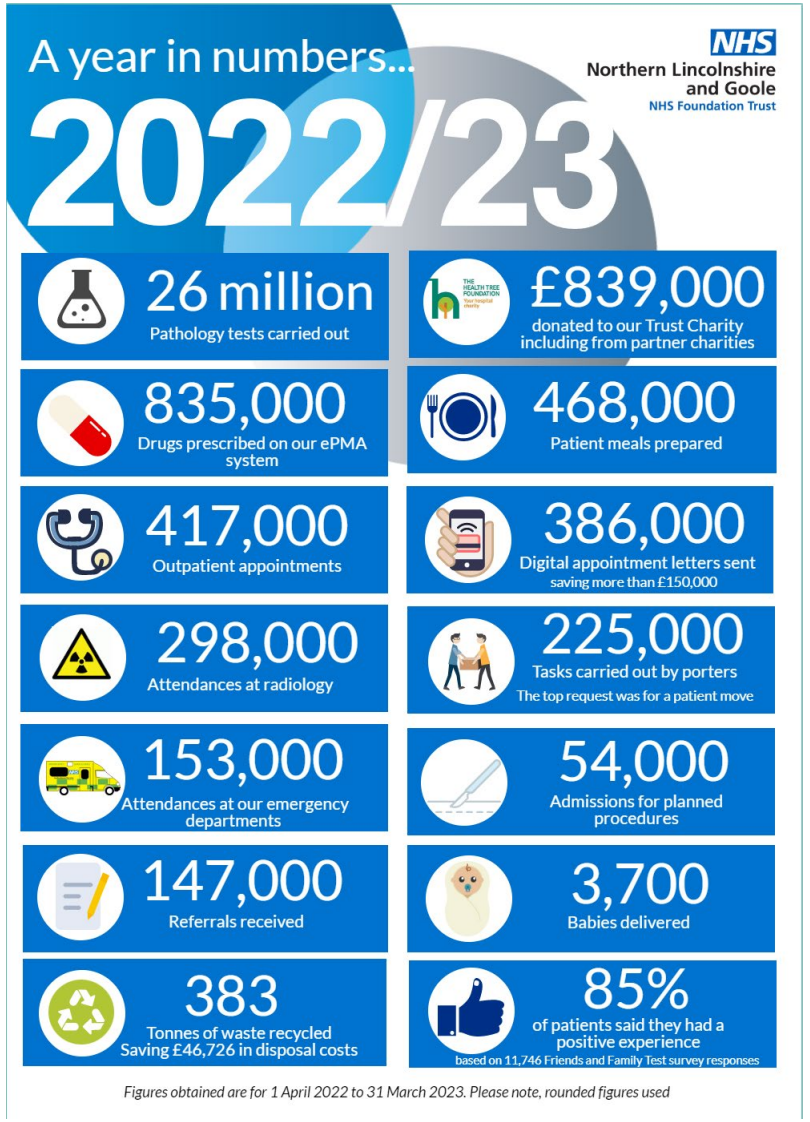
THE HEALTH TREE FOUNDATION
Your hospital charity

Supporting the Health Tree Foundation

In May, we let staff know about a new project to refurbish staff rooms in our hospitals. The Health Tree Foundation team will be improving areas identified on a priority list. We also sent out a news release about the Mayor of North East Lincolnshire's (also a staff member) fundraising drive for The Pink Rose Suite

Annual infographic – A year in numbers…

We produced an infographic covering the financial year 22-23 to highlight the sheer scale of what our staff do over the course of a year



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. The Manager update goes out once a month.

The most popular edition of the Monday Message, with 7,472 opens, came from Simon Nearney and was on the Be The Change – Leading with Kindness, Courage and Respect Leadership Programme.
Building Our Future was opened times 62,199 times and generated 1,866 click throughs.

There were 1459 opens of the May Manager Update and 1208 in June.

2,667
Opens of the Manager email

62,199
Opens of Building Our Future

Senior Leadership Briefing (SLC)

79 senior leaders attended the SLC briefing in May and 71 joined in June.

Staff App

There were 366 downloads of the staff app in this period, with 478,248 page views and 130,816 sessions. The top pages were eRoster, webmail and ESR.

366
Downloads of the staff app

71
Senior leaders attended the last SLC briefing

Improving staff morale and engagement

Giving staff a voice

Ask the Execs

Following the departure of the Chief Executive in May, Ask Peter has been rebranded ‘Ask the Execs’.

There were 226 questions submitted in May and June, which was an increase of 38 from the previous two months. During this period, we have redacted 10 questions, and removed three which were felt to go against the board rules and the Trust values of kindness and respect. The directorates with the most question continue to be People with HR queries, Estates and Facilities and the Chief Nurse. Hot topics include: bank pay and lump sum, band two pay, heating, shuttle bus/park and ride and smoking/vaping.

226
Ask The Execs questions

Staff Thank You

Since the ‘Thank you’ system launched staff have sent more than 1,300 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.

“Well done to Kayleigh for the care she gave to an End of Life patient. She made sure the care in the last days of life document was completed, and the patient's individual needs were met and addressed. Kayleigh also made sure the medical team completed their assessments involving family members in a timely fashion."

Improving reputation through external communications

Media coverage

There were 39 stories about the Trust in the media during this period. 87% of media coverage was positive or neutral in tone.
87% of coverage was in print or online media.

We categorise the media coverage into themes – in this period '**press release'** was the top theme, followed by 'performance/data'

We issued 10 proactive news releases and the most covered was a story was around the funding being secured for a new Scunthorpe Community Diagnostic Centre. Staff have been interviewed on the Trust coming out of special measures, preparations for the junior doctor strikes, the new diagnostic centre, and the maternity incentive scheme.

Community and Therapy Services had the most positive media coverage.

87%
Of media coverage was positive or neutral

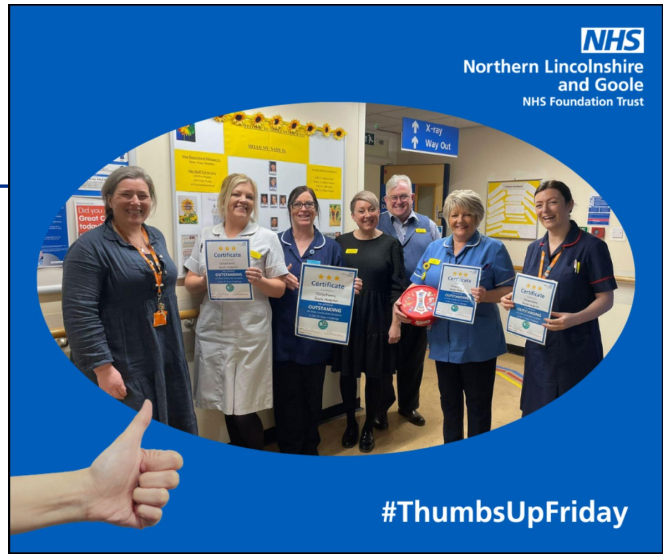
Media enquiries

43 media enquiries were handled in this time, 93% were dealt with within the requested timescale.
The majority of requests came from Print/Online outlets.

The main reason journalists got in touch was to request a statement. 11 reactive statements were issued in this period

93%
Of media enquiries dealt with on deadline

Social media



Social media overview

Followers update for the Trust's corporate accounts:

- 14,614 on the Trust's Facebook page
- 5,541 followers on Twitter
- We are rated 4.6 out of 5 stars on reviews on Facebook
- 5,559 on LinkedIn
- 673 subscribers on YouTube

We shared 10 ThankYouNHS posts and 15 #ThumbsUpFriday posts in this p
Since we started ThankYouNHS it's generated 366,599 impressions, 30,455 engagements and 475 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 had more than 3.450 staff members on there at the end of June.

The majority of posts are positive and helpful. From time-to-time admins have to get involved. in this period 14 comments or posts were deleted, comments were turned off on posts 10 times and 8 requests for anonymous posts were declined due to the content.

Facebook group stats
3,450 members
603 posts in this period
6,286 comments
22,021 reactions

Social media

Twitter

Our top tweet, (by impressions) was a post encouraging patients to nominate their stars for our staff awards event (Patient's Choice Award) and our top mention was from one of our Doctors celebrating the success of their recent charity cricket match

Jun 2023 • 30 days

TWEET HIGHLIGHTS

Top Tweet earned 656 impressions

Seen a star in one of our hospitals or community services? We want your nominations for the Patient's Choice Award! Whether they were a clincial member of the team or one of our vital suport staff, we want to hear from you!**#OurStars2023**: buff.ly/3IQ97iZ pic.twitter.com/iDxyzdgFDs

1 2

View Tweet activity

View all Tweet activity

Top mention earned 117 engagements

Satpal Shekhawat
@shekhawatgp · Jun 27

Thank you all for supporting our charity match, over £2k raised for **@alzheimerssoc** . Lovely photos from **@MariaElaineR** and congratulations to **@NHSNLaG** for their win. Thanks for the support **@ansaq @SinghVK78 @KSBCricket @ScunnyTownCC @HaribansalSingh** pic.twitter.com/UJ2U3MUDrq

3 2 31

JUN 2023 SUMMARY

Tweets	Tweet impressions
38	21.6K
Profile visits	**Mentions**
1,537	77

New followers

Top media Tweet earned 553 impressions

Know one of our amazing volunteers? Help recognise their efforts by putting them forward for our Volunteer of the Year Award, at Our Stars 2023. Both staff and patients can nominate: Staff nominate here:buff.ly/3N3AQiN Patients nominate here: buff.ly/3IQ97iZ pic.twitter.com/BSVCF45O18

2 2

Please note due to a technical issue on Twitter the May stats are currently unavailable

Social media

Facebook page

The Facebook post with the highest engagement was a celebration of International Nurses Day. Meanwhile a post on the Intensive Care Unit rehab garden reached nearly 17,000 people.

Performance

Add chart note

Engaged Users	Post Impressions	Reactions	Post Reach
46,733 ↗ 40%	663,434 ↗ 17%	9,085 ↗ 33%	304,569 ↗ 19%

Page & Post Engagements	Link Clicks	New Fans	Posts
91,872 ↗ 70%	2,679 ↗ 65%	105 ↘ 33%	156 ↘ 7%

Hashtag performance

Northern Lincolnshire and Goole NHS Foundation Trust

Add chart note

Rank	Hashtag	Posts	Average Reach ↓	Average Eng. Rate
1	#NHSjobs	1	10,608	22.08%
2	#EidMubarak	1	6,373	27.04%
3	#OurStars2023	1	4,487	10.97%
4	#ThankYouNHS	11	3,540	6.54%
5	#VolunteersWeek	5	2,961	12.51%

Post insights

Northern Lincolnshire and Goole NHS Foundation Trust

Add chart note

Showing 5 posts in total — Sorted by Impressions

May 12, 2023 03:45pm

Happy International Nurse's Day! A big thank you for all your hard work

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
7,246	386	22,789	15,435	33.63%	–

June 22, 2023 03:49pm

A garden to promote patient rehabilitation following critical illness will be unveiled next month. Volunteers have been working tirelessly over the last few months on the Intensive Therapy Unit ITU garden at Grimsby hospital. They've had donations from the Grimsby Hospital League of Friends and a relative of a form

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
974	156	16,876	16,167	6.78%	–

May 22, 2023 11:00am

We're re-introducing overnight stays for birth partners at Grimsby hospital from today Monday 22 May . On Honeysuckle, Blueberry, Jasmine and Holly wards only, we welcome overnight stays for birth partners in the following circumstances: • When established labour has begun regular contractions and a

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
1,151	87	16,227	14,129	8.51%	–

May 10, 2023 02:56pm

Mum-of-two Emma Land has been a proud member of our Scunthorpe Portering team for five years – in fact, you could say it's her dream job! We caught up with her during her busy shift at Scunthorpe's new Emergency Department to find out more about why she loves it so much. We're also looking for the per

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
1,960	386	10,887	10,608	22.08%	–

May 15, 2023 02:00pm

It was National Operating Department Practitioner ODP yesterday! Here's a big shout out to all our amazing ODPs who play such a vital role in helping us to deliver excellent patient care in our theatres.

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
2,627	144	10,257	9,026	27.20%	–

Trust website

External website – www.nlg.nhs.uk

The Trust remains in the top 20 of all NHS websites on the Silktide Web Accessibility Index which is a real accomplishment.
Key stats:

- 38,000 users, 417,000 events and 148,000 page views
- Average engagement time was 1 min 30
- 5366 forms submitted
- 350 file downloads
- Safari was the top browser used to access the site followed by Chrome. IOS was the top operating system followed by Android. 76% of users were mobile users
- Most visited page:ward visiting times followed by consultants were the top sections

The top three news releases viewed on the website were on the Scunthorpe Community Diagnostic Centre funding being approved, the joint chief executive appointment and the coming out of special measures announcement.

Enquiries, information requests and membership

General enquiries

The team receives general enquiries via a form on the Trust website. In this period 95 were received and dealt with. These can be anything from chasing appointments and results to providing feedback on services. For many of these the team act as a conduit for the Trust and filter them to other teams to deal with, but some are more complex and take more time.

Freedom of Information requests (FOIs)

Complex FOIs are continuing to require more time than in the past to pull together an appropriate response which meets the statutory requirements. There were 69 submitted in May – of these 63 are closed, 2 are still in progress and 4 are awaiting a response from the requester. There were 78 submitted in this period – of these 64 are closed, 10 are still in progress and 4 are awaiting a response from the requester.

Membership

The Summer edition of the Members' Newsletter had 1,429 opens.

Members survey – earlier this year we worked with Governors to send out a survey to 6341 members – 3,376 by email, 2,965 by post. Just 295 responses were received, a response rate of 4.5%. We gained 103 email addresses. The team are working with the Membership and Governor Working Group to take the findings forward. Members said they wanted to receive quarterly updates from the Trust. 51 people expressed an interest in volunteering with us and 140 in helping shape services for the future.

95
General enquiries dealt with

147
FOIs received

1,429
Opens of the Member newsletter

Social media

LinkedIn

Stats

1664 page views
595 unique visitors
816 reactions
17 comments
109 reposts

Content

A post on welcoming our international recruits was the most popular content.

You Tube

Stats

Views	Watch time (hours)	Subscribers
7.9K	195.9	+33

Content

Our top content continues to be one created by our Maternity services giving advice on bottle feeding. Instructional videos from Audiology also made it into the top five videos viewed

	Content	Average view duration	Views
1	Bottle feeding Jul 27, 2018	1:43 (27.2%)	1,925
2	Audiology - hearing aids - mould fit Apr 21, 2020	1:04 (30.1%)	1,088
3	Take a tour of our new Grimsby Emergency D... Sep 30, 2022	1:15 (23.1%)	509
4	Everything you need to know about parking Feb 7, 2023	1:33 (61.6%)	291
5	Audiology - hearing aids- fault finding Apr 21, 2020	3:12 (38.0%)	282

NLG(23)160

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1 August 2023	
Director Lead	Shaun Stacey, Interim 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 (June 2023 – NLG(23)122).	
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**
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Action Required

The Trust Board is asked to note the report.

NLG(23)161

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	1 August 2023	
Director Lead	Helen Harris, Director of Corporate Governance	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	**Trust Board Reporting Framework**	
Purpose of the Report and Executive Summary (to include recommendations)	To provide a scheduled of reports due at the Trust Board Meeting.	
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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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						
Executive Report Performance - Key Issues	F&PC	Chief Operating Officer	Bi-monthly	Noting						
Q&SC Highlight Report & Board Challenge	Q&SC	NED Chair of Q&SC	Bi-Monthly	Assurance						
Executive Report Quality and Safety - Key Issues	WC	Chief Medical Officer and Chief Nurse	Bi-monthly	Noting						
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						
Executive Report Workforce - Key Issues	WC	Director of People	Bi-monthly	Noting						
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-	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 views of individuals and organisations to whom this guidance will apply to ensure that it is helpful. To monitor	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 T&Cs	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			
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	

NLG(23)162

Name of the Meeting	**Trust Board**
Date of the Meeting	1 August 2023
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Statutory COVID-19 Inquiry Preparation and Update**
Purpose of the Report and Executive Summary (to include recommendations)	To provide an update on the progress of the UK COVID-19 Inquiry and how this will impact the Trust. The Trust Board is asked to: a) note the report was received by the Trust Management Board at its meeting on 5 June 2023 and the report was recommended to the Trust Board to provide oversight and assurance, b) receive and note the Statutory COVID-19 Inquiry Preparation report.
Background Information and/or Supporting Document(s) (if applicable)	COVID-19 Inquiry Terms of Reference UK Covid-19 Inquiry (covid19.public-inquiry.uk)
Prior Approval Process	✓ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance ✓ Information ☐ Review ☐ Other: Click here to enter text.

***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

Statutory Covid-19 Inquiry Preparation and Update

Helen Harris, Director of Corporate Governance

June 2023

CONTENTS **PAGE**

1. Executive Summary

1.1. Baroness Heather Hallett officially launched the Inquiry on 21 July 2022 and opened its first investigation into how well the UK was prepared for a pandemic, examine the UK's response to and impact of the Covid-19 pandemic; and learn lessons for the future.

1.2. The Covid-19 Inquiry held its first procedural hearing related to Module 3 on 28 February 2023 where the Inquiry heard from 36 Core Participants, which included NHS England (NHSE). Module 3 will include consideration of the healthcare consequences of how the governments and the public responded to the pandemic.

1.3. The Inquiry is currently evidence gathering and issuing Rule 9 Requests. Further information can be reviewed in Appendix 1 as to the scope of Module 3. Substantive hearings on Module 3 will commence in 2024.

1.4. The Trust Management Board received an update at its meeting on 5 June 2023, 7 November 2022 and 2 August 2021.

2. Strategic Objectives

2.1 The report does not directly link to the Trust's Strategic Objectives.

3. Introduction and Background

3.1. Baroness Heather Hallett officially launched the Inquiry on 21 July 2022 and opened its first investigation into how well the UK was prepared for a pandemic, examine the UK's response to and impact of the Covid-19 pandemic; and learn lessons for the future.

4. Current Status

4.1. Module 3: Investigate the Impact of COVID and governmental and societal responses to it on healthcare system, including patients, hospital and other healthcare workers, and staff.

4.1.1. NHSE as a Core Participant is representing English NHS bodies, but was clear that it "cannot speak directly on behalf of individual healthcare providers, nor on behalf of their employers" and "as a national body, NHSE cannot account fully for the diversity of actions and limitation taken at provider level in response to the pandemic – not indeed comprehensively account for the actions, decisions and experiences of their staff."

4.1.2. Themes emerging from the scope of module 3 are: unequal impact of the pandemic and looking at structural racism, Rule 9 requests and relationship with other modules and how the overlap will be managed.

4.1.3. The Voice of the NHS Workforce and How it Will be Heard

There will be a listening exercise: Every Story Matters, which will inform the Inquiry about personal stories and experiences, through targeted face to face sessions.

Any Rule 9 response should reflect the workforce experience, have a Well-Being Guardian available should any matters arise, signpost staff to information and support, preparing for possible sickness absence and reinforcing the positives of the Inquiry.

4.1.4. Witness Statements

If the Trust is required to prepare a witness statement, the COVID Team and Legal Services Provider will provide support. When responding to Rule 9 questions, the Trust will be expected to use the Inquiry Teams headings and the Trust will have to make clear what is from memory and what is based on supporting evidence, and to be factual.

4.1.5. Rule 9 Requests

The Trust will sometimes have short time periods to respond to the Inquiry and appropriate resourcing will need to be made available. When providing a statement and collating evidence, the Trust must state whose document and whose decision it was. If the documentation was produced by Department of Health and Social Care (DHSC), NHSE etc, then it won't be relevant to the Inquiry.

The Trust has a duty of candour, to be open and transparent, reflective and demonstrate learning.

Providing data to national bodies will be subject to their powers under legislation ie. NHS Act 2006, Inquiries Act 2005, Inquiry Rules 2006 and UK General Data Protection Regulations (GDPR) / Data Protection Act (DPA) 2018; and FOI Act 2000.

[As per the Inquiries Act 2005, Chapter 7, Inquiry Procedure, Rule 9: Written Statements:

> 255. Rule 9 provides that the inquiry panel must send a written request for a written statement to any person from whom the inquiry proposes to take evidence. It does not allow the inquiry itself to take statements from witnesses.

4.1.6. Level of Involvement

The level of involvement by individual Trusts is unlikely to happen. It is expected that if a Trust is an outlier, they may be asked to participate or be asked for evidence on a particular matter. The Inquiry team will direct the scope of disclosure that is required, however, the Trust can ask more specifics if unsure of the request.

4.1.7. Reporting from the Inquiry Team

Interim reports with analysis, findings and recommendations will be delivered whilst the Inquiry's investigations are ongoing, so that key lessons from the pandemic are learned quickly and implemented promptly by all organisations.

4.1.8. Media Issues

The Trust must avoid comment in the media on issues the Inquiry will be covering, but must continue to deal with investigations and duty of candour to patients / families as usual.

4.1.9. Record Keeping

- A public inquiry is an exercise in trying to uncover what happened in relation to a particular incident or event of serious public concern, scrutinising past decisions and actions Covid Inquiry is looking at events that took place in the recent past, contrast with other inquiries which have looked at events which took place some time ago.
- The Inquiry is not just interested in formal records but anything which reveals thinking of a decision-maker.
- It is important to have an accurate record of actions taken.

4.1.10. Freedom of Information Requests

If the Trust receives a Freedom of Information (FOI) request for information that has been prepared for the Inquiry, then it is the Inquiries document and cannot be shared at that time. Each FOI request should be reviewed on an individual basis by Trust Management.

4.2. Lessons Learned from Previous Inquiries

- The need to properly resource the response team
- Ensure clear Board oversight
- Consider the reputational aspects – be open in a response
- Be prepared for civil claims or criminal investigations
- Consider the human impact on patients, staff and the public
- Keep clear corporate logs on engagement and evidence.

5. Implications / Impact

5.1. Medical Gas Pipeline

It is possible that the Inquiry will seek further information, perhaps via a rule 9 statement or disclosure (eg. Reports), however the fact that the reports concluded that no patients were harmed means that it is unlikely to be a focus for hearings unless it would be part of a broader pattern.

5.2. Risks / Issues

i. Not properly resourcing the team could risk the Trust not being responsive to the Inquiry, leading to reputational damage
ii. Potential civil claims or criminal investigations
iii. Serious action taken either by organisation or a professional regulator resulting in increased scrutiny which could arise if an individual makes a referral because a family member came to harm
iv. Individual cases of care could be referred to a regulator
v. Destroying records when the Trust has been instructed not to
vi. Staff shortages due to sickness / holiday
vii. Covid-19 future wave
viii. Not understanding the requests and preparing poorly written statements resulting in criticisms

ix. Local decisions not aligning with national decisions
x. Media enquiries and increase in freedom of information requests.

6. Recommendations

The Trust Board is asked to:

c) note the report was received by the Trust Management Board at its meeting on 5 June 2023 and the report was recommended to the Trust Board to provide oversight and assurance,

d) receive and note the Statutory COVID-19 Inquiry Preparation report.

Compiled By: Helen Harris, Director of Corporate Governance
Date: June 2023
Version: Final

Appendix 1 - Module 3 Provisional Scope

This module will consider the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland. This will include consideration of the healthcare consequences of how the governments and the public responded to the pandemic. It will examine the capacity of healthcare systems to respond to a pandemic and how this evolved during the Covid-19 pandemic. It will consider the primary, secondary and tertiary healthcare sectors and services and people's experience of healthcare during the pandemic, including through illustrative accounts. It will also examine healthcare-related inequalities (such as in relation to death rates, PPE and oximeters), with further detailed consideration in a separate designated module. In particular, this module will examine:

1. The impact of Covid-19 on people's experience of healthcare.

2. Core decision-making and leadership within healthcare systems during the pandemic.

3. Staffing levels and critical care capacity, the establishment and use of Nightingale hospitals and the use of private hospitals.

4. 111, 999 and ambulance services, GP surgeries and hospitals and crosssectional co-operation between services.

5. Healthcare provision and treatment for patients with Covid-19, healthcare systems' response to clinical trials and research during the pandemic. The allocation of staff and resources. The impact on those requiring care for reasons other than Covid-19. Quality of treatment for Covid-19 and non-Covid-19 patients, delays in treatment, waiting lists and people not seeking or receiving treatment. Palliative care. The discharge of patients from hospital.

6. Decision-making about the nature of healthcare to be provided for patients with Covid-19, its escalation and the provision of cardiopulmonary resuscitation, including the use of do not attempt cardiopulmonary resuscitation instructions (DNACPRs).

7. The impact of the pandemic on doctors, nurses and other healthcare staff, including on those in training and specific groups of healthcare workers (for example by reference to ethnic background). Availability of healthcare staff. The NHS surcharge for non-UK healthcare staff and the decision to remove the surcharge.

8. Preventing the spread of Covid-19 within healthcare settings, including infection control, the adequacy of PPE and rules about visiting those in hospital.

9. Communication with patients with Covid-19 and their loved ones about patients' condition and treatment, including discussions about DNACPRs.

10. Deaths caused by the Covid-19 pandemic, in terms of the numbers, classification and recording of deaths, including the impact on specific groups of healthcare workers, for example by reference to ethnic background and geographical location.

11. Shielding and the impact on the clinically vulnerable (including those referred to as "clinically extremely vulnerable").

12. Characterisation and identification of Post-Covid Condition (including the condition referred to as long Covid) and its diagnosis and treatment.
(Reference: www.covid19.public-inquiry.uk)

NLG(23)169

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	1 August 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 (ARG) Annual Report 2022/23**
Purpose of the Report and Executive Summary (to include recommendations)	The annual report summarises the key work of the Audit, Risk and Governance Committee during 2022/23. It contains details of membership and attendance at each meeting throughout the year, the principal areas of review undertaken by the Committee in terms of governance, risk management and internal control. Appendix 1 details attendees at meetings, either members, regular attendees or ad-hoc attendees. Appendix 2 is the Committee's annual rolling work plan for 2023/24. This report is presented to both the Trust Board and the Council of Governors for information. The Trust Board is asked to note the annual report from the Audit, Risk and Governance Committee.
Background Information and/or Supporting Document(s) (if applicable)	Healthcare Financial Management Association (HFMA) Audit Committee Handbook 2018
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: July 2023 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.

Northern Lincolnshire and Goole NHS Foundation Trust

AUDIT, RISK AND GOVERNANCE COMMITTEE

ANNUAL REPORT

FOR THE YEAR ENDED 31 MARCH 2023

Simon Parkes – Non-Executive Director
Chair of Audit, Risk and Governance Committee

20 July 2023

1. Introduction and Purpose of the Report

The Audit, Risk and Governance Committee of Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) is established under Trust Board delegation with approved terms of reference that are aligned with the latest Audit Committee Handbook (2018), as published by the Healthcare Financial Management Association (HFMA) in association with the Department of Health and Social Care.

The Audit, Risk and Governance Committee independently reviews, monitors and reports to the Board on the effectiveness of control systems and financial reporting processes.

This report sets out how the Committee has satisfied its terms of reference during 2022/23 and provides the Board with assurance to underpin its responsibilities for the Annual Governance Statement (AGS).

2. Terms of Reference

The Membership and Terms of Reference for the Committee are subject to regular review and revision as necessary, most recently in February 2023. The April 2023 Trust Board subsequently ratified the revised terms of reference for a further year. The terms of reference will be reviewed again during 2023/24 in line with the Committee's annual work plan to consider whether they remain fit for purpose, and also to consider any necessary adjustments to reflect the Group Model being implemented with the arrival of the new Group Chief Executive in August 2023.

The HFMA has also advised that they will be re-issuing the NHS Audit Committee Handbook during 2023, therefore once published it will be reviewed against the existing terms of reference and adjustments made as necessary to reflect latest best practice.

The Committee also revisited and re-approved adjustments to its rolling 2022/23 annual work plan during the year.

As part of the Committee's regular review of its own governance arrangements, it undertook a self-assessment exercise in February 2023 using the latest HFMA NHS Audit Committee Handbook self-assessment checklist. This exercise did not identify any gaps in the Committee's processes or terms of reference. The results of this latest exercise were submitted to the Trust Board for information in April 2023.

3. Membership and Attendance

The Committee consists of three non-executive directors (NEDs), of which two must be present at a meeting of the Committee for it to be quorate. The Committee has been chaired by Simon Parkes, NED, since October 2021. NED members during the year were Michael Whitworth, Vice Chair (last meeting before leaving the Trust - July 2022), Gill Ponder (Vice Chair from November 2022) and Kate Truscott (first meeting November 2022). There is cross NED membership with other Trust Board sub-committees.

The Committee continued to meet virtually via MS Teams throughout 2022/23, with this format continuing to work well, having been adopted at the on-set of the Covid-19 pandemic in 2020. It allows for ad-hoc attendees to dial in only for their item in line with their allocated time slot, meaning more efficient use of their time.

The Committee met on five occasions during 2022/23 - four full meetings plus an additional meeting for the audited accounts 2021/22 to be approved under delegated authority from the

Trust Board. The Committee has discharged its responsibilities for scrutinising risks and controls that affect all aspects of the Trust's business.

A record of attendance by Committee members and regular attendees is provided at **Appendix 1**. The record once again shows excellent attendance from both core members and regular attendees, with a good cross section of other officers attending on an ad-hoc basis to provide assurance to the Committee on various matters as and when necessary.

4. Principal Review Areas

4.1 Governance, Risk Management and Internal Control

The Committee would normally review relevant disclosure statements for the year, in particular the Annual Governance Statement (AGS), the Head of Internal Audit Opinion (HoIAO), the External Audit opinion, the Trust's Annual Report and other appropriate independent assurances. However, although the Committee has reviewed the draft AGS and the final version of the HoIAO for 2022/23, as a result of the difficulties appointing a new External Auditor the year-end financial statements and associated annual documents are not yet complete. These will all be completed however by December 2023, in line with a revised submission deadline agreed with NHSE as part of the External Auditor appointment process. Further details on this can be found in section 4.4 of this report.

The Committee received regular reports during the year on the Trust's Board Assurance Framework and Strategic Risk Register (BAF/SRR). The Committee also reviewed and commented on certain risks and their associated scores contained within it.

4.2 Internal Audit

The Trust's internal audit service is provided by Audit Yorkshire, who commenced in June 2018 with a contract for a period of three years, with the option to extend for a fourth and final year which was subsequently taken up following approval by the Committee. A further competitive procurement exercise commenced in January 2022 to award a new contract commencing 1 June 2022. Audit Yorkshire were successful in being awarded a new three year contract with the Trust, commencing with the 2022/23 financial year, with the option to extend for a fourth and final year. An agreed Internal Audit Charter is in place with Audit Yorkshire.

The Committee received the Annual Internal Audit Report for 2021/22 from its internal auditors at its June 2022 meeting.

An internal audit plan was considered and agreed for 2022/23 at the April 2022 meeting of the Committee. As in previous years, the Committee sought to work effectively with Internal Audit throughout the year to review, assess and develop internal control processes as necessary. The Committee reviewed progress against the agreed internal audit work plan for 2022/23 via routine written progress reports from its internal auditor at each meeting, at which an internal audit representative was always present. Written progress reports outline the status of the planned audit work for the year and the outcome of individual reviews performed, along with associated recommendations where appropriate.

During 2022/23 Internal Audit completed 20 reviews plus the Board Assurance Self-Certification presentation, of which 3 were pieces of advisory/benchmarking work and an assurance rating not applied. Assurance ratings, as to the adequacy and effectiveness of control arrangements in place, for the remaining 18 reviews were as follows:

- 1 review with High Assurance rating;
- 11 reviews with Significant Assurance rating;
- 6 reviews with Limited Assurance rating;
- 0 with Low Assurance rating.

The 2022/23 Head of Internal Audit Opinion was also received by the Committee which was as follows: ***The overall opinion for the 2022/23 reporting period provides Significant Assurance, that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently*.** The 2022/23 HoIAO is included within the AGS, which forms part of the publicly available Trust Annual Report.

The Trust also formulated its annual internal audit plan for 2023/24. The Executive Team provided individual suggestions for the plan and these were then discussed further collectively and refined into a programme of audits for the forthcoming year, in line with the allotted 200 day annual internal audit plan. The proposed internal audit plan for 2023/24 was presented to the April 2023 meeting of the Committee for consideration and duly approved.

Audit Yorkshire operates an electronic follow-up process for all recommendations made, which involves the relevant managers receiving automated prompts to provide periodic updates and evidence, via the electronic system, on the implementation status of recommendations, including those considered to be closed. A routine report is prepared by Audit Yorkshire to show the status of recommendations made, and this is presented to each meeting of the Committee for assurance or the consideration of further action as appropriate. Long overdue recommendations were a source of concern for the Committee during 2021/22 and escalated the issue to the Executive Team and the Trust Board. A much improved position was reported to the Committee by Internal Audit at the June 2022 meeting and a positive position has been maintained throughout 2022/23. The Committee will continue to routinely monitor the implementation of audit recommendations over the coming year and address any concerns relating to lack of progress if the need arises.

4.3 Counter Fraud

The Audit, Risk and Governance Committee continued to receive regular written progress reports from the Trust's Local Counter Fraud Specialist (LCFS) throughout the year. Additionally, the Annual Counter Fraud Report for 2021/22 and the Annual Counter Fraud Operational Plan for 2022/23 were also submitted to the Committee during the reporting year.

The LCFS continued working to develop a strong anti-fraud culture, whilst at the same time investigating allegations of fraud to a criminal standard. The LCFS also continued to liaise effectively with the Trust's Human Resources team with a view to applying appropriate internal disciplinary and sanctions as necessary. The Committee remained pleased by the level of counter fraud activities performed by the LCFS over the reporting year, particularly the introduction of mandatory fraud awareness eLearning for all staff every three years. This was only introduced in mid-January 2023 but by the end of June 2023 had reached 87% compliance.

The Trust continues to host and manage an in-house counter fraud collaborative, known as Counter Fraud Plus (CFP) between itself, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust, Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Community Health Services NHS Trust (LCHS). This collaborative arrangement commenced in July 2013 (with LPFT and LCHS joining in September 2020) under a formal SLA arrangement. It is designed to provide a more resilient

counter fraud service between the organisations involved. The Committee has received reports that the collaborative continues to work effectively and successfully across all five local organisations. Hull University Teaching Hospitals NHS Trust became a new addition to the in-house counter fraud collaborative from April 2023.

4.4 External Audit

The Trust appointed its former External Auditor, Mazars, in September 2019 following a competitive tendering exercise. The Committee duly supported the Council of Governors with the appointment process. The contract was for a term of three years, with the option to extend for a further year, and commenced with the audit of the Trust's financial statements for 2019/20. At the beginning of 2022, the extension option was duly being considered and a fee for the extension year was requested in order to allow the February 2022 meeting of the Committee to make an informed decision on recommending the option year be taken up, to the Council of Governors.

However, upon requesting details of the fee Mazars advised it may not be able to resource and deliver the 2022/23 financial statements audit following a number of retirements and other staff losses within the firm and felt it only right and proper to inform the Trust of this potential risk to delivery should the extension year be taken up [by the Trust]. To mitigate that risk, the Trust considered it necessary to retender the External Audit service, a position endorsed by the Committee and approved by the Council of Governors in April 2022.

A tender process duly commenced in early July 2022 (once potential External Audit service providers had concluded their busiest period of NHS year end work) with a view to securing a new External Auditor by Autumn 2022, commencing with work on the 2022/23 public disclosure statements. As in previous tender exercises for external audit services, a sub-committee of the Council of Governors was convened supported by appropriate advisors from the Audit, Risk and Governance Committee and members of the Finance and Procurement team.

The initial tender exercise commenced in July 2022 but no bids were received. Although disappointing, this was not entirely unexpected as it was known that other Trusts were encountering difficulties in securing the services of an External Auditor as a result of issues in the External Audit market. A second tender exercise commenced in October 2022 and one bid was received and following evaluation by the Council of Governors (CoG) sub-group and approval from the full CoG, the contract was awarded in December 2022. However, shortly after the award was made the firm involved withdrew citing that the Trust was likely to be over the £500m threshold for falling under the regulation of the Financial Reporting Council and their audit quality review team. The firm advised that as they did not yet have any NHS clients that fell within this additional audit regime their Board would not take this on for one client as they did not have the infrastructure in place to deal with it.

The Chief Financial Officer therefore contacted NHS England (NHSE) in December 2022 to advise them of the difficulties and position with securing an External Auditor for the audit of the 2022/23 accounts and seek their advice on next steps. NHSE then reached out to possible suppliers on behalf of the Trust with the offer of an extended submission deadline for the audited accounts. NHSE eventually introduced the Trust to ASM Chartered Accountants based in Belfast, Northern Ireland and an initial discussion took place with ASM in May 2023. ASM provided their fee offer and confirmed in writing that they could meet the Trusts requirements as set out in the tender specification. A paper was duly prepared for the Council of Governors and at its meeting on 22 June 2023 they approved the appointment of ASM as

the Trust's new External Auditor. The contract was awarded on a contract term of 3+1+1 years.

As a result of the difficulties and resulting delay in appointing an External Auditor NHSE agreed to extended accounts submission deadlines, namely 31 December 2023 for the 2022/23 audit and 23 August 2024 for the 2023/24 audit. Future years will revert to scheduled NHSE submission deadlines. Timings for the audits will therefore be as follows:

2022-23

- Planning visits – to be agreed when contract is progressed (i.e., as soon as practically possible).
- Interim – w/c 25 September 2023 for one week
- Fieldwork – w/c 16 October 2023 for 4 weeks (with one week follow up)
- Completion – First week of December 2023
- Submission to NHSE – by 31 December 2023

2023-24

- Planning visits – December 2023 / January 2024
- Interim – February / March 2024
- Fieldwork – commencing mid-June 2024 for 4 weeks (with one week follow up)
- Completion – w/c 19 August 2024
- Submission to NHSE – by 23 August 2024

The Trust's former External Auditor (Mazars) attended meetings of the Committee in April, June and July 2022 in connection with their audit of the 2021/22 financial statements. They also attended the Annual Members Meeting in September 2022 following the conclusion of their audit work. Oral or written progress reports are received from the Trust's External Auditor at Committee meetings, including the audit opinion on the Trust's annual financial statements. However, there was no External Auditor presence at the remainder of meetings for 2022/23 as shown in Appendix 1.

During the year a private meeting with both the external and internal auditors took place before the June 2022 meeting of the Committee, and no matters of concern were raised. However, in line with its Terms of Reference, there is an open offer to all parties (the Trust, external auditors and internal auditors) to request a private meeting at any time.

The Committee also formally considered the performance of the Trust's External Auditor at its July 2022 meeting following the conclusion of their year-end accounts work. No issues of concern were identified as part of the evaluation.

In line with Regulator guidance, the Trust has a '*Policy for Engagement of External Auditors for Non-Audit Work*' to avoid any potential conflicts of interest, either real or perceived, in terms of the objectivity of their opinion on the financial statements of the Trust. The policy, which can be found on the documents section of the Trust intranet, is subject to annual review and minor revisions were duly considered and approved by the Committee at its February 2023 meeting. The revisions related to the latest release of the Code of Governance for NHS Provider Trusts and the latest Auditor Guidance Note (AGN) 1 reflecting the creation of Integrated Care Boards and Integrated Care Partnerships. The value of non-audit services is routinely disclosed in the Trust's accounts, however there was no such work performed by Mazars during 2022/23.

5. Financial Reporting

At its April and June 2022 meetings the Committee reviewed the draft and audited annual financial statements for 2021/22 before submission to the External Auditor and NHS England, and we understand these were in agreement with our accounting records and the current Regulatory requirements.

Prior to the preparation of the 2022/23 financial statements, the Committee reviewed and agreed the detailed accounting principles at its February 2023 meeting. The Committee also reviewed the draft annual accounts for 2022/23 at its April 2023 meeting, prior to the anticipated submission of this report to the August 2023 Trust Board meeting.

At the April 2023 Committee meeting the issue of 'Going Concern' status was discussed. As a result, the Committee endorsed the view that the Trust is a going concern for the purposes of the annual accounting exercise. This will also be discussed with the new External Auditor as part of their audit work.

Given the difficulties appointing an External Auditor, as referred to earlier, there is an extended timescale for the audit of the 2022/23 draft accounts and associated disclosure documents and their submission to NHSE, etc. The Committee have therefore yet to receive the audited financial statements for 2022/23 (which under normal circumstances would have been received at a meeting of the Committee in June 2023 in line with formal delegated authority given by the Board in February 2023). The Committee will oversee the completion of the 2022/23 process in the coming months, in line with the revised timetable.

6. Management Reports

The Committee has requested and reviewed various management assurance reports from a range of Directors and managers within the organisation in relation to relevant areas of enquiry during the financial year 2022/23. We thank all those who assisted the Committee in these matters.

7. Other Matters Worthy of Note

The Committee followed its agreed annual work plan throughout the year and received regular reports including Waiving of Standing Orders; Losses and Compensations; Hospitality and Sponsorship declarations; Salary Overpayments; and Document Control. Additional information is called for as appropriate. The Committee once again received the Local Security Management Specialist (LSMS) work plan and annual report for information and assurance.

Throughout the year the Committee also received the highlight reports and action logs from the Trust's main assurance Trust Board sub-committees in order to assess the effectiveness of the Trust's governance arrangements.

Minutes of the Committee's meetings and a Chair's Highlight Report of matters to be escalated are submitted to the Trust Board for information, assurance or decision as necessary.

The Committee members would like to place on record their thanks to the Trust's former External Auditors (Mazars), Internal Auditors (Audit Yorkshire), and our in-house counter-fraud service. All have provided a professional and effective service throughout another challenging year during 2022/23.

8. Conclusion and Plans for 2023/24

The Audit, Risk and Governance Committee's latest refreshed annual rolling work plan for 2023/24 is attached at **Appendix 2**. It will be adjusted accordingly to reflect the requirement to receive the audited accounts and associated public disclosure documents in line with the delayed timetable for 2022/23. The Committee will work with the new External Auditor (ASM) to ensure the production of the audited accounts for 2022/23 is completed efficiently and effectively and meets the extended timescale agreed with NHSE, as set out in section 4.4.

The Committee will remain active in reviewing the risks, internal controls, reports of auditors and audit recommendations and will continue to press for action and improvements where required throughout the coming year.

The Council of Governors will also receive a copy of this annual report and work plan.

Appendix 1 - Schedule of Attendance at Audit Committee meetings during 2022/23

Member / Attendee	Apr-22	Jun-22	Jul-22	Nov-22	Feb-23
Members:					
Simon Parkes – NED / Chair	Y	Y	Y	Y	Y
Michael Whitworth – NED / Deputy Chair	Y	N	Y[1]	-	-
Gill Ponder – NED	Y	Y	Y	Y	Y
Kate Truscott – NED (from November 2022)	-	-	-	Y	Y
Regular Attendees:					
Lee Bond – Chief Financial Officer	Y	Y	N	N	Y
Helen Harris – Director of Corporate Governance	N[2]	N	Y	Y	Y
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	Y	Y	Y	Y	Y
Nicki Foley – Local Counter Fraud Specialist	Y	N[3]	Y	Y	Y
Data Protection Officer and Lead for IT (SM)	Y	N[3]	Y	Y	Y
Head of Procurement (IP)	Y	N[3]	Y	Y	Y
Internal Audit (Audit Yorkshire)	Y	Y	Y	Y	Y
External Audit (Mazars)	Y	Y	Y[4]	-	-
Deputy Lead Governor (RP)	Y	Y	N	Y	N[5]
Ad-hoc Attendees:					
Assistant Director of Corporate Governance (AH)	Y[2]	-	-	-	-
Asst. DoF – Process & Control (NP)	Y	Y	-	-	Y
Director of Estates & Facilities (JJ)	Y	-	-	-	-
Deputy Director of Estates & Facilities (ST)	-	-	-	Y	-
Associate Director of Safety & Statutory Compliance (BP)	Y	-	Y	-	-
CEO (PR)	-	Y	-	-	-
Associate Director of Communications & Engagement (AB)	-	Y	-	-	-
Associate Director of Central Operations (MO)	-	-	Y	-	-
Associate Director of Pathology (MC)	-	-	Y	Y	Y

Member / Attendee	Apr-22	Jun-22	Jul-22	Nov-22	Feb-23
Ad-hoc Attendees continued…					
Associate Director of Quality Governance (AL)	-	-	**Y**	-	-
Associate Director of IM&T (SM)	-	-	**Y**	-	-
IT Data Security Manager (TF)	-	-	**Y**	-	-
Director of People (CB)	-	-	**Y**	-	-
Deputy Medical Director (KS)	-	-	-	**Y**	-
Freedom to Speak Up Guardian (LH)	-	-	-	-	**Y**
Emergency Planning Manager (AL)	-	-	-	-	**Y**

Notes:

[1] Last meeting before leaving the Trust
[2] Alison Hurley attended to deputise for Helen Harris
[3] Not required to attend, Final Accounts meeting only
[4] Last meeting as Trust's External Auditor (Mazars)
[5] Ian Reekie attended in the absence of Rob Pickersgill

APPENDIX 2 - AUDIT, RISK AND GOVERNANCE COMMITTEE - 12 MONTH ROLLING WORK PLAN

Item of Business		Jul 23	Nov 23	Feb 24	Apr 24	Jun/Aug 24 (Public Disclosure Statements meeting)
Audit Committee - Annual Review of Terms of Reference				X		
Audit Committee - Annual Review of Work Plan				X		
Audit Committee - Annual Self-Assessment Exercise & Results				X		
Audit Committee - Annual Report to Trust Board / CoG						X
Audit Committee - Annual meeting dates/times/locations		X				
Audit Committee - Annual Review of External Auditor Performance		X				
Private Discussion with Auditors (internal and external)		as needed	X	as needed	as needed	X
Receive highlight reports & action logs from Board Sub-committees (excl. RATS)		X	X	X	X	
Receive annual summary report of business from RATS Committee					X	
New from April 2020 – Any Covid-19 ARGC Related Business		as needed	as needed	as needed	as needed	as needed
External Audit – Audit Strategy Memorandum (Audit Plan / Timetable / Fees)		TBA		X		
External Audit - Routine Progress Reports		X	X	X	X	X
External Audit - Audit Completion Report & Letter of Representation		TBA				X
External Audit – Auditor's Annual Report		TBA				
External Audit – Changes to service provider (supporting Council of Governors)		as needed	as needed	as needed	as needed	
Internal Audit - Annual Internal Audit Plan				X	X (If needed)	
Internal Audit - Routine Progress Report		X	X	X	X	
Internal Audit - Head of Internal Audit Opinion					X (Draft)	X (Final)
Internal Audit - Annual Report (inc. client feedback survey results)						X
Internal Audit - Receive Status Report on Implementation of IA Recommendations		X	X	X	X	X
Internal Audit – Changes to service provider		as needed	as needed	as needed	as needed	
Public Disclosure Statements: Review changes to Accounting Policies				X		
Going Concern Report					X	
Draft annual accounts and VFM conclusion					X	
Annual Governance Statement					X (Draft)	X (Final)
Audited annual accounts & Trust Annual Report (under TB delegated authority)			X			X

Item of Business		Jul 23	Nov 23	Feb 24	Apr 24	Jun/Aug 24 (Public Disclosure Statements meeting)
LCFS - Annual Counter Fraud Operational Plan					X	
LCFS - Annual Counter Fraud Report		X				
LCFS - Written Progress Reports		X	X	X	X	
LCFS - Concluding investigation reports / related issues		as needed	as needed	as needed	as needed	
LCFS - Annual review of Fraud and Corruption Policy					X	
LCFS - Results of Staff Fraud Awareness Survey - every 2 years		X				
LSMS - Annual Security Management Report		X				
LSMS - Annual Security Management Work Plan					X	
LSMS - Ad-hoc reports and updates		as needed	as needed	as needed	as needed	
Review of Waiving of Standing Orders		X	X	X	X	
Review of Losses and Compensations			X		X	
Review of Standards of Business Conduct Declarations			X		X	
Review of Salary Overpayments & Underpayments			X		X	
Review of Procurement KPI data inc. Invoices without PO's and Contracts Update			X			
Review of finance related policies (Standing Financial Instructions (SFIs) / Standing Orders / Scheme of Delegation, Recovery of Salary Overpayments Policy, Standards of Business Conduct Policy, etc.)		as needed	as needed	as needed	as needed	
Annual Review of Policy for Engagement of External Auditors for Non-Audit Work				X		
Board Assurance Framework (BAF) and Risk Register report		X (Q1)	X (Q2)	X (Q3)		X (Q4)
Review of Assurance Sub-Committees' Conduct of Risk Oversight		X	X	X	X	
Annual Review of Risk Management Strategy / Development Plan Progress Report		X				
Annual Review of Trust's freedom to speak up arrangements / FTSU Guardian				X		
Annual IG Toolkit Return		X				
IG Steering Group Highlight reports - quarterly		X	X	X	X	
Document Control report			X		X	

Item of Business		Jul 23	Nov 23	Feb 24	Apr 24	Jun/Aug 24 (Public Disclosure Statements meeting)
Annual Health and Safety Policy Statement					X	
Annual Emergency Preparedness, Resilience and Business Continuity Report inc. medical gas testing oversight		X				
Clinical Audit Annual Work Plan		X				
Review of Data Quality Dimensions (*new item from HFMA checklist 2018*)		as needed	as needed	as needed	as needed	as needed
New HFMA NHS Audit Committee Handbook Items – July 2018						
Cyber security – Review the Trust's information governance and cyber security arrangements annually *(Private agenda item)*		X	as needed	as needed	as needed	as needed
Mergers and acquisitions – review new arrangements		as needed	as needed	as needed	as needed	as needed
Working with regulators - oversee action plans relating to regulatory requirements (e.g. NHS oversight framework; use of resources)		as needed	as needed	as needed	as needed	as needed
Working at Scale – oversee developing partnership arrangements (e.g. integrated care systems)		as needed	as needed	as needed	as needed	as needed