Northern Lincolnshire and Goole NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD

Tuesday, 7 February 2023
In the Main Boardroom, DPOWH
Time – 9.00 am – 1.00 pm
(Lunch – 1.00 pm – 1.30 pm)
For the purpose of transacting the business set out below

		Note / Approve	Time	Ref
1.	**Introduction**			
1.1	**Chair's Opening Remarks** Sean Lyons, Chair	Note	09:00 hrs	Verbal
1.2	**Apologies for Absence** Sean Lyons, Chair	Note		Verbal
1.3	**Patients' Story and Reflection** Jo Loughborough, Senior Nurse – Patient Experience	Note		Verbal
2.	**Business Items**			
2.1	**Declarations of Interest** Sean Lyons, Chair	Note	09:25 hrs	Verbal
2.1.2	**Fit & Proper Persons Annual Declaration** Alison Hurley, Assistant Trust Secretary	Note		NLG(23)004 Attached
2.2	**To approve the minutes of the Public meeting held on Tuesday, 6 December 2022** Sean Lyons, Chair	Approve		NLG(23)005 Attached
2.3	**Urgent Matters Arising** Sean Lyons, Chair	Note		Verbal
2.4	**Trust Board Action Log – Public** Sean Lyons, Chair	Note		NLG(23)006 Attached
2.5	**Chief Executive's Briefing** Dr Peter Reading, Chief Executive	Note	09:35 hrs	NLG(23)007 Attached
2.6	**Integrated Performance Report (IPR)**	Note		NLG(23)008 Attached
3.	**Strategic Objective 1 – To Give Great Care**			
3.1	**Quality & Safety Report – Key Issues** Ellie Monkhouse, Chief Nurse & Mr Kishore Sasapu, Deputy Medical Director	Note	09:45 hrs	NLG(23)008 Attached

3.2	**Quality & Safety Committee Highlight Report and Board Challenge** Fiona Osborne, Non-Executive Director & Chair of the Quality & Safety Committee	Note	09:55 hrs	NLG(23)009 Attached
3.3	**Maternity / Ockenden Update** Jane Warner, Associate Chief Nurse Midwifery	Note	10:00 hrs	NLG(23)010 Attached
3.4	**Neonates, Children & Young People's Strategy** Debbie Bray, Associate Chief Nurse, Family Services	Approve	10:10 hrs	NLG(23)011 Attached
3.5	**Executive Report – Digital** Shauna McMahon, Chief Information Officer	Note	10:20 hrs	NLG(23)012 Attached
3.6	**Performance Report – Key Issues including** • Waiting Lists • Mutual Aid Shaun Stacey, Chief Operating Officer	Note	10:30 hrs	NLG(23)008 Attached
3.7	**Finance & Performance Committee Highlight Report and Board Challenge – Performance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	10:55 hrs	NLG(23)013 Attached
BREAK – 11:00 hrs – 11:10 hrs				
4.	**Strategic Objective 2 – To Be a Good Employer**			
4.1	**Workforce Report – Key Issues** Simon Nearney, Interim Director of People	Note	11:10 hrs	NLG(23)008 Attached
4.2	**Gender Pay Gap Report** Simon Nearney, Interim Director of People	Approve	11:20 hrs	NLG(23)014 Attached
4.3	**Freedom to Speak Up (FTSU) Policy** Liz Houchin, FTSU Guardian	Approve	11:25 hrs	NLG(23)015 Attached
4.4	**Modern Slavery Act Statement** Simon Nearney, Interim Director of People	Approve	11:35 hrs	NLG(23)016 Attached
4.5	**Workforce Committee Highlight Report and Board Challenge** Sue Liburd, Chair of the Workforce Committee and Non-Executive Director	Note	11:45 hrs	NLG(23)017 Attached
5.	**Strategic Objective 3 – To Live Within Our Means**			
5.1	**Finance – Month 09 – Key Issues** Lee Bond, Chief Financial Officer	Note	11:50 hrs	NLG(23)018 Attached
5.2	**Annual Accounts – Delegation of Authority** Lee Bond, Chief Financial Officer	Approve	12:00 hrs	NLG(23)019 Attached
5.3	**Finance & Performance Committee Highlight Report & Board Challenge – Finance** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	Note	12:10 hrs	NLG(23)020 Attached
6.	**Strategic Objective 4 – To Work More Collaboratively**			
6.1	**Strategic & Transformation Report – Key Issues** Ivan McConnell, Director of Strategic Development	Note	12:15 hrs	NLG(23)021 Attached
7.	**Strategic Objective 5 – To Provide Good Leadership**			
7.1	None			

8.	**Governance**			
8.1	**Audit, Risk & Governance Committee Terms of Reference** Simon Parkes, Non-Executive Director and Chair of the Audit, Risk & Governance Committee	Approve	12:25 hrs	NLG(23)024 Attached
8.2	**Board Assurance Framework (BAF) – Quarter Three** Alison Hurley, Assistant Trust Secretary	Note	12:30 hrs	NLG(23)025 Attached
9.	**Approval (Other)**			
9.1	**Trust Management Board Terms of Reference** Dr Peter Reading, Chief Executive	Approve	12:35 hrs	NLG(23)026 Attached
9.2	**Business Case for the Establishment of a Shared Procurement Collaborative** Ed James, Director of Procurement, Humber and North Yorkshire Procurement Collaborative	Approve	12:40 hrs	NLG(23)027 Attached
10.	**Items for Information / To Note (please refer to Appendix A)** Sean Lyons, Chair	Note	12:50 hrs	
11.	**Any Other Urgent Business** Sean Lyons, Chair	Note		Verbal
12.	**Questions from the Public**	Note		Verbal
13.	**Date and Time of Next meeting** **Board Development** Tuesday, 7 March 2023, 9.00 am **Public & Private Meeting** Tuesday, 4 April 2023, 9.00 am	Note		Verbal

- In accordance with Standing Order 14.2 (2007), any Director wishing to propose an agenda item should send it with 8 clear days' notice before the meeting to the Chairman, who shall then include this item on the agenda for the meeting. Requests made less than 8 days before a meeting may be included on the agenda at the discretion of the Chairman. Divisional Directors and Managers may also submit agenda items in this way.
- 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.

10.	**Items for Information / To Note**	
	Sub-Committee Supporting Papers:	
	Finance & Performance Committee	
10.1	**Finance & Performance Committee Minutes – November & December 2022** Gill Ponder, Non-Executive Director & Chair of the Finance & Performance Committee	NLG(23)028 Attached
	Quality & Safety Committee	
10.2	**Quality & Safety Committee Minutes – November & December 2022** Fiona Osborne, Non-Executive Director & Chair of the Quality & Safety Committee	NLG(23)029 Attached
10.3	**Nursing Assurance Report** Ellie Monkhouse, Chief Nurse	NLG(23)030 Attached
10.4	**Midwifery Safe Staffing Review** Elie Monkhouse, Chief Nurse	NLG(23)031 Attached
	Workforce Committee	
10.5	**Workforce Committee Minutes – November 2022** Sue Liburd, Non-Executive Director & Chair of the Workforce Committee	NLG(23)032 Attached
	Other	
10.6	**Communication Round-Up** Ade Beddow, Associate Director of Communications	NLG(23)033 Attached
10.7	**Documents Signed Under Seal** Dr Peter Reading, Chief Executive	NLG(23)034 Attached

NLG(23)004

Name of the Meeting	**Trust Board (Public)**	
Date of the Meeting	7 February 2023	
Director Lead	Sean Lyons, Trust Chair	
Contact Officer/Author	Helen Harris, Director of Corporate Governance	
Title of the Report	**Fit and Proper Persons Test: Chair's Annual Declaration**	
Purpose of the Report and Executive Summary (to include recommendations)	The Trust's Fit and Proper Persons Policy (Section 4.2.1) requires an annual declaration by the Trust Chair at a Board meeting held in public that all those covered by the scope of the policy continue to meet the requirements of the Fit and Proper Persons Test. An audit of the files has evidenced that it is clear that completion of the required checks and the recording of those checks are comprehensive and thorough. An annual review and updating of the Register of Directors' Interests (Appendix A) has also been completed, as per the requirements of the Fit and Proper Person's Policy. The Trust Board is asked to receive the content of this paper and record that the Fit and Proper Persons Test has been conducted for the period 1 February 2022 to 31 January 2023 and all Board members satisfy the requirement.	
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.

Fit and Proper Persons Requirements: Chair's Annual Declaration

1. Purpose

1.1. The purpose of this paper is to provide annual assurance that all Board directors remain fit and proper for their roles.

2. Background

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

2.2. The Trust's Fit and Proper Persons Policy specifies the scope of the staff who are included as: "Section 3. Individual Executive Directors, Non-Executive Directors, the Trust Secretary and the Associate Director of Communications are responsible for ensuring compliance with the Fit & Proper Persons Test and this policy and for declaring where they may no longer meet these requirements."

2.3. The Policy requires a full Fit and Proper Person Test to be completed on appointment. It also requires ongoing assurance as follows: "Section 4.2. The fitness of directors will be reviewed on an annual basis so that the Chair is assured that all directors remain fit and proper for their roles. An annual appraisal process will also be carried out. Relevant directors and employees will be required to complete and sign an annual self-declaration which will be retained on their personal file."

2.4. The Director of Corporate Governance is responsible for initiating audit or review of the compliance on behalf of the Trust Chair and for an annual assurance report to be submitted to the Board.

3. Fit and Proper Person: On Recruitment and Annual Assessment of Continued Compliance

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

- Determination and evidence of employment history and specific qualifications/requirements set out within the job description and person specification and contained within an application form and/or CV and tested during a competency based interview (evidence of the latter may be provided in an interview pack or itinerary (which may include details of a presentation or the actual presentation) and/or interview notes)1
- Receipt of references
- Identity checks e.g. passport/birth certificate/driving licence
- Qualification checks

- Professional body registration checks, if applicable
- Occupational health checks
- Right to work checks e.g. passport/birth certificate/EU Visa/Non-EU Tier 2 Visa
- Disclosure and Barring Service (DBS) checks
- Fit & Proper Person Checks (in addition to the above listed standard employment checks):
  - Insolvency and bankruptcy register checks
  - Disqualified directors' register checks
  - Disqualified charity trustee checks
  - Web based or reasonable search of the individual using key words such as 'NHS', 'Criminal', 'Fraud', 'Dismissed', 'Investigation', 'Disqualified'

3.2. The annual assurance check consists of the following:

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

4. Outcome of the Annual Fit and Proper Persons Checks

4.1. The completed declarations and the outcome of the searches have been saved on each personal file and will be refreshed in July (declarations) and August 2023 (searches and DBS), in line with the annual process.

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

4.4 An audit of files of the relevant individuals against the Trust's Fit & Proper Persons Policy was undertaken by the Director of Corporate Governance and Trust Chair; to review specifically the Fit and Proper Persons checks required on recruitment and those required on an ongoing basis, to ensure capture of the required information and assurances.

The audit and sample testing identified that completion of the required checks and the recording of those checks are comprehensive and thorough.

5. Recommendations

5.1 The Trust Board is asked to:

a) receive and note that the Fit and Proper Persons Test has been conducted for the period 1 February 2022 to 31 January 2023 and all Board members satisfy the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test,

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

Sean Lyons
Trust Chair
February 2023

SUMMARY OF DECLARATIONS OF INTEREST FOR DECISION MAKING STAFF ONLY										
Forename	**Surname**	**Job Title**	**Division**	**Consultants**	**Pharmacy, Digital Services or Procurement**	**Band 8c or above**	**Register of Interest Annual Cohort**	**Declaration of Interest for Loyalty, Shareholdings & Patents (including nil returns)**	**Secondary / Outside Employment (including nil returns)**	**Gifts, Hospitality & Sponsorship (including nil returns)**
Adrian	Beddow	Associate Director of Communications and Engagement	Chief Executive Office Division	No	No	Yes	Yes	Completed	Completed	Completed
Lee	Bond	Chief Financial Officer		No	No	Yes	Yes	Completed	Completed	Completed
Stuart	Hall	Associate Non-Executive Director		No	No	Yes	Yes	Completed	Completed	Completed
Helen	Harris	Director of Corporate Governance	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Linda	Jackson	Vice Chair	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Jugdeep	Johal	Director of Facilities	Facilities Management	No	No	Yes	Yes	Completed	Completed	Completed
Susan	Liburd	Non Executive Director	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Sean	Lyons	Chair		No	No	Yes	Yes	Completed	Completed	Completed
Ivan	McConnell	Programme Director - Humber Acute Services	Strategic Development	No	No	Yes	Yes	Completed	Completed	Completed
Shauna	McMahon	Chief Information Officer	Digital Services Management Team	No	Yes	Yes	Yes	Completed	Completed	Completed
Eleanor	Monkhouse	Chief Nurse	Chief Nurses Office	No	No	Yes	Yes	Completed	Completed	Completed
Simon	Nearney	Director of People	People and Organisational Effectiveness	No	No	Yes	Yes	Completed	Completed	Completed
Fiona	Osborne	Non Executive Director	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Simon	Parkes	Non Executive Director & Chair of Audit Risk & Governance	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Gillian	Ponder	Non Executive Director	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Peter	Reading	CEO	Chief Executive Office Division	No	No	Yes	Yes	Completed	Completed	Completed
Shaun	Stacey	Chief Operating Officer	Operations	No	No	Yes	Yes	Completed	Completed	Completed
Kate	Truscott	Associate Non Executive Director	Trust Board Division	No	No	Yes	Yes	Completed	Completed	Completed
Katherine	Wood	Chief Medical Officer	Chief Medical Officer	No	No	Yes	Yes	Completed	Completed	Completed

SUMMARY OF DECLARATIONS OF INTEREST FOR DECISION MAKING STAFF ONLY									
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Comments**	**Consent to publish**
ROI Declaration of Interests	28/12/2022	Lee	Bond	Chief Financial Officer	Trust Board Division	Loyalty Interests	Chief Finance Officer and Deputy Chief Executive at Hull University Teaching Hospital		Yes
ROI Declaration of Interests	28/12/2022	Lee	Bond	Chief Financial Officer	Trust Board Division	Loyalty Interests	Trustee of WISHH Charity		Yes
ROI Declaration of Interests	28/12/2022	Lee	Bond	Chief Financial Officer	Trust Board Division	Loyalty Interests	Vice President, Healthcare Financial Management Association (HFMA)		Yes
ROI Declaration of Interests	23/01/2023	Lee	Bond	Chief Financial Officer	Trust Board Division	Loyalty Interests	Am the CFO at HUTH as well as NLAG		Yes
ROI Declaration of Interests	10/10/2022	Stuart	Hall	Trust Board	Trust Board Division	Loyalty Interests	Non-Executive/Vice Chair, Hull University Teaching Hospitals NHS Trust		Yes
ROI Declaration of Interests	10/11/2022	Stuart	Hall	Associate Non-Executive Director	Trust Board Division	Other	Vice Chair - Hull University Teaching Hospital	Works as Vice Chair at Hull University Teaching Hospital	Yes
ROI Declaration of Interests	10/11/2022	Stuart	Hall	Associate Non-Executive Director	Trust Board Division	Other	Partner is Lay Member of Yorkshire Clinical Senate	Partner is Lay Member of Yorkshire Clinical Senate	Yes
ROI Declaration of Interests	10/11/2022	Stuart	Hall	Associate Non-Executive Director	Trust Board Division	Other	Member of Advisory Committee on Clinical Excellence Awards	N/A	Yes
ROI Declaration of Interests	01/08/2022	Helen	Harris	Director of Corporate Governance	Trust Board Division	Other	Member of Patient Participation Group, Central Surgery, Barton upon Humber (NLCCG)		Yes
ROI Declaration of Interests	30/11/2022	Linda	Jackson	Chairman	Trust Board Division	Other	Associate Non-Executive Director at HUTH.		Yes
ROI Declaration of Interests	25/10/2022	Linda	Jackson	Vice Chair	Trust Board Division	Other	Sister works at DPoW in Family Services division	sister and sister in law work in family services DPOW	Yes
ROI Declaration of Interests	25/10/2022	Linda	Jackson	Vice Chair	Trust Board Division	Other	Sister-in-law works at DPoW in Family Services division	it is sister and sister in law work in the family services division at DPOW Linda	Yes
ROI Declaration of Interests	06/10/2022	Jugdeep	Johal	Director of Facilities	Facilities Management	Other	Chairman, Asian Sports Foundation		Yes
ROI Declaration of Interests	24/05/2022	Jugdeep	Johal	Director of Facilities	Facilities Management	Other	Charity	Chair of the Asian Sports Foundation a UK registered Charity.	Yes
ROI Declaration of Interests	23/01/2023	Susan	Liburd	Non Executive Director	Trust Board Division	Other	Managing Director and Principal Consultant of Sage Blue	Nil NHS, Health & Social Care or Associated contracts undertaken. Will declare interest prior to and in any meeting at any relevant agenda item and abstain where necessary. Act in accordance with all confidentiality agreements.	Yes
ROI Declaration of Interests	01/03/2022	Sean	Lyons	Chair	Trust Board Division	Other	Daughter is a student nurse at Sheffield Hallam University	Will have attachments to Trusts in South Yorkshire and Bassetlaw	Yes
ROI Declaration of Interests	20/01/2023	Sean	Lyons	Chair	Trust Board Division	Other	Chairman at Hull University Teaching Hospitals Trust	Joint Role between HUTH and NLAG	Yes
ROI Declaration of Interests	31/01/2023	Sean	Lyons	Chair	Trust Board Division	Other	Chairman of Vision West Nottinghamshire College, Derby Road, Mansfield, NG18 5BH	No conflicts with NLAG	Yes

SUMMARY OF DECLARATIONS OF INTEREST FOR DECISION MAKING STAFF ONLY									
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Comments**	**Consent to publish**
ROI Declaration of Interests	10/10/2022	Shauna	McMahon	Chief Information Officer	IT Operations	Other	On exam writing group adding UK content to the Certified Health CIO credential with 10 NHS CIO's	As a CIO I receive 2-3 requests weekly via LinkedIn to a round table or speak to a consultant about a survey. All have been declined to date. They are unsolicited and I delete them. I am approached regularly by partners/suppliers or NHS agencies to speak at conferences / events. These are development sessions arranged by / for professionals. No remuneration in some cases travel expenses are reimbursed or a meal provided. Alternative DOI will be completed for these.	Yes
ROI Declaration of Interests	11/07/2022	Eleanor	Monkhouse	Chief Nurse	Chief Nurses Office	Other	May have contacts with other consultants in Trust	Husband is Yorkshire & Humber Regional Consultants and Specialist Committee Member. Husband is Consultant Foot & Ankle (Leeds Teaching Hospitals)	Yes
ROI Declaration of Interests	26/01/2023	Simon	Nearney	Director of People	People and Organisational Effectiveness	Other	Family Members working at NLAG	Wife - Health Care Worker Daughter - Health Care Worker - Bank Staff Sister In Law - Patient Experience Officer	Yes
ROI Declaration of Interests	26/01/2023	Simon	Nearney	Director of People	People and Organisational Effectiveness	Other	Director at Cleethorpes Town FC / The Linden Club	There is no conflict of interest with CTFC as the club has no dealings with the NHS	Yes
ROI Declaration of Interests	12/09/2022	Fiona	Osborne	Associate Non Executive Director	Trust Board Division	Loyalty Interests	Parish Councillor: Leverton Parish Council, Lincolnshire		Yes
ROI Declaration of Interests	06/01/2023	Fiona	Osborne	Non Executive Director	Trust Board Division	Other	Trustee - Leverton Poor's Land Charity, Parish Councillor - Leverton Parish Council	My roles with the Parish Council nor the charity that owns and rents farming acreage to those living in Leverton Parish is unlikely to a cause any conflict with my Trust duties. However is being declared for completeness	Yes
ROI Declaration of Interests	23/01/2023	Fiona	Osborne	Non Executive Director	Trust Board Division	Loyalty Interests	Leverton Poor's Land Charity, Leverton Parish Council, Foghorn Consulting Ltd, English Country Life	Trustee - Leverton Poor's Land Charity Parish Councillor - Leverton Parish Council Director - Foghorn Consulting Ltd Partner - English Country Life Partnership NB. None of these organisations overlap with the Trust however are included for completeness.	Yes
ROI Declaration of Interests	12/08/2022	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Shareholdings	Director of Lincoln Science and Innovation Park (Unremunerated).	I understand the Trust is considering the lease of a property on the Lincoln Science Park. I am not involved in negotiations or setting terms and will declare relevant interest if and when it comes to NLaG Board - stepping back from from any discussion or decision on the matter.	Yes
ROI Declaration of Interests	07/02/2022	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Loyalty Interests	Lay Canon and Chair of the Finance Committee	Lincoln Cathedral, Minster Yard, Lincoln, LN2 1PJ	Yes

SUMMARY OF DECLARATIONS OF INTEREST FOR DECISION MAKING STAFF ONLY									
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Comments**	**Consent to publish**
ROI Declaration of Interests	07/02/2022	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Loyalty Interests	Senior Independent Director of Lincolnshire Housing Partnership	Lincolnshire Housing Partnership, Westgate Park, Charlton Street, Grimsby, DN31 1SQ	Yes
ROI Declaration of Interests	12/08/2022	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Loyalty Interests	Deputy Vice Chancellor and CFO of the University of Lincoln	University of Lincoln, Brayford Pool, Lincoln, LN6 7TS	Yes
ROI Declaration of Interests	21/03/2022	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Shareholdings	Director of Visit Lincoln	Unremunerated.	Yes
ROI Declaration of Interests	11/10/2022	Gillian	Ponder	Non Executive Director	Trust Board Division	Other	Employment	Employed by Openreach Ltd in role responsible for large scale recruitment, supply chain and logistics. In the event of any Board discussions about network service contracts or disputes, I would not take part in the discussions or vote on the issue.	Yes
ROI Declaration of Interests	21/03/2022	Peter	Reading	CEO	Chief Executive Office Division	Other	Spouse of Dr Catherine Reading, Director, Catherine Reading Limited		Yes
ROI Declaration of Interests	21/03/2022	Peter	Reading	CEO	Chief Executive Office Division	Other	Company Secretary of spouse's company, Catherine Reading Limited		Yes
ROI Declaration of Interests	21/03/2022	Peter	Reading	CEO	Chief Executive Office Division	Other	Co-Chair of the Disabled NHS Directors Network (DNDN)		Yes
ROI Declaration of Interests	05/09/2022	Katherine	Wood	Medical Director	Medical Directors Office	Loyalty Interests	Husband is Trust employee (Theatre Manager, DPoW)		Yes

SUMMARY OF DECLARATIONS OF INTEREST FOR DECISION MAKING STAFF ONLY						
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Consent to publish**
ROI Nil Return Declaration of Interest	24/10/2022	Adrian	Beddow	Associate Director of Communications and Engagemen	Chief Executive Office Division	Yes
ROI Nil Return Declaration of Interest	10/11/2022	Susan	Liburd	Non Executive Director	Trust Board Division	Yes
ROI Nil Return Declaration of Interest	11/10/2022	Ivan	McConnell	Programme Director - Humber Acute Services	Strategic Development	Yes
ROI Nil Return Declaration of Interest	05/10/2022	Shaun	Stacey	Chief Operating Officer	Operations	Yes
ROI Nil Return Declaration of Interest	02/11/2022	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Yes

SUMMARY OF DECLARATIONS OF INTEREST FOR DECISION MAKING STAFF ONLY											
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Organisation Name**	**Declaration Start Date**	**Comments**	**Consent to publish**
ROI Outside/secondary employment	10/11/2022	Stuart	Hall	Associate Non-Executive Director	Trust Board Division	Non-executive roles	Vice Chair	Hull University Teaching Hospital NHS Trust	01/04/2020	N/A	Yes
ROI Outside/secondary employment	18/10/2022	Susan	Liburd	Non Executive Director	Trust Board Division	Directorships	Managing Director and Principal Consultant	Sage Blue, Newark Beacon, Beacon Hill Office Park, Cafferata Way, Newark, NG24 2TN	01/12/2000	Nil NHS, Health & Social Care or Associated contracts undertaken. Will declare interest prior to and in any meeting at any relevant agenda item and abstain where necessary. Act in accordance with all confidentiality agreements.	Yes
ROI Outside/secondary employment	20/01/2023	Sean	Lyons	Chair	Trust Board Division	Non-executive roles	Chair at Hull University Teaching Hospital NHS Trust	Hull University Teaching Hospitals NHS Trust	01/02/2022	Joint role between HUTH & NLAG	Yes
ROI Outside/secondary employment	31/01/2023	Sean	Lyons	Chair	Trust Board Division	Non-executive roles	Chairman	Vision West Nottinghamshire College, Derby Road, Mansfield, NG18 5BH	01/02/2022	No conflicts with NLAG role	Yes
ROI Outside/secondary employment	08/11/2022	Fiona	Osborne	Associate Non Executive Director	Trust Board Division	Directorships	Director	Foghorn Consulting Ltd, Hideaway Cottage, Hampton Lane, Old Leake, Boston, PE22 9JS	01/04/2021	N/a	Yes
ROI Outside/secondary employment	08/11/2022	Fiona	Osborne	Associate Non Executive Director	Trust Board Division	Directorships	Partner	English Country Life Partnership, Hideaway Cottage, Hampton Lane, Old Leake, Boston, PE22 9JS	01/04/2021	N/A	Yes
ROI Outside/secondary employment	15/12/2022	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Outside employment	Deputy Vice Chancellor	University of Lincoln, Brayford Pool, Lincoln, LN6 7TS	12/08/2021	Start date predates employment with the NLaG. University of Lincoln students have placements in the Trust hospitals but I am not involved in those arranegements	Yes
ROI Outside/secondary employment	07/11/2022	Gillian	Ponder	Non Executive Director	Trust Board Division	Outside employment	Head of Business Analysis, Planning & Resourcing	Openreach Ltd, 81 Newgate Street, London, EC1A 7AJ	01/04/2021	Flexible working which enables me to undertake NED role. Open Reach actively encourage Senior Managers to be NEDs, JPs, Governors, MIlitary Servists	Yes
ROI Outside/secondary employment	20/12/2022	Peter	Reading	Chief Executive	Chief Executive Office Division	Outside employment	Company Secretary	Catherine Reading Limited, Foxhill Farm, Stocking Lane, East Leake, Loughborough, LE12 5RL	01/01/2003	Unpaid work. Company does not trade with the NHS.	Yes
ROI Outside/secondary employment	18/10/2022	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Non-executive roles	Interim Chair	Active Lincolnshire, Newland House, The Point, Weaver Road, Lincoln, LN6 3QN	01/09/2022	Current Role.	Yes
ROI Outside/secondary employment	18/10/2022	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Non-executive roles	Vice Chairman	Vision West Nottinghamshire College, Derby Road, Mansfield, NG18 5BH	01/09/2022	Current role.	Yes
ROI Outside/secondary employment	18/10/2022	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Non-executive roles	Trustee	Linkage Community Trust, Toynton Hall, Toynton All Saints, Spilsby, LN9 6HU	01/09/2022	Current role.	Yes

SUMMARY OF DECLARATIONS OF INTEREST FOR DECISION MAKING STAFF ONLY											
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Organisation Name**	**Declaration Start Date**	**Comments**	**Consent to publish**
ROI Outside/secondary employment	18/10/2022	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Non-executive roles	Trustee	Children's Links, Suite 1&4 Gymphlex Buildings, Boston Road, Horncastle, LN9 6HU	01/09/2022	Current role.	Yes

SUMMARY OF DECLARATIONS OF INTEREST FOR DECISION MAKING STAFF ONLY						
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Consent to publish**
ROI Nil Return Outside Employment	14/07/2022	Adrian	Beddow	Associate Director of Communications and Engagemen	Chief Executive Office Division	Yes
ROI Nil Return Outside Employment	05/12/2022	Lee	Bond	Chief Financial Officer	Trust Board Division	Yes
ROI Nil Return Outside Employment	08/08/2022	Helen	Harris	Director of Corporate Governance	Trust Board Division	Yes
ROI Nil Return Outside Employment	26/07/2022	Linda	Jackson	Vice Chair	Trust Board Division	Yes
ROI Nil Return Outside Employment	14/07/2022	Jugdeep	Johal	Director of Facilities	Facilities Management	Yes
ROI Nil Return Outside Employment	14/07/2022	Ivan	McConnell	Programme Director - Humber Acute Services	Strategic Development	Yes
ROI Nil Return Outside Employment	19/09/2022	Shauna	McMahon	Chief Information Officer	IT Operations	Yes
ROI Nil Return Outside Employment	02/11/2022	Shauna	McMahon	Chief Information Officer	IT Operations	Yes
ROI Nil Return Outside Employment	26/01/2023	Simon	Nearney	Director of People	People and Organisational Effectiveness	Yes
ROI Nil Return Outside Employment	26/07/2022	Eleanor	Monkhouse	Chief Nurse	Chief Nurses Office	Yes
ROI Nil Return Outside Employment	04/05/2022	Shaun	Stacey	Chief Operating Officer	Operations	Yes
ROI Nil Return Outside Employment	18/07/2022	Katherine	Wood	Medical Director	Medical Directors Office	Yes

SUMMARY OF DECLARATIONS OF INTEREST FOR DECISION MAKING STAFF ONLY											
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Category**	**Description of interest**	**Organisation Name**	**Declaration Start Date**	**Consent to publish**	**Value (£)**
ROI Gifts and Hospitality	30/12/2021	Adrian	Beddow	Associate Director of Communications and Engagement	Chief Executive Office Division	Gift	n/a	Pace Communications	16/12/2021	Yes	<£10
ROI Gifts and Hospitality	14/02/2022	Jugdeep	Johal	Director of Facilities	Facilities Management	Sponsored Event	HSJ Awards	Grant Thornton LLP, 5th Floor, 7 Exchange Crescent, Conference Square, Edinburgh, EH3 8AN	01/06/2021	Yes	594
ROI Gifts and Hospitality	17/11/2022	Jugdeep	Johal	Director of Facilities	Facilities Management	Hospitality	university & health care estates & innovation - conference 15/11/2022 - presenting	UHEI	15/11/2022	Yes	n/a
ROI Gifts and Hospitality	31/01/2023	Sean	Lyons	Trust Chair	Trust Board Division	Sponsored Event	Speaking Engagement or Association of British Clinical Diabatologists (£250 will be donated 50/50 to NLAG and HUTH Trust Charities)	Associate of British Clinical Diabatologists, 483 Green Lanes, London, N13 4BS	29/09/2022	Yes	£370
ROI Gifts and Hospitality	04/11/2021	Shauna	McMahon	Chief Information Officer	IT Operations	Hospitality	Digital Hospital Panel at Conference. Speaker on digital innovation and after dinner event	Convenzis - Public Sector Educational Events and speaker session presented by Atos	03/11/2021	Yes	30
ROI Gifts and Hospitality	14/10/2022	Shauna	McMahon	Joint Chief Information Officer	IT Operations	Sponsored Event	Presentation on Digital Leadership/ICS Challenges for Digital	HPN Conferences Public Sector	13/10/2022	Yes	£150
ROI Gifts and Hospitality	24/05/2022	Peter	Reading	Chief Executive	Chief Executive Office Division	Hospitality	HSJ Provider Summit, 31 March to 1 April 2022	Health Service Journal (HSJ)	14/03/2022	Yes	200-250
ROI Gifts and Hospitality	07/12/2022	Peter	Reading	CEO	Chief Executive Office Division	Hospitality	Attendance at the NHS Providers Annual Conference (15-16 November 2022) and one night accommodation.	Saffron Cordery, Interim CEO, NHS Providers, One Birdcage Walk, London, SW1H 9JJ	10/11/2022	Yes	£584.00

SUMMARY OF DECLARATIONS OF INTEREST FOR DECISION MAKING STAFF ONLY						
Cohort	**Approved Date**	**Forename**	**Surname**	**Job Title**	**Division**	**Consent to publish**
ROI Nil Return Gifts and Hospitality	02/11/2022	Lee	Bond	Chief Financial Officer	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	16/08/2022	Stuart	Hall	Trust Board	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	08/08/2022	Helen	Harris	Director of Corporate	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	26/07/2022	Linda	Jackson	Vice Chair	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	10/10/2022	Jugdeep	Johal	Director of Facilities	Facilities Management	Yes
ROI Nil Return Gifts and Hospitality	11/10/2022	Jugdeep	Johal	Director of Estates and Facilities	Facilities Management	Yes
ROI Nil Return Gifts and Hospitality	10/11/2022	Susan	Liburd	Non Executive Director	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	08/11/2022	Sean	Lyons	Chair	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	14/07/2022	Ivan	McConnell	Programme Director - Humber Acute Services	Strategic Development	Yes
ROI Nil Return Gifts and Hospitality	26/07/2022	Eleanor	Monkhouse	Chief Nurse	Chief Nurses Office	Yes
ROI Nil Return Gifts and Hospitality	26/01/2023	Simon	Nearney	Director of People	People and Organisational Effectiveness	Yes
ROI Nil Return Gifts and Hospitality	07/11/2022	Fiona	Osborne	Non Executive Director	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	14/12/2022	Simon	Parkes	Non Executive Director & Chair of Audit Risk & Gov	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	10/11/2022	Gillian	Ponder	Non Executive Director	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	04/05/2022	Shaun	Stacey	Chief Operating Officer	Operations	Yes
ROI Nil Return Gifts and Hospitality	02/11/2022	Kate	Truscott	Associate Non Executive Director	Trust Board Division	Yes
ROI Nil Return Gifts and Hospitality	18/07/2022	Katherine	Wood	Medical Director	Medical Directors Office	Yes

NLG(23)005

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (PUBLIC)

Minutes of the Public Meeting held on Tuesday, 7 December 2022 at 9.00 am
By MS Teams

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Chair
Linda Jackson	Vice Chair
Dr Peter Reading	Chief Executive
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
Simon Parkes	Non-Executive Director

In Attendance:

Adrian Beddow	Associate Director of Communications
Lynn Benefer	Deputy Head of Safeguarding (for item 3.3)
Christine Brereton	Director of People
Kay Fillingham	Lead Mental Health Professional (for item 1.3)
Keith Fowler	Associate Director Facilities & Sustainability (for item 5.2 & 5.3)
Helen Harris	Director of Corporate Governance
Liz Houchin	Freedom to Speak Up Guardian (for item 4.2 & 4.3)
Jo Loughborough	Senior Nurse – Patient Experience (for item 1.3)
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Simon Tighe	Deputy Director of Estates & Facilities (representing J Johal)
Kate Truscott	Associate Non-Executive Director
Jane Warner	Associate Chief Nurse Midwifery (for item 3.4)
Sarah Meggitt	Personal Assistant to the Chair, Vice Chair & Director of Corporate Governance (note taker)

1. Introduction

1.1 Chair's Opening Remarks

Sean Lyons welcomed everyone to the meeting and declared it open at 9.00 am. Karen Green one of the new Public Governors at the Trust was welcomed to the meeting.

As this was the first board meeting held since the Care Quality Commission (CQC) Report had been received Sean Lyons wanted to thank all staff for the work undertaken since the previous inspection. Real improvements had been recognised and this had been endorsed by the CQC. Thanks were given to Dr Peter Reading and Dr Kate Wood for the staff briefings held to update staff on the CQC Report. It is envisaged that the Trust would be removed from quality special measures and could look forward to continued improvements. Board members were asked to communicate to staff where possible the improvements that had been recognised and that Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) was not in special measures.

1.2 Apologies for Absence

Apologies for absence were received by Jug Johal represented by Simon Tighe, Deputy Director Estates and Facilities and Stuart Hall. It was noted Simon Parkes would arrive later to the meeting. Sean Lyons and Lee Bond would also need to leave the meeting for a period of time due to the CQC Well Led Inspection at Hull University Teaching Hospital (HUTH).

1.3 Patients' Story and Reflection

Jo Loughborough and Kay Fillingham shared "Tracy's" story a lady that had been referred to the Mental Health Service due to other treatment that had highlighted this need. Tracy spoke about the positive support that had been experienced with the team. It was felt it would be more beneficial for patients if the service was more available and if communication between health professionals could be improved. Tracey wanted to say a huge thank you to the mental health team for the care provided.

Kay Fillingham advised the story highlighted the physiological support required for patients with long term health care issues, unfortunately this was something that could not be provided to all patients at the moment.

Dr Peter Reading thanked Jo Loughborough and Kay Fillingham for sharing the story as it was important for the board to recognise some of the complex issues patients encountered. The service provided by psychological services was important but was an under resourced service that would need further support in the future. Ellie Monkhouse advised the Safeguarding Report now incorporated vulnerabilities in respect of bringing this together as a holistic approach across the organisation, this would hopefully make a patients' experience more improved in the future.

Kate Truscott queried what relationships were like with partners of the Trust when offering this service. Kay Fillingham advised NLAG worked closely with four providers and that all worked to different models. Learning lessons were being undertaken to ensure the pathway experience worked as it should.

Sean Lyons thanked Jo Loughborough and Kay Fillingham for sharing the story as it had made the board more aware of how those issues affected patients. Kay Fillingham was asked whether there was anything else the board needed to be aware of. Kay Fillingham advised there were a number of reports available if the board would welcome them being shared. Psychology was already embedded in some services which had helped. Following further discussion it was agreed a board development session would be arranged to ensure the board were sighted on what the service provided patients.

Action: A Development session on Mental Health Services would be arranged for Trust Board members

Sean Lyons thanked Jo Loughborough, Kay Fillingham and Tracy for sharing the story.

At this point Sean Lyons and Lee Bond left the meeting and Linda Jackson, Vice Chair took over the responsibility for Chairing the meeting.

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 October 2022 – NLG(22)208

The minutes of the meeting held on the 4 October 2022 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made.

- Dr Kate Wood referred to page five, item 3.1 in respect of sepsis. The context needed to be changed to state the following. It was noted that sepsis was not an area of concern for the organisation as triangulated through incidents, claims, complaints and structured judgement reviews, however, the documentation of this remained poor.

- Dr Kate Wood referred to page ten, item 4.3. The wording should be changed to refer to the reporting as being exception not exceptional.

2.3 To approve the minutes of the Public Meeting held on Monday, 14 November 2022 – NLG(22)249

The minutes of the meeting held on the 14 November 2022 were accepted as a true and accurate record and would be duly signed by the Chair.

2.4 Urgent Matters Arising

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

2.5 Trust Board Action Log – Public by exception NLG(22)209

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

- Item 3.1 2, August 2022 – Fiona Osborne advised the Quality & Safety Committee (Q&SC) had received a paper at the September 2022 meeting which addressed the robust management of patient initiative follow ups. It was recognised this was not suitable for every specialty but was working well in some, a further paper would be shared at the December 2022 meeting to review evidence of this. The Committee would continue to receive reports on this issue. Dr Kate Wood added this related to clinicians understanding and taking responsibility for how the process worked. It was agreed this action could be closed for the board.

- Item 3.4 4, October 2022 - Dr Peter Reading advised the Executive team had discussed the introduction of bank incentives for staff and work had been undertaken within teams. This work had almost concluded, the option would then be approved through the Trust Management Board (TMB) which would include the period of how long this would be for. Linda Jackson requested if the paper shared with TMB could be shared with Non-Executive Directors once it was approved. Dr Peter Reading agreed this would be shared along with a communication sent to staff.

  Action: Dr Peter Reading

2.6 Chief Executive's Briefing – NLG(22)210

Dr Peter Reading referred to the report shared and wanted to acknowledge the enormous pressure staff and services were under at the moment with the highest number of attendees being recorded in the Emergency Department (ED) at Grimsby the previous evening. The national concern was noted regarding the Strep A infection and the board were assured NLAG clinical staff were briefed on this. The resilience of staff continued to be very impressive.

2.7 Integrated Performance Report (IPR) – NLG(22)211

Linda Jackson 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 Key Issues – Quality & Safety - NLG(22)211

Dr Kate Wood wanted to thank all staff in respect of the CQC Report as this was a combination of hard work over a number of years.

Dr Kate Wood was aware there were issues with the documentation for sepsis and it was noted a considerable amount of work continued with this, with support from the Quality Improvement (QI) team. The work would be mapped with key stakeholders over the next few months. More work was being undertaken in respect of recording the weight of patients as this was important for the administration of drugs due to the amount given including the nutrition of patients.

Ellie Monkhouse wanted to thank the team and colleagues in respect of the CQC Report particularly in relation to the strong outcomes around fundamental care. It was noted the current compliance for complaint responses was 64% which was an increase to the current reporting shared but a deterioration from where we were. It was highlighted the operational pressures on staff had affected complaint response times due to those staff not being able to comment within required deadlines. The ongoing QI work with the Patient Advice Liaison Service (PALS) responses had seen an increase of 20% being responded to on time. In relation to performance, the Trust continued to do well in managing Covid and other respiratory illnesses, however, the increase in those patient numbers had impacted on operational performance and this would continue into January. Linda Jackson was pleased to see the QI team was supporting with the sepsis work. It was recognised the operational pressures had impacted on complaint response times reducing and that this was being monitored.

Dr Kate Wood advised the Trust had received more than 100 “must dos” following the CQC 2020 report which was a significant improvement from the last inspection. These would continue to be embedded and sustained. An action plan would be completed in conjunction with the divisions for the 2022 inspection and would incorporate actions outstanding from previous inspections. The Trust continued to make improvements following the inspection this year and previous visits. It was hoped everything would be aligned by the end of January 2023 with immediate actions being shared with the CQC at the beginning of January.

3.2 Quality & Safety Committee Highlight Report and Board Challenge – NLG(22)212

Fiona Osborne referred to the highlight report and noted key issues. The board were referred to the recommendations requested and the reasons for this. It was noted the committee had been advised of the Never Event in respect of a foreign body. Dr Kate Wood explained the Never Event was going through the correct processes of investigation.

Linda Jackson asked the board to agree the recommendation that TMB would review the cancer request to test Trust targets in line with Best Practice Timed Pathways (BPTP), a further recommendation was for seven day working in Pathology to be given consideration in the 2023/24 Business Planning process to aid delivery of BPTP. The Trust Board agreed to the recommendations.

Action: An update would be provided on the recommendations through a future Q&SC Highlight Report

3.3 Safeguarding Vulnerabilities Annual Report – NLG(22)213

Vicky Thersby and Lynn Benefer shared the Safeguarding Vulnerabilities Annual Report and referred to key highlights. Ellie Monkouse wanted to thank the team for the report and presentation shared. The report had highlighted the complexities the team faced along with the extent of the work involved. It was felt this would be increased over coming years.

Dr Peter Reading wanted to note thanks to the team and offer congratulations for the work completed over the past year. A query was raised as to whether North East Lincolnshire (NEL) Children Services being found inadequate had impacted on the team and whether there was anything the board should be made aware of. Vicky Thersby advised the most impact had been due to timely assessments not being carried out for very vulnerable children. The team were praised on how the assessments had then been completed following the delays, along with the mitigations in place to ensure health needs had been met for individuals. A further inspection on NEL was expected in February 2023.

Gill Ponder thanked the team for an informative report. It was noted that Dr Peter Reading had circulated the Oliver McGowan training and queried whether this would be mandated for clinical staff. Vicky Thersby felt the training was key and should be rolled out to ensure staff on wards were aware of additional support patients may need. Dr Peter Reading confirmed this was being arranged through Wendy Kelvin, Head of Training, Education and Development and would be mandatory for all National Health Service (NHS) staff from next year.

Sue Liburd thanked the team for an informative report and queried whether the team were well resourced due to the increased work. Although the report was very detailed it had not highlighted the issues experienced by the team, a request was made for future reports to include this information. Vicky Thersby advised that the team had now started to see the impact of Covid 19 in respect of the domestic abuse workload, NLAG would, therefore, benefit appointing a Domestic Abuse Lead to support the work. The workload had impacted on staff due to more cases needing to be reviewed. It was felt the cost of living crisis would also impact the team with an expectation of increased cases. A business case for additional support would be submitted for the approval of additional resource.

The Trust Board approved the report received along with a pledge of support from the board.

Linda Jackson thanked Vicky Thersby and Lynn Benefer for an interesting informative report and all the hard work the team were putting into the service.

Action: Vicky Thersby and Lynn Benefer to include resourcing issues experienced by the Safeguarding and Vulnerabilities Team in future reports

3.4 Maternity / Ockenden Update – NLG(22)214

Jane Warner explained the Clinical Negligence Scheme for Trusts (CNST) ten actions had been discussed at a recent confirm and challenge meeting and it was

expected all ten safety actions would be met by the 2 February 2023. The most challenging action had been Saving Babies Lives (SBL) and Mandatory Training. Mandatory training had met 90% for all staff groups and SBL had now been met due to ongoing work from the team. Linda Jackson noted the excellent work on the progress against the 92 point action plan coming out of the Ockenden recommendations since the previous update.

Ellie Monkhouse wanted to assure the board of the comprehensive review of the Clinical Negligence Scheme for Trusts (CNST) submission which was due to be submitted. An update of this would be provided at the Private Board in January 2023. The board would receive an update at the next meeting of the Birth Rate Plus position as this had meant a balanced position for the Trust. This was shared at TMB the previous day for oversight and review.

3.5 Key Issues – Performance – NLG(22)211

Shaun Stacey referred to the report and advised the Trust continued with a challenging time in respect of performance and targets. The operation teams were commended for the work to date. It was noted attendances in the ED continued to be high. Home first had been introduced in North Lincolnshire and had run on around 17 beds which had saved the North Lincolnshire patch around 200 bed days. A point to note was overall length of stay for non-elective work as there were due to be changes in bed reporting for the Trust.

The challenge around staffing continued due to sickness and vacancies. Although 52 week waits had increased, this was due to the support being offered to partners across the region. The cancer issues were sighted on and a lot of work was being carried out to improve performance as a system. Kate Truscott queried what impact the potential strike of ambulance staff would have on the Trust and performance. Shaun Stacey advised a system wide contingency plan was in place for the industrial action and support would be offered from the military. Category one and two responses would be maintained, and work would be supported in respect of the other categories. Sue Liburd queried whether the organisation was on track in respect of virtual wards going live. A further query related to earlier in the day discharges and whether NLAG were trying to factor in achieving this. Shaun Stacey confirmed virtual wards had gone live. In terms of discharge this was sometimes difficult to undertake before noon due to the receipt of results for particular patients. Work was being undertaken with the QI team to ensure the discharge lounge was better utilised for early discharge to ensure ward beds were then available.

Ellie Monkhouse advised that although NLAG nurses had made the decision to not strike the industrial action of other Trusts could impact on the organisation due to the redirection of patients from other Trusts. Shaun Stacey advised the system had participated in a regional planning test which proved very useful as it had highlighted some weaknesses that would need to be resolved. These would now be strengthened.

Shaun Stacey wanted to note the current stress and pressure staff were under due to the winter period and the ongoing sickness of staff. Dr Peter Reading

highlighted NLAG continued to deliver elective recovery during this challenging time.

Linda Jackson thanked Shaun Stacey for the update provided and all the staff that were working so hard to keep NLAG patients safe.

3.6 Data Quality Assurance – NLG(22)257

Shauna McMahon took the paper as read and noted key highlights. It was noted NLAG had not been notified of any data quality issues in the past. If delays were to occur the relevant partners would be notified.

3.7 Finance & Performance Committee Highlight Report and Board Challenge – Performance - NLG(22)216

Gill Ponder referred to the report and noted key highlights.

4. Strategic Objective 2 – To Be a Good Employer

4.1 Key Issues - Workforce – NLG(22)211

Christine Brereton referred to the IPR report and advised the recruitment target had not been met for registered and non-registered nurses. However, this was being addressed and that plans in place and would be shown in the next report. Sickness absence was high, and it was anticipated this would increase going into the winter period. Statutory and mandatory training had some areas with low compliance which would be addressed, further work would be undertaken in respect of this issue through the Performance Review and Improvement Meetings (PRIMs).

Gill Ponder referred to the changes being made to the National Health Service (NHS) pensions and whether this was something NLAG was sighted on. Christine Brereton advised there had been some consultation around this and guidance had been received. A policy would be introduced to include any changes. Dr Peter Reading explained the changes were modest, however, NHS Providers had been very critical of this.

Simon Parkes referred to the statutory and mandatory training particularly Information Governance training, one challenge raised was the pressures on wards in respect of releasing staff to attend training. It was felt there needed to be more understanding around the priorities for mandatory training. It was queried whether mandatory training should be reviewed to focus more on the training around the delivery of safe patient care with an option to ease off on other mandatory training. The length of training had been reviewed to try and support staff completing this. The team were now able to identify staff that had not covered specific training with the support of Power Business Intelligence (BI). The overall compliance for NLAG was as it should be.

Fiona Osborne recognised there was notable success around recruitment, but it had been highlighted at the Q&SC that there were some areas of concern, particularly in midwifery and pharmacy. Christine Brereton agreed this had been

noted and work was ongoing around midwifery and other areas. It was agreed an update would be provided to the Q&SC on the work being undertaken to provide assurance.

Action: Sue Liburd / Christine Brereton

4.2 Freedom to Speak Up Self-Assessment – NLG(22)217

Christine Brereton thanked board members for the comments provided in respect of the Self-Assessment and asked for approval of the final document.

The Trust Board agreed the Freedom to Speak Up Self-Assessment.

4.3 Freedom to Speak Up Guardian – Quarter Two Report – NLG(22)218

Liz Houchin referred to the report shared and noted key highlights. Dr Peter Reading referred to the changes in reporting to what it had been previously and wondered if this was reflected in the quarter two report. Liz Houchin advised some related to quarter two. Dr Peter Reading queried whether a board statement should be issued on the routes staff could speak up in light of issues at another Trust. Liz Houchin advised some other Trusts were putting this in place.

Dr Kate Wood advised the CQC Report had mentioned the organisation was more open to speaking up through the various routes available. It was felt staff needed to be encouraged to do this when required to include where issues could be raised. This was agreed by board members that felt this should be communicated more to staff.

Linda Jackson sought board approval of the report, this was approved by the board.

A statement to staff from the board on how to speak up was also agreed. Dr Peter Reading agreed for this to be put in place.

Action: Dr Peter Reading / Ade Beddow

4.4 Workforce Committee Highlight Report and Board Challenge – NLG(22)219

Sue Liburd referred to the report and highlighted key points.

Ellie Monkhouse wanted to thank the committee for noting the support required to retain staff over 50 years of age, particularly in nursing and midwifery. Staff within those groups often held senior roles and early retirement of those staff could have an impact on the organisation.

4.4.1 Workforce Committee Terms of Reference – NLG(22)219

Sue Liburd referred to the updated Terms of Reference for the Workforce Committee and sought board approval. It was noted the executive attendance had been strengthened.

Gill Ponder noted the amendments included the frequency of deputy attendance and queried whether this would be consistent in other sub-committees. Sue Liburd advised this had been put in place to ensure more consistency for the committee. Christine Brereton advised the amendments had been made to ensure the committee was quorate due to previous attendance. Dr Peter Reading advised other committees had greater executive attendance than Workforce so this would only be put in place for that committee.

The Trust Board approved the updated Terms of Reference.

5. Strategic Objective 3 – To Live Within our Means

5.1 Key Issues - Finance – Month 07 - NLG(22)220

Brian Shipley referred to the report and noted key highlights. It was noted that the additional support with staffing had caused some financial pressures.

Dr Kate Wood referred to the overspend in respect of doctors working hours and queried whether this was discussed at any particular meetings to identify which specialty this was related to. Brian Shipley advised each division held a workforce meeting that reviewed overspends including vacancies on a regular basis. Dr Kate Wood felt this information should be fed through to the divisional boards and relevant committees. It was noted the challenges with junior doctors' rotas in respect of registration referred to on page 42 had now been resolved.

Fiona Osborne referred to the forecast position at Month 07 in respect of the overspend of £2 million and queried what this related to. Brian Shipley advised this was due to the pay award as it had been higher than the planned assumption. This was due to separate issues which were being reviewed.

5.2 Green & Travel Plan – NLG(22)221

Keith Fowler went through the presentation with the board and referred to key points within the report.

Linda Jackson thanked Keith Fowler for the update provided. Gill Ponder advised the F&PC had received the paper and discussed this in great detail. Fiona Osborne felt this was the right way forward, however, lack of infrastructure may impact on this being developing in the future so the board would need to be sighted on this.

Simon Tighe wanted to thank Keith Fowler and the team for the work undertaken to date. This had meant NLAG was ahead on what was required. It was advised further updates would be shared at the board during 2023.

The Trust Board approved the Green and Travel Plan.

5.3 Finance & Performance Committee Highlight Report and Board Challenge – Finance - NLG(22)223

Gill Ponder referred to the report and highlighted key points.

6. Strategic Objective 4 – To Work More Collaboratively

6.1 Key Issues – Strategic & Transformation – NLG(22)224

Ivan McConnell referred to the report and noted key highlights. It was important to recognise there would be further work required in respect of financial issues, colleagues in the system would be included in discussions.

6.2 Health Tree Foundation Trustees' Committee (HTFTC) Highlight Report & Board Challenge – May 2022 – NLG(22)225

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

6.3 Strategic Development Committee (SDC) Highlight Report & Board Challenge – NLG(22)226

Linda Jackson referred to the report and highlighted key points.

6.4 Humber Acute Services Development Committee Highlight Report & Board Challenge (Committees in Common) – NLG(22)227

Linda Jackson referred to the report and noted key points. It was noted there was an error within the report as it should refer to the Interim Clinical Plan and not Integrated Care Programme Update.

7. Strategic Objective 5 – To Provide Good Leadership.

7.1 There were no items to discuss under this section.

8. Governance

8.1 Audit, Risk & Governance Committee (AR&GC) Highlight Report & Board Challenge – NLG(22)228

At this point Lee Bond re-joined the meeting.

Simon Parkes referred to the report and shared key highlights.

Lee Bond highlighted the internal auditors were to complete a report on patient losses and how they were managed at ward level. It was hoped this would then lead to an improved procedure for how these are dealt with.

In respect of the body store at Goole it was noted the committee did not have assurance for this, however, this had been received for Grimsby and Scunthorpe. In respect of Goole, enquiries had been made as to whether the store could be closed and local undertakers provide support for this, however, this was not able to be put in place. The team were now reviewing whether the Scunthorpe Body Store was able to support, but this was proving a challenge. The work around this was ongoing and the committee would continue to monitor this.

At this point Sean Lyons re-joined the meeting.

Dr Kate Wood felt the body store issue was a must do in respect of providing assurance. It was queried whether the organisation was assured the mitigation in place was correct to ensure the dignity of patients being held there. Simon Parkes did not feel this was the case at the moment due to issues around divisional ownership of the store. Shaun Stacey was concerned the committee had not gained assurance as processes were the same as the other sites so this would need to be reviewed further. The Matron at Goole had been undertaking regular audits so the committee should have been provided with this information. The mortuary at Goole had been downgraded to a cold room so did not sit within the guidance, however, there was a need ensure there was dignity and respect for patients. The challenge with using the Scunthorpe body store was that it did not have enough capacity to cope with two sites. The problems around this were being reviewed but had not been resolved as yet. It was noted the committee would be provided with an update on the actions being taken to provide assurance. Apologies for this not being provided were noted by the board. Dr Kate Wood thanked Shaun Stacey for a detailed response.

It was agreed Dr Kate Wood and Shaun Stacey would meet outside the meeting to tighten up assurance processes. It was noted that as the next committee was due to be held in February 2023 the committee members would receive an update prior to this date.

Action: Dr Kate Wood & Shaun Stacey

8.2 Board Assurance Framework (BAF) – Quarter Two - NLG(22)229

Helen Harris referred to the report and advised this had been shared with relevant committees. There was still a significant amount of high risks as detailed within the report, the High Level Risk Register was now included within the report for detail. The board were asked if assurance had been provided in respect of the current ratings. The Trust Board agreed assurance had been provided.

8.3 Provider Licence Consultation – NLG(22)230

Helen Harris referred to the report and drew the boards attention to key highlights. The report was shared for noting purposes.

8.4 Enforcement Guidance Consultation – NLG(22)231

Helen Harris referred to the report and drew the boards attention to the key highlights and required action.

The Trust Board approved the report.

8.5 New Code of Governance – NLG(22)232

Helen Harris referred to the report and drew the boards attention to key highlights including required actions. The board were advised a development session would be held in 2023 to provide updates on various governance documents.

Linda Jackson referred to the updated report coming into effect on the 1 April 2023 which would instigate other documents needing to be reviewed against it. Helen Harris confirmed this was the case.

Sean Lyons asked if Governors could be included within any developments as they occurred. It was agreed a Governor briefing would be held when required.

Action: Helen Harris

9. Approval (Other)

9.1 Equality, Diversity and Inclusion Strategy – NLG(22)233

Christine Brereton referred to report and asked for approval of an extension until the 30 June 2023 to ensure the Strategy was fit for purpose to enable a Humber wide approach. Dr Peter Reading supported the extension as it would be in line with the National Equality Diversity Inclusion Strategy being reviewed.

The Trust Board approved the extension until the 30 June 2023.

9.2 Smokefree

Dr Kate Wood referred to the report and noted key highlights. It was noted the Trust had achieved the requirements, however, this required board approval to enable Sean Lyons and Dr Peter Reading to sign this off.

The Trust Board approved the pledge.

10. Items for Information

The following items were shared at the December 2022 meeting:

- F&PC Minutes – September & October 2022
- Q&SC Minutes – September & October 2022
- Nursing Assurance Report
- Workforce Committee Minutes – September 2022
- Guardian of Safe Working Hours Quarter Two Report
- AR&GC Minutes – July 2022
- HTFTC Minutes – September 2022
- Communications Round-Up
- Documents Signed Under Seal
- Covid 19 Inquiry Update

11. Any Other Urgent Business

There were no items of any other business raised.

As it was Christine Brereton's last formal board meeting Linda Jackson wanted to note thanks on behalf of the board. The workforce agenda had moved forward during Christine Brereton's time at the Trust.

12. Questions from the Public

Linda Jackson asked for questions from the public. No questions were received.

13. Date and Time of the next meeting

Formal Trust Board Meeting

Tuesday, 7 February 2023, Time: 9.00 am

Board Development

Tuesday, 7 March 2023, Time: 9.00 am

The Private Trust Board meeting was due to follow at 13:15 hours.

Linda Jackson closed the meeting at 12:20 hours.

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

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

NLG(23)006

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2022/2023

Kindness · Courage · Respect

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	07.02.2023	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.			
1.3	06.12.2022	Patient Story - Development Session		Development session on Mental Health Services to be arranged	Helen Harris	07.02.2023	Session added to the Trust Board Development Programme.			
3.2	06.12.2022	Quality & Safety Committee Highlight Report & Board Challenge - Best Practice Timed Pathways		Trust Management Board to review the cancer request to test Trust targets in line with Best Practice Timed Pathways (BPTP), and report the outcome to Q&SC.	Dr Peter Reading / Fiona Osborne	07.02.2023	This action would be monitored through the Quality & Safety Committee.			
3.2	06.12.2022	Quality & Safety Committee Highlight Report & Board Challenge -Seven-Day Working - Pathology		Pathology to present the case for seven-day working in the 2023-24 Business Planning process to aid delivery of BPTP, and report the outcome to Q&SC.	Shaun Stacey /Fiona Osborne	07.02.2023	This action would be monitored through the Quality & Safety Committee.			
3.3	06.12.2022	Safeguarding Vulnerabilities Annual Report		Action to be processed through Safeguarding.	Ellie Monkhouse / Safeguarding Team	07.02.2023	Action to be monitored by Safeguarding Team for next report			
4.1	06.12.2022	Key Issues - Workforce		Assurance to be provided to the Quality & Safety Committee on actions being undertaken around issues with recruitment of staff.	Sue Liburd / Simon Nearney	07.02.2023	Update to be provided to the Quality & Safety Committee. This action would be monitored by the committee.			
4.3	06.12.2022	Freedom to Speak Up Guardian Quarter Two Report		Communication to be shared with Trust staff on the processes of reporting concerns	Dr Peter Reading / Ade Beddow	07.02.2023	Update on communication shared to be provided at the February 2023 meeting.			
8.1	06.12.2022	Audit, Risk & Governance Committee Highlight Report & Board Challenge		Meeting to be held to ensure processes were in place for the body store requirements at Goole Hospital.	Shaun Stacey / Dr Kate Wood	07.02.2023	Update on assurance processes to be provided to the Audit, Risk & Governance Committee following the meeting held. The committee would retain oversight of this action.			
8.5	06.12.2022	New Code of Governance		Governor Briefing sessions to be arranged.	Helen Harris	07.02.2023	It was agreed Governor briefings sessions would be arranged when required.			

Key:

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

Trust Board Public Meeting

2022/23

Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
3.5	07.06.2022	Volunteer Strategy		Volunteer Strategy to be updated following proof reading	Ellie Monkhouse	02.08.2022	Update to be provided at the August Trust Board meeting. Amendments had been made to the report.			
3.6	07.06.2022	Key Issues - Performance		Update to be provided on whether the IPR could include exact timings patients had waited over a 12 hr breach.	Shauna McMahon	02.08.2022	Update to be provided at the August Trust Board meeting. At decision was made as to what would be included in the report going forward along with a deep dive at the F&PC meeting.			
3.7	07.06.2022	Finance & Performance Committee Highlight Report & Board Challenge		Deep Dive on ventilation and air conditioning to be shared with Ellie Monkhouse.	Gill Ponder	02.08.2022	Update to be provided at the August Trust Board meeting. This action could be closed as the report had been shared.			
6.2	07.06.2022	HTFTC Highlight Report & Board Challenge		Communication to be sent to staff on the process for accessing Health Tree funds.	Ade Beddow	02.08.2022	Update to be provided at the August Trust Board meeting. The Charity Manager was attending meetings to update colleagues on the progress. An update was also to be provided at the SLC on the current process.			
8.1	07.06.2022	ARG Highlight Report & Board Challenge		BAF Session to be added to the Trust Board Development Session timetable	Dr Peter Reading / Helen Harris	02.08.2022	Update to be provided at the August Trust Board meeting. It was advised the board development programme was being updated to reflect accommodating this session.			
2.7	07.06.2022	CEO Briefing		Update to be provided on how collaboratives would fit within NLAGs Assurance Frameworks.	Sean Lyons & Dr Peter Reading	04.10.2022	A board development session would be held on this item.			
3.2	07.06.2022	Quality & Safety Committee Highlight Report & Board Challenge		Update to be provided from the Q&SC regarding board visits.	Mike Proctor, Dr Kate Wood, Ellie Monkhouse	02.08.2022	It was agreed this item would be discussed outside the meeting between Fiona Osborne and Ellie Monkhouse.			
4.1	07.06.2022	Key Issues - Workforce		Christine Brereton to look at opportunites with Universities in terms of recruiting family members of overseas students. Joint discussion to take place with Simon Nearney.	Christine Brereton	02.08.2022	This item would be monitored through the Workforce Committee.			
10	07.06.2022	Items for Information		Christine Brereton to advise of factual accuracies in specific ARG Minutes	Christine Brereton	04.10.2022	It was agreed this item would be resolved outside of the meeting with the relevant Chair.			
3.6	02.08.2022	Key Issues - Performance		Quality & Safety Committee to review what areas patient initiative follow ups mapped across appropriate in relevant areas.	Quality & Safety Committee	06.12.2022	Update to be provided at the December Trust Board meeting.		December 2022 minutes - action log reference	
3	14.11.2022	Trust Constitution		It was agreed Christine Brereton would circulate the Principles Framework for Determining the Remuneration & Terms of Service for the Chief Executive and Executive Directors to the Executive Team.	Christine Brereton	06.12.2022	Document was circulated to Exec Team.			

Key:

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

NLG(22)007

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	7 February 2023	
Director Lead	Dr Peter Reading, Chief Executive	
Contact Officer/Author	Dr Peter Reading, Chief Executive	
Title of the Report	**Chief Executive's Briefing**	
Purpose of the Report and Executive Summary (to include recommendations)	To brief Board members on certain items of broad interest and/or not covered elsewhere on the Board agenda.	
Background Information and/or Supporting Document(s) (if applicable)	Not applicable.	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	✓ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ✓ Digital ✓ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ✓ 1 - 1.2 ✓ 1 - 1.3 ✓ 1 - 1.4 ✓ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ✓ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Not applicable.	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable.	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
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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

Chief Executive's Briefing

1. National Service and Operational Guidance

The Delivery Plan for Recovering Urgent and Emergency Care Services has been published by NHS England. This covers the full range of services which have an impact upon emergency and urgent care to patients, flow through hospitals and community services, and social care resources. It includes recommendations about best models of care and expectations about delivery required of health care systems.

With regard to elective activity, the main focus across the country and within Humber and North Yorkshire, is on the elimination of any waiting times for elective care exceeding 78 weeks by the end of March 2023. As part of this programme, the Trust is focusing not just on delivery for its own local patients but also on optimising the delivery of Mutual Aid that it can provide to its neighbours at Hull University Teaching Hospitals (HUTH) and York and Scarborough Teaching Hospitals, each of which have substantial numbers of patients waiting longer than 78 weeks.

2. Impact of Industrial Action

Following ballots by a number of trades unions and staff associations across the country, to date, the only organisation which has voted in favour of industrial action at the Trust has been the Hospital Consultants and Specialists Association (HCSA). It has only a very, very small number of members at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and no information is yet available about their plans for industrial action. None of the other unions or staff associations which have balloted so far have achieved the necessary numbers legally to support industrial action at the Trust. There are still some further ballots expected, including from the British Medical Association (BMA).

NLaG has been affected indirectly by industrial action within East Midlands Ambulance Service (EMAS) and Yorkshire Ambulance Service (YAS) in December and January, although our hospitals and community services, working closely with all partners including the ambulance services, have been able to provide very largely a full service on the days of the industrial action.

3. Investment in our Estate

The construction of the new Emergency Department at Scunthorpe General Hospital (SGH) is well advanced, with handover of the building expected at the end of February and its opening in March/April. In addition, refurbishment work, funded by NHS England, has commenced on three operating theatres at SGH and DPOW. The new gamma camera and fluoroscopy rooms at Grimsby are due to be completed by the end of March. The Changing Places facility at SGH (largely funded from the national Changing Places programme via North Lincolnshire Council), is also due for completion in March 2023, as is the upgrade of the mortuaries at SGH and Grimsby.

4. Our Stars 2023

The Trust is re-instating its traditional Our Stars staff awards in 2023. The process will commence shortly. In the meantime, the Baths Hall in Scunthorpe has been booked for the Awards Ceremony on the evening of Friday, 24 November 2023, and substantial commercial sponsorship has been secured to support the event. Board members are asked to put this date in their diary.

Dr Peter Reading
Chief Executive

NLG (23) 008

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 7th February 2023
Director Lead	Shaun Stacey, Chief Operating Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Chief Medical Officer Christine Brereton, Director of People
Contact Officer/Author	Shauna McMahon, Chief Information Officer
Title of the Report	**Integrated Performance Report (IPR)**
Purpose of the Report and Executive Summary (to include recommendations)	**1. Introduction** The IPR aims to provide the Board with a detailed assessment of the performance against the agreed indicators and measures and describes the specific actions that are under way to deliver the required standards. **2. Access and Flow** The executive summary of the Access and Flow section is provided over on page 4. **3. Quality and Safety** The executive summary of the Quality and Safety section is provided over on page 5. **4. Workforce** The executive summary of the Workforce section is provided over on page 7. **5. Appendix** a) Appendix A National Benchmarked Centiles b) Appendix B Extended Scorecards as presented to each respective Sub-Committee **6. The Trust Board is requested to:** a) Receive the IPR for assurance. b) Note the performance against the agreed indicators and measures. c) Note the report describes the specific actions which are under way to deliver the required standards.
Background Information and/or Supporting Document(s) (if applicable)	Access and Flow Quality and Safety Workforce
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable

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

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IPR EXECUTIVE SUMMARY **Date: January2023**

1. ACCESS & FLOW – Shaun Stacey

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

- Cancer – Two Week Wait
- Cancer – 31 Day Surgery
- Percentage of Patients Discharged Same Day As Admission (excluding daycase)

Lowlights: (share 3 areas of challenge/struggle)

- Ambulance Handover Delays 60+ Minutes
- Number of Incomplete RTT Pathways 52 Weeks
- Outpatient Did Not Attend (DNA) Rate

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Ambulance Handover Delays 60+ Minutes	Delivery of improvements within the Ambulance Handover Plan	The Ambulance Handover Plan helps to streamline the process and therefore should reduce the Handover Delays
Number of Incomplete RTT Pathways 52 Weeks	Continue to push for funding for WLIs to uplift theatre activity to support performance and waiting list position	WLIs should increase the capacity to see and treat patients and therefore close more 52-week pathways
Outpatient Did Not Attend (DNA) Rate	Deep dive into DNA – reports in development to identify patients who persistently DNA/Cancel their appointment	The deep dive will identify the reasons for the patient DNA/Cancellations which will allow processes to be put in place to reduce an common causes.

2. QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

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

- Statistically significant improvement in the percentage of patients admitted to IAAU with an actual weight recorded due to the new facility at DPoW ECC to weigh patients in the ambulance arrivals area.
- SHMI continues to be within the expected range. (Further reduced to 101.48 for the period September 2021-August 2022, reported since chart production).
- VTE risk assessment rate continues to meet target.
- The Trusts FFT response rate increase is the highest total of the whole year with areas owning identified actions f to increase their responses and staff engagement
- The total number of falls reported has decreased across all 3 sites
- New formal complaint numbers remain consistent. Following some focused work complaints over 60 working day timescale has reduced by 38% in October and we are now seeing a small and consistent improvement in the last 3 months

Lowlights: (share 6 areas of challenge/struggle)

- The National Patient Safety Alert in relation to insulin pumps and the potential risk of insulin leakage which was due to be closed by 26 November 2022 remains open due to difficulties in the Medicine division to provide robust assurance.
- The Trust successfully transitioned from ORIS the Trust's electronic SJR system on the 19 December to NHS England's new electronic SJR Plus system. Unfortunately, 20 cases did not have the SJR completed ahead of the transition date due to clinical pressures. Therefore, we have a backlog 74 SJRs (20 cases that were in progress and 54 new cases pending distribution).
- In acute the number of pressure ulcer incidents reported has increased slightly for the second consecutive month however, there has been a sustained improvement in the number of pressure ulcers reported over the last eight months
- It is unlikely that the case threshold of 21 for C. difficile will be met as the Trust has reported number of 19 cases so far.
- Incidences of pressure ulcers in Community has seen a slight decrease, however this is a notable reduction from previous data

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Patient safety alerts	A best practice example was shared with staff to provide education. We have been working closely with the diabetes clinical nurse specialists and the division's Clinical Governance Lead to provide education and support to enable the division to provide robust evidence to allow the alert to be closed.	Education and increased understanding regarding what 'good' evidence looks like to enable future alerts to be closed in a timely manner.
SJR backlog	Allocation of new SJR cases has commenced. NHS England are providing training sessions for new reviewers in Jan, Feb and March. These sessions are being supplemented by local in-house training to ensure new reviewers are supported to undertake SJRs.	Timely completion of SJRs and improved quality of reviews.

3. WORKFORCE – Simon Nearney

Highlights:

- Unregistered Nursing Vacancies have continued the downward trend of reducing the Nursing vacancy rate 5.5% from July to November 22. Unregistered Nursing Vacancies remain above target of 8%
- Medical Vacancies remain below the target of 15%
- Turnover has continued to reduce over the last 5 months from 12.69% to 11.4%, Turnover is above target of 10%

Lowlights:

- Core Training is at 89% this below the target of 90%
- Role Specific Training has remained at 75% compliance, against a target of 80%
- Sickness Absence rate has dropped to 5.59% this is above the trust target of 4.1%

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Registered Nursing Vacancies The key issue to address registered nurse vacancies is to continue to recruit international nurses, which at the end of December exceed the planned target with 91 starting in post in 2022. Further starts are planned by March 2023 to take the total up to circa 111. In addition to international nurses a campaign will be launched in January to source domestically trained nurses. **Role Specific Training –** Accommodation and capacity of resource to deliver role specific training is in progress, this will allow larger cohorts to be trained options for the two predominate concerns of resuscitation and moving and handling training. Additional concern release of staff to undertake the training. **Sickness Absence** – the key issue to be addressed within this period is to support the reduction of Sickness Absence is improve managers understanding and capability in relation to the sickness absence policy and process.	**Registered Nursing Vacancies** Recruitment Plans have been created detailing forecasts and have been circulated. Pipeline for international nursing is being diversified to reduce reliance on nurses from a particular area. **Role Specific Training** – Walkarounds taken place at DPOW and Scunthorpe to review options for potential training venues. Sourcing of equipment in progress with expectation to use larger classrooms from March 23. **Sickness Absence** - Relaunched the sickness absence line manager training with the launch of the new sickness absence policy. HR team supporting managers to produce sickness audits to ensure the policy been applied correctly. Exploring options for modifying training	**Registered Nursing Vacancy** - An improved vacancy position is anticipated to reduce turnover rates and increase retention. The introduction of nursing apprenticeships will see reliance on international nurse sourcing reduce longer term, however in the short term this will need to continue. A funding bid for recruitment of international nurses between April and December 2023 is currently being considered, taking CPD, accommodation, and skill mix into account. **Role Specific Training –** Estate increase will lead to greater classroom size and trainer resource. Increase access to training for operational staff. **Sickness Absence** - The expected outcome from the relaunch of the sickness absence line manger training ensuring managers, have the ability to manage sickness absence at the earliest opportunity. The expected outcome of this is short sickness periods and reduce long term sickness absence processes.

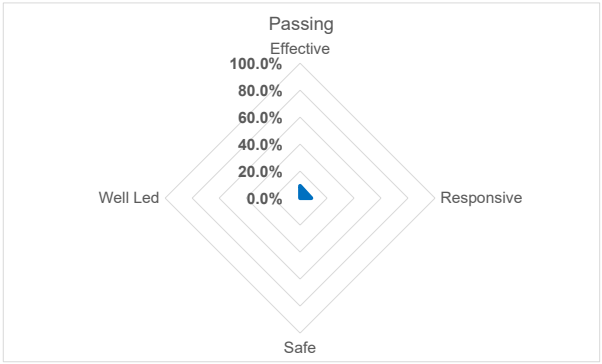
Radar

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

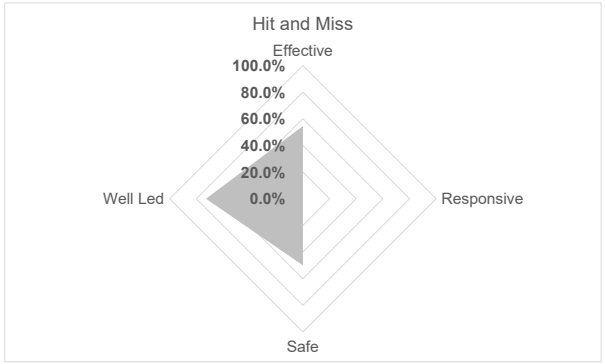
Total: 2



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

Hit and Miss

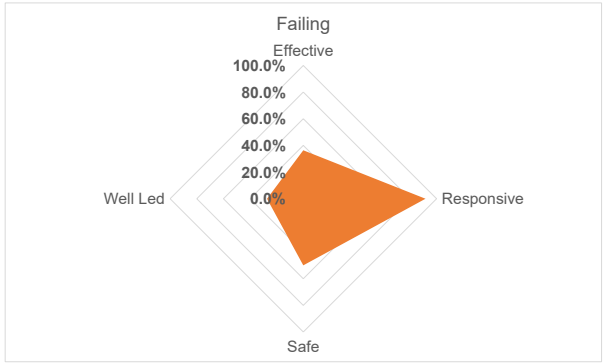
Total: 15



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

Consistently Failing

Total: 19



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

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

Scorecard - Access and Flow

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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Planned	% Under 18 Weeks Incomplete RTT Pathways*	Dec 2022	63.8%	92.0%	Alert		
	Number of Incomplete RTT pathways 52 weeks*	Dec 2022	450	0	Alert		
	Total Inpatient Waiting List Size	Dec 2022	11,571	11,563	Alert		
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Dec 2022	38.8%	1.0%	Alert		
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Dec 2022	33,317	9,000	Alert		
	Outpatient Did Not Attend (DNA) Rate	Dec 2022	7.7%	5.00%	Alert		
	% Outpatient Non Face To Face Attendances	Dec 2022	26.9%	25.00%	Alert		
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Dec 2022	59.1%	85.0%	Alert		
	Cancer Waiting Times - 104+ Days Backlog*	Dec 2022	45	0	Alert		
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Dec 2022	25.0%	75.0%	Alert		
	Cancer - Request To Test In 14 Days*	Dec 2022	80.5%	100.0%	Alert		
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Dec 2022	53.1%	95.0%	Alert		
	Number Of Emergency Department Attendances	Dec 2022	13,313	No Target	Alert		n/a
	Ambulance Handover Delays - Number 60+ Minutes	Dec 2022	883	0	Alert		
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Dec 2022	960	0	Alert		
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Dec 2022	615	0	Alert		
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Dec 2022	41.2%	40.0%			
	% of Extended Stay Patients 21+ days	Dec 2022	13.4%	12.0%			
	Inpatient Elective Average Length Of Stay	Dec 2022	2.5	2.5			
	Inpatient Non Elective Average Length Of Stay	Dec 2022	3.5	3.9			
	Number of Medical Patients Occupying Non-Medical Wards	Dec 2022	324	No Target	Alert		n/a
	% Discharge Letters Completed Within 24 Hours of Discharge	Dec 2022	88.9%	90.0%			
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Dec 2022	16.4%	30.0%	Alert		
	Bed Occupancy Rate (G&A)	Dec 2022	88.8%	92.0%			
COVID	Number of COVID patients in ICU beds (Weekly)	Dec 2022	1	No Target			n/a
	Number of COVID patients in other beds (Weekly)	Dec 2022	45	No Target			n/a
	% COVID staff absences (Weekly)	Dec 2022	19.3%	No Target			n/a

Scorecard - Quality and Safety

NHS Northern Lincolnshire and Goole NHS Foundation Trust

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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Nov 2022	0.00	see analysis			n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Nov 2022	0.10	see analysis			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Nov 2022	0.10	see analysis			n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Nov 2022	0.05	see analysis			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Nov 2022	0.21	see analysis			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Sep 2022	98.9	As expected	**Alert**	H	As expected
	Summary Hospital level Mortality Indicator (SHMI)	Jul 2022	102.8	As expected		L	As expected
Safe Care	Patient Safety Alerts actioned by specified deadlines	Nov 2022	0%	0%	**Alert**	L	n/a
	Number of Serious Incidents raised in month	Nov 2022	7	No target			n/a
	Occurrence of 'Never Events' *(Number)*	Nov 2022	1	0		n/a	n/a
	Duty of Candour Rate	Nov 2022	100%	100%		H	?
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Nov 2022	5.2	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Nov 2022	3.8	No target		L	n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Dec 2022	95.1%	95.0%	**Alert**	H	F
	Care Hours Per Patient Day (CHPPD)	Nov 2022	8.5	No target			n/a
	Mixed Sex Accommodation Breaches	Nov 2022	8	0		n/a	n/a
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Oct 2022	5.5	No target			n/a
	Complaints Responded to on time	Oct 2022	64.0%	85.0%	**Alert**		F
	Friends and Family Test (FFT)						
	Number of Positive Inpatient Scores	Nov 2022	1028 out of 1124	No target		n/a	n/a
	Number of Positive A&E Scores	Nov 2022	502 out of 678	No target		n/a	n/a
	Number of Positive Community Scores	Nov 2022	236 out of 272	No target		n/a	n/a
	Number of Positive Outpatient Scores	Nov 2022	102 out of 114	No target		n/a	n/a
	Number of Positive Maternity Antenatal Scores	Nov 2022	0 out of 0	No target		n/a	n/a
	Number of Positive Maternity Birth Scores	Nov 2022	62 out of 70	No target		n/a	n/a
	Number of Positive Maternity Post-Natal Scores	Nov 2022	0 out of 1	No target		n/a	n/a
	Number of Positive Maternity Ward Scores	Nov 2022	0 out of 0	No target		n/a	n/a

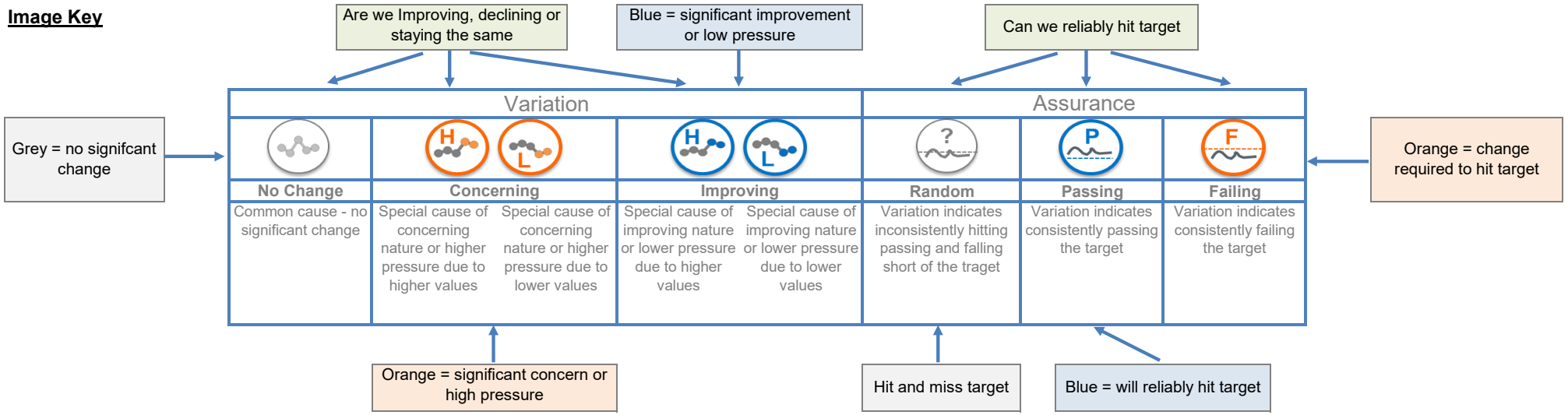
Scorecard - Workforce

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

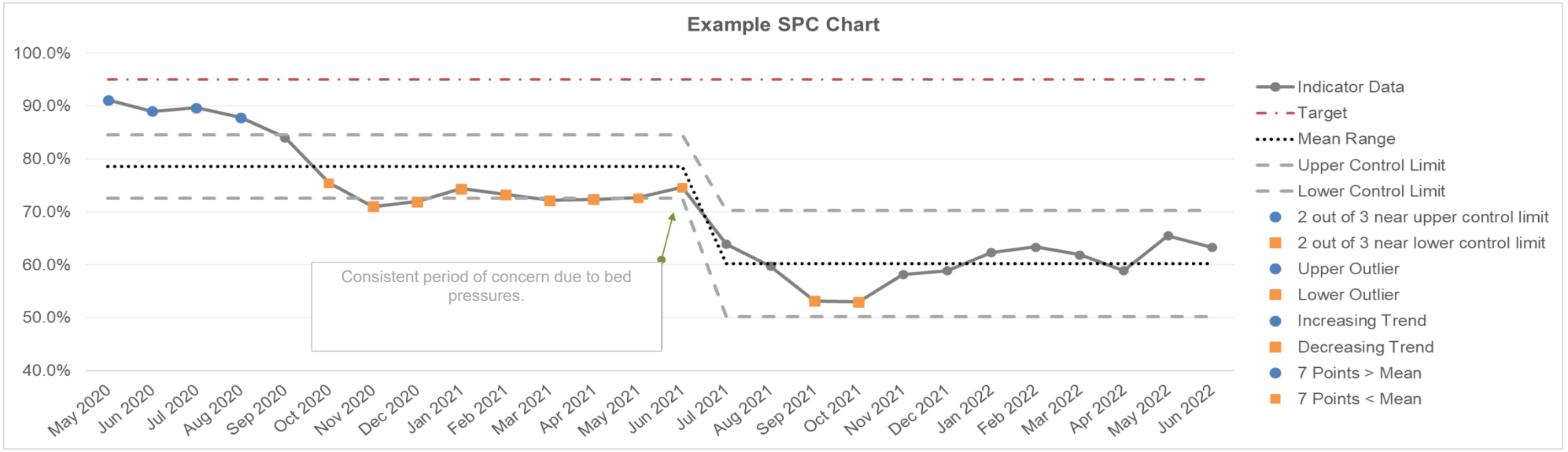
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate	Nov 2022	13.3%	8.0%	Highlight		
	Registered Nurse Vacancy Rate	Nov 2022	12.8%	8.0%	Alert		
	Medical Vacancy Rate	Nov 2022	14.5%	15.0%	Alert		
	Trustwide Vacancy Rate	Nov 2022	11.4%	8.0%	Highlight		
Staffing Levels	Turnover Rate	Dec 2022	11.7%	10.0%	Alert		
	Sickness Rate	Nov 2022	5.6%	4.1%	Alert		
Staff Development	PADR Rate	Dec 2022	83.0%	85.0%	Highlight		
	Medical Staff PADR Rate	Dec 2022	91.0%	85.0%			
	Combined AfC and Medical Staff PADR Rate	Dec 2022	83.7%	85.0%	Highlight		
	Core Mandatory Training Compliance Rate	Dec 2022	89.0%	90.0%	Alert		
	Role Specific Mandatory Training Compliance Rate	Dec 2022	75.0%	80.0%	Alert		

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.

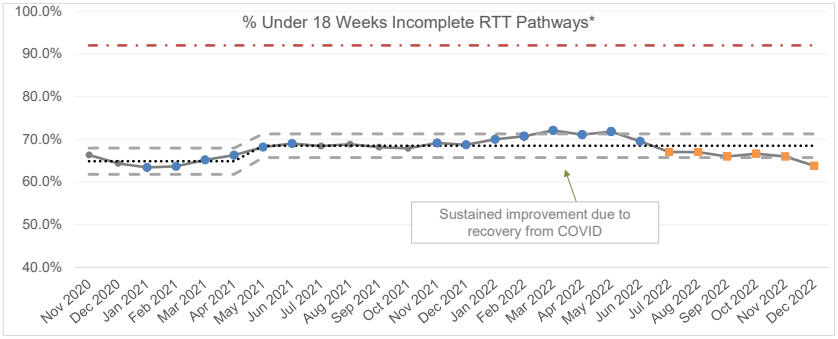
This might be shown as:-

- 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.

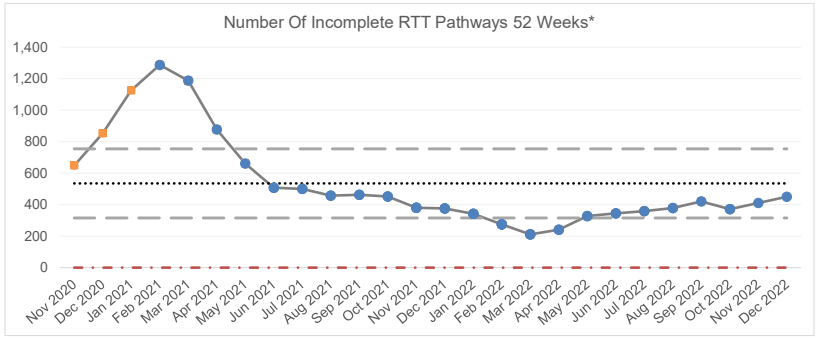
Re-calculation, when appropriate, allows us to see whether we are likely to consistently achieve any target and will still allow us to see of improvement or deterioration is occurring.

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

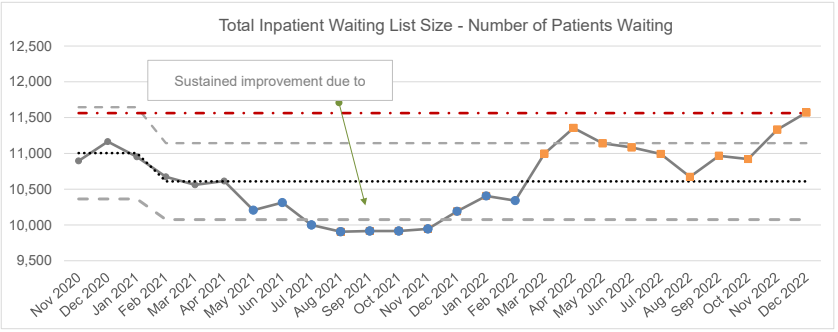
- There should be an identifiable real process change that resulted in the above.
- The change must have been sustained for an appropriate number of data points.



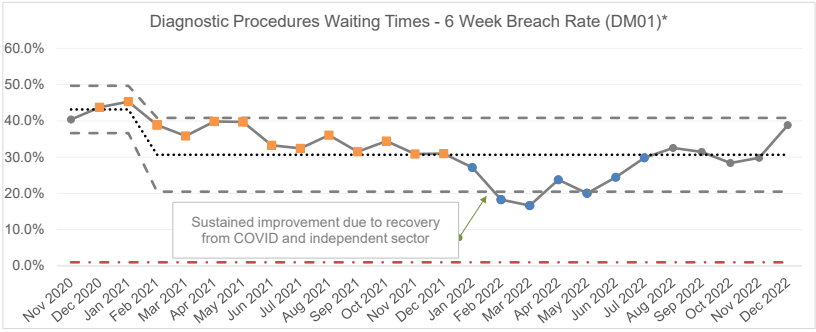
Dec 2022	Target	Variance	Assurance
63.8%	92.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target



Dec 2022	Target	Variance	Assurance
450	0	Special cause of improving nature or lower pressure due to lower values	Consistently falling short of the target



Dec 2022	Target	Variance	Assurance
11,571	11,563	Special cause of concerning nature or higher pressure due to higher values	Consistently passing the target



Dec 2022	Target	Variance	Assurance
38.8%	1.0%	Common cause - no significant change	Consistently falling short of the target

Data Analysis:
Under 18 weeks incomplete*: Although recent data has been largely stable, the trend is showing special cause concern in the last 6 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 decreased over the past 18 months, and shows overall improvement following the spike in 2020. Current data indicates that the target will not be met without action, planned actions outlined below.
Inpatient waiting list: The number of patients on the waiting list over the past 9 months has increased and variance is showing special cause concern, with Nov 22 exceeding the upper process limit and Dec 22 marginally breaching the national target. The indicator can reliably be expected to meet the target.
Diagnostics 6 Week Wait (DM01)*: The performance remains within the expected range, however Dec 22 figures are approaching the upper process limit. Data indicates that the target will not be met without action, planned actions outlined below.

Challenges:
- Acceptance of Mutual Aid
- Significant pressures in anaesthetic assessment capacity due to Mutual Aid creating a bottle neck in the pathway and sickness, vacancy and leave position (SGH Anaesthetics).
- Consultant workforce vacancies
- Echo DM01 waiting times have increased - insufficient capacity in core - secured IS provider, need to continue into 2022/23
- The balance of risk of unplanned vs planned care activity
- Ongoing performance management of the IS Provider contracts
- Increased medical staff sickness in November & December
- Paediatric service -increased ward admissions December 2022
- Reduction in ISP provider Diagnostic activity due to Christmas and New Year
- Significant increase in Diagnostic DNA's in month

Key Risks:
- Potential further COVID waves and staff sickness
- Carry over of annual leave - clinician availability and peak leave in December
- Unable to mitigate the activity gaps of tenders not being realised - ENT and Ophthalmology
- Ongoing management of high levels of acute activity impacting elective work
- Theatre nurse staffing vacancy, retention and high sickness rates - ODP vacacny

Actions:
- Continue to push for funding for WLIs to uplift theatre activity to support performance and waiting list position (ongoing)
- Robust recruitment plan for theatres with external company (ongoing)
- Continual management of medical workforce (ongoing)
- Ongoing use of the Independent Sector is required (March 23)
- Continue with recovery with additional sessions by NLaG clinicians. (March 2023)
- Review of Demand and Capacity across specialties to quantify current context and identify any imbalances and required remedial action (January 2023)
- Digitial solutions being explored and implemented to improve efficiencies wihtin the Diagnostic booking processes (ongoing)
- Working with the region to source additional capacity for MRI and CT (ongoing)

Mitigations:
- 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 treatmen
- Robust structure in place to regularly review waiting lists and focus on long waiting and high risk patients
- Risk stratification programme continues across all specialities
- Locum staff in place where able to secure
- Weekly assurance that on the planning numbers we continue to see a reduction in longer waiters and movement towards constitutional standards

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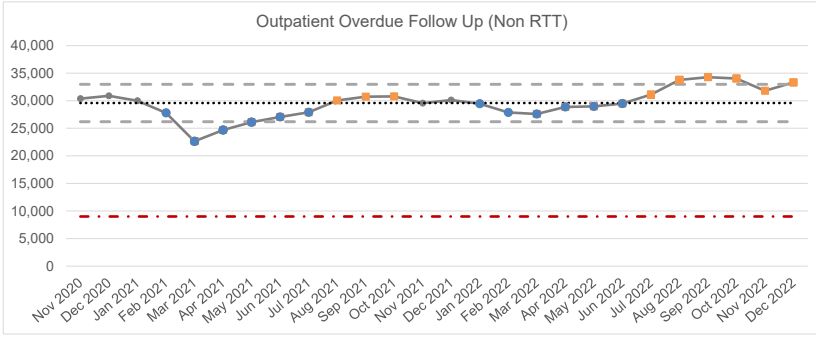
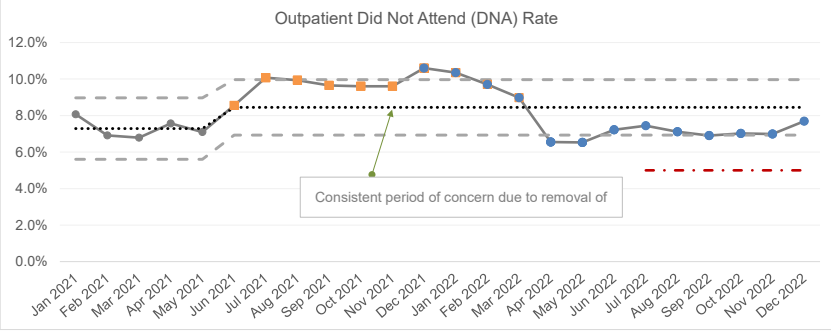
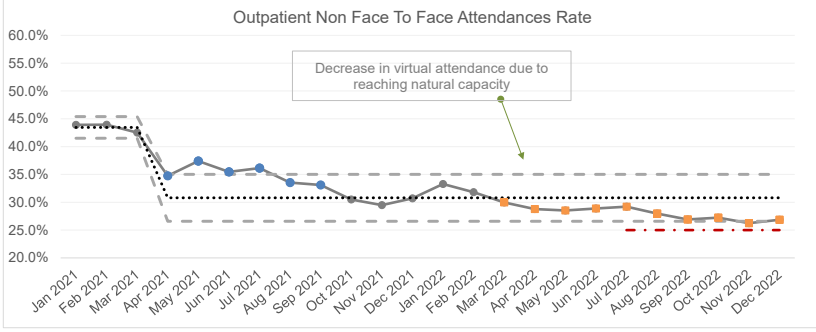


Dec 2022	Target	Variance	Assurance
33,317	9,000	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target



Dec 2022	Target	Variance	Assurance
7.7%	5.0%	Special cause of improving nature or lower pressure due to lower values	Consistently falling short of the target



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

Data Analysis:

Outpatient Overdue follow up: Performance has recorded concern fo the past 6 months. Over this period the indicator has consistently failed the target of 9,000 by some margin. Current data indicates that the target will not be met without action, planned actions outlined below.

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

Non Face to Face Outpatient: Note: Process limit re-calculation from Apr 21. The figure has consistently fallen below the mean for 10 consecutive months, triggering special cause concern. However, performance is reliably achieving the ICS target. Local target is 32% by end March 2023.

Challenges:

- Seasonal variation has seen an increase in DNA's, this will be monitored.
- The number of patients put on a PIFU pathway has decreased marginally
- System financing models are not conducive to system working. Funding arrangements for the CHN model post 22-23 financial year remains challenging - no funding has been identified to support the CHN model from April 23 onwards.
- A&G requests have marginally increased in month, but remains significantly behindthe local target
- Balance between providing overdue follow ups and reducing follow ups by 25%

Key Risks:

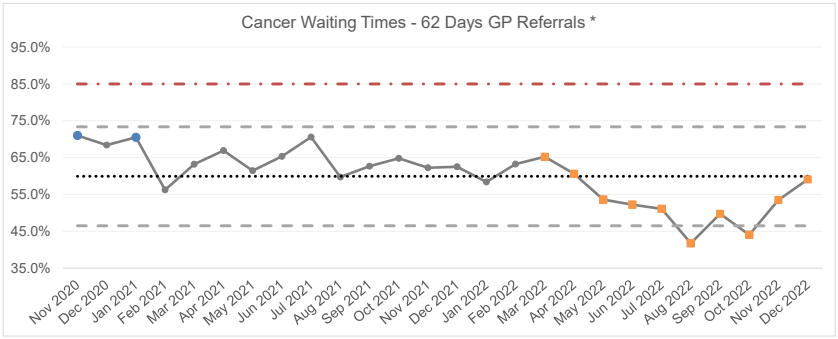
- Clinical buy-in across some specialities to embed PIFU as standard clinical practice
- Inability to secure a long-term finance model for CHN when pump prime funding expires from March 2023
- There is significant risk that the follow up backlog continues to increase unless there is significant focus on changing traditional models of working through emracing PIFU as part of the patient's pathway, discharge where there is no clear benefit from a follow up appointment, reduce follow-up activity and A&G
- Increased levels of Acute/unplanned activity affecting delivery of scheduled elective activity.

Actions:

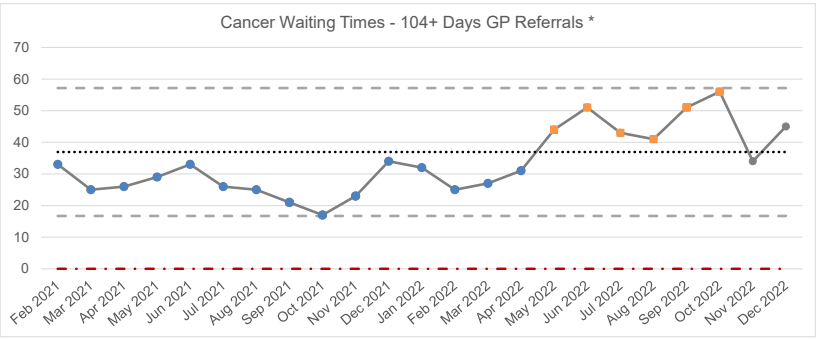
- Deep dive into DNA - reports in development to identify patients who persistently DNA/Cancel their appointment (February 23)
- Phase 2 for the digital letters project commenced go-live with non-leaflet Inpatient Letters and is on a rolling programme including SMS text messaging (January 23)
- CHN long-term funding for the CHN model is being highlighted as part of the planning round (March 23)
- Working with Clinical Leads to engage all speciality leads to include PIFU in pathways where clinically appropriate (Ongoing)
- GIRFT Clinicall led Outpatient Guidance circulated to AGM's and Divisional ACOOs to include as part of 23-24 business planning (June 2023)
- Heart Failure at home being trialled as part of PKB in Cardiology (Ongoing)
- Specialty Level trajectories for achieving a reduction in the backlog of overdue follow ups, increasing PIFU numbers and improved response times to A&G in the Business Planning for 22-23 (March 2023)

Mitigations:

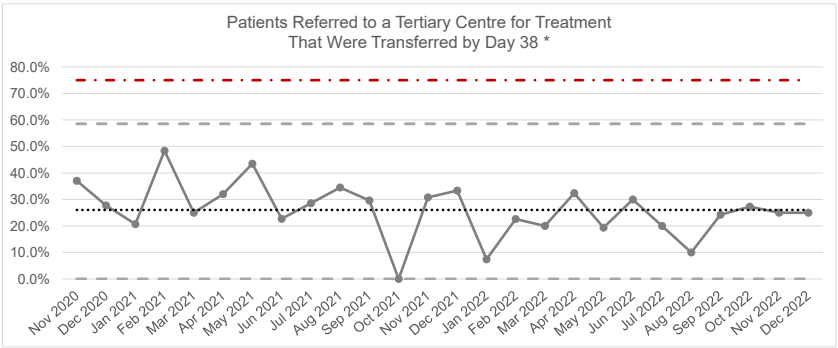
- Director of Place at North LIncs is co-orindating a group to develop a BS to secure funding to support the CHN Model from March 2023 onwards
- Weekly assurance meetings on the activity planning numbers - we continue to see a reduction in longer waiters and movement towards achievement of constitutional standards
- Risk Stratification of outpatient waiting lists
- Mutually agree the majority of out-patient appointments, to minimise DNA rates



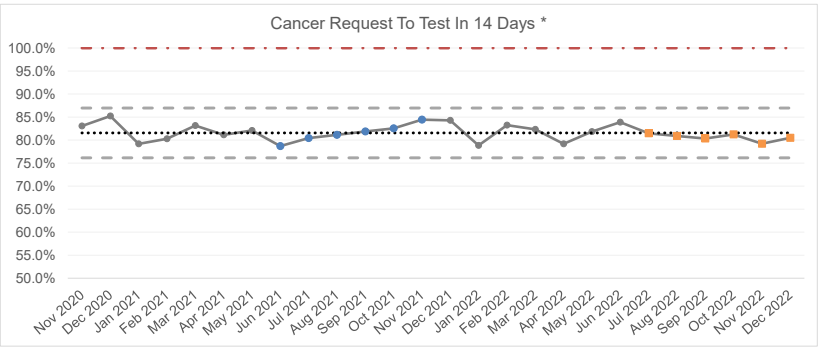
Dec 2022	Target	Variance	Assurance
59.1%	85.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target



Dec 2022	Target	Variance	Assurance
45	0	Common cause - no significant change	Consistently falling short of the target



Dec 2022	Target	Variance	Assurance
25.0%	75.0%	Common cause - no significant change	Consistently falling short of the target



Dec 2022	Target	Variance	Assurance
80.5%	100.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target

Data Analysis:

62 days GP referral*: Performance has shown a special cause concern for the last 10 months, and has remained below the mean for the last 8 months. This target has not been achieved over the last 2 years. Current data indicates that the target will not be met without action, planned actions outlined below.

104+ days GP referrals*: Performance is largely within the process limits, with one-off variation meeting the upper process limit. The indicator is consistently failing the target and current data indicates that the target will not be met without action, planned actions outlined below.

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

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

Challenges:

- Management of complex unfit patients requiring significant work-up are causing delays
- All tumour sites are affected by the increasing waiting times for oncology consultant appointments resulting in increased breaches of 62 days
- Most tumour sites are unable to achieve 62 day standard due to multiple factors, including diagnostic and pathoogy turnaround times, patient choice.
- Notable increase in Urological Cancer referrals over last 3 months

Key Risks:

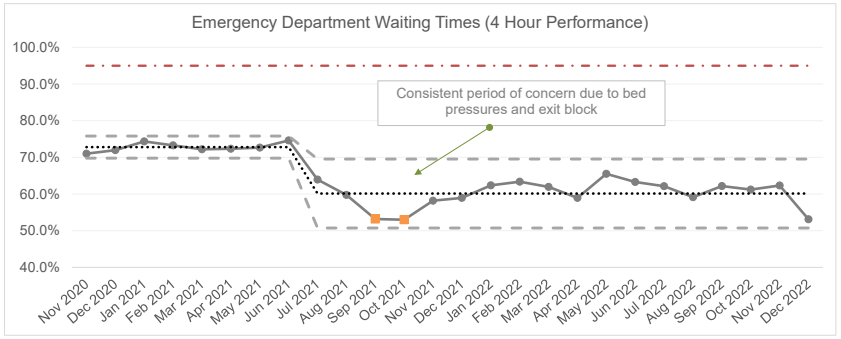
- For UGI and H&N surgery is carried out in Hull which is currently causing significant delay- small numbers
- Lack of Oncology Capacity for 1st appointments - now booking 6 weeks from point of referral
- Covid +
- One Clinician at SGH running STT UGI service - manageable as small numbers but during leave and sickness leaves service vulnerable
- HUTH have relocated Urology oncologist to Breast, which is causing a significant risk to waiting times
- Urology cancer consultant now on phased return following extended sick leave.
- There are a number of issues related to visiting consultant services (e.g urology, oncology), tertiary based staging scans (EUS, PET CT) which affect the ability to transfer (IPT) for treatment by Day 38
- Request to test (14 days) - in order to meet 28 day Faster Diagnosis Standard, this needs to be reduced to 7 calendar days.
- Meeting the 38 day IPT standard is impacted through delays occurring with tertiary diagnostics/staging TAT, and visitng consultant/oncology services (urology - prostate)

Actions:

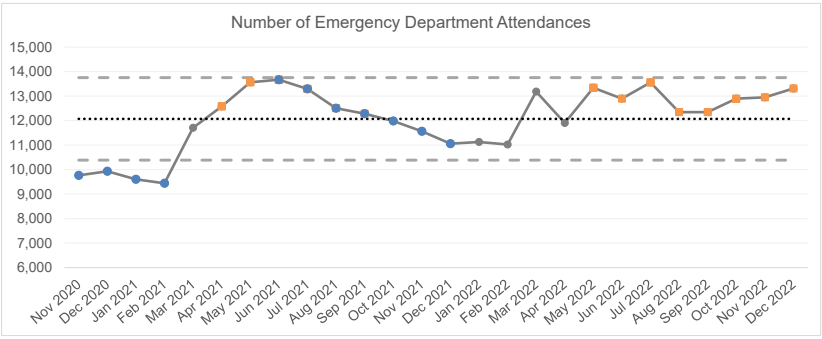
- Colorectal recovery plan in place with improvements already seen to 28 day faster diagnosis pathway - further actions to be implemented with all short and medium term actions (March 23)
- Urology service review completed with additional one stop clinics introduced - impact on pathways being monitored over the next 8 weeks (February 23)
- UGI - consultant led straight to test (June 23)
- Single Lung MDT with HUTH & NLaG (June 23)
- Timely removal of patients from cancer tracking once non-malignancy confirmed (ongoing)

Mitigations:

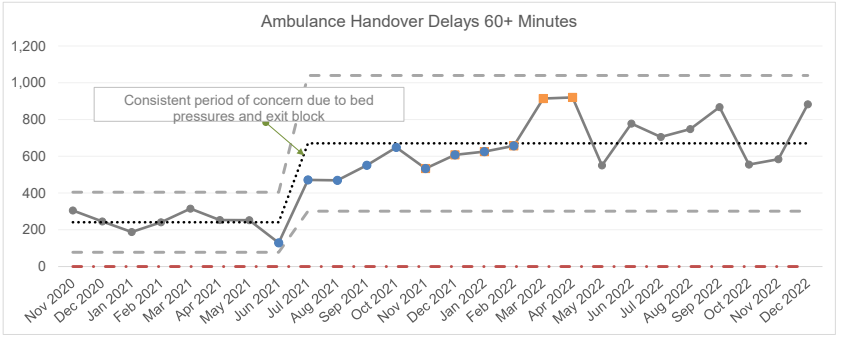
- Increase RDC capacity to work alongside STT to streamline service in Colorectal- managing numbers albeit increased
- Funding approved to recruit to Band 3 and Band 2 admin support
- RDC to be opened up to non site specific pathway from 1st May 2022 with minimal uptake - this remains minimal after nealry 1 year
- 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.
- The pathway analyser tool that has been developed within NLAG (using the IST tool) and the in depth analysis of pathways will enable teams to identify where improvements in NLAG can be achieved. Lung completed and fed back to clinical team - remedial actions being discussed.
- The joint transformation pathway work with HUTH will help with the transfer of patients between NLAG/ HUTH and to identify areas where the pathway can be accelerated



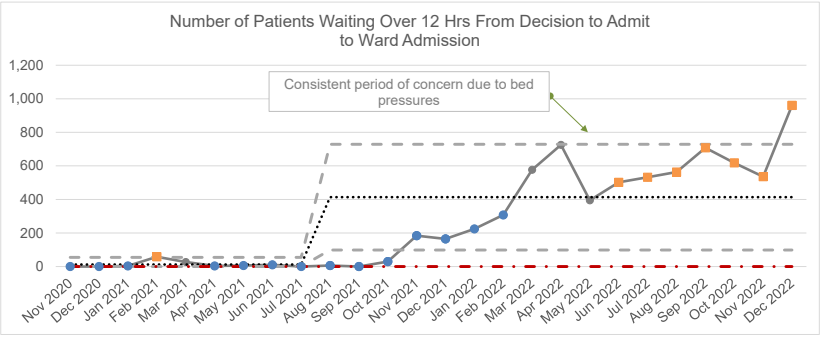
Dec 2022	53.1%
Target	95.0%
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target



Dec 2022	13,313
Target	No Target
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	There is no target therefore target assurance is not relevant



Dec 2022	883
Target	0
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target



Dec 2022	960
Target	0
Variance	Special cause of concerning nature or higher pressure due to higher values
Assurance	Consistently falling short of the target

Data Analysis:

ED 4 hour waiting: Following the significant deterioration in the summer of 2021, performance has been stable and within the recalculated expected range. Current data indicates that the target will not be met without action, planned actions outlined below.

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

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

DTA 12 hours: Process limit re-calculation from Aug 21. This indicator continues to record very high, increasing levels triggering concern, with Dec 22 exceeding the upper process limit. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

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

Key Risks:

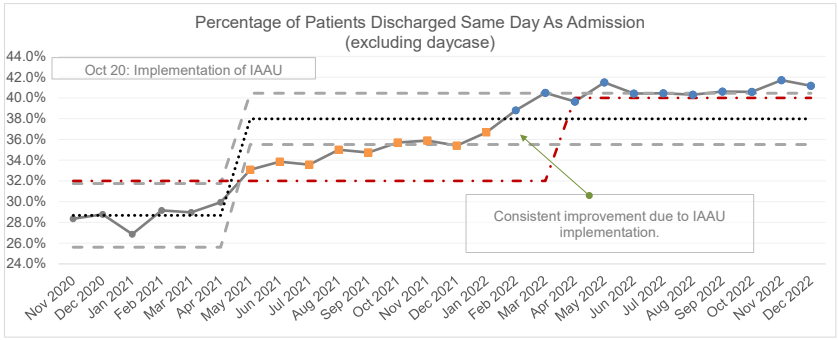
- Staffing gaps in both medical and nursing
- High levels of agency and locum staff
- Inability to achieve Ambulance Handover targets due to patient flow within the hospital
- Inability to meet patient waiting times in ED
- Staff burnout
- The current substantive SDEC staffing establishment does not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

Actions:

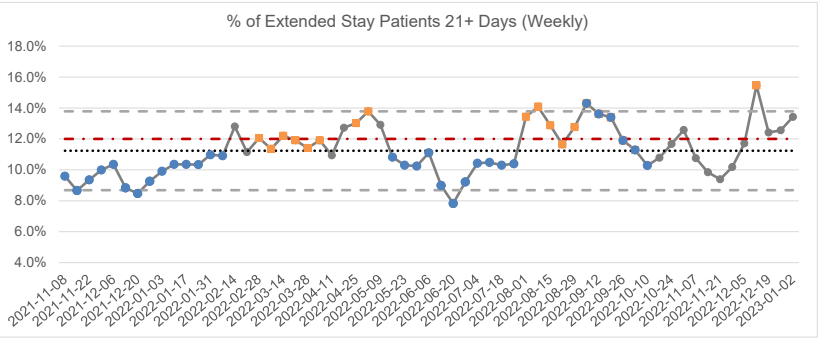
- Work continues on the new build increase footprint with SGH New Emergency Department going live (February 23)
- Paper completed in relation to additional staffing for Medical staffing as part of a Quality Improvement Project (January 23)
- Work continues on improvement to pathways (March 23)
- Review of all Urgent Care Services across Northern Lincolnshire has commenced to look at reducing pressure across the system by ensuring that patients are seen at the right place, by the right person, first time - Feedback has been sent to CCG from NLaG (ongoing)
- Delivery of the improvements within the Ambulance Handover Plan (January 23)
- Working with Single Point of Access to improve direct referrals to SDEC (GP/EMAS) (ongoing)
- Funding now approved for SDEC staffing establishment (ongoing)
- Working with family Services to mitigate the risk of increased paeds attendances (April 23)

Mitigations:

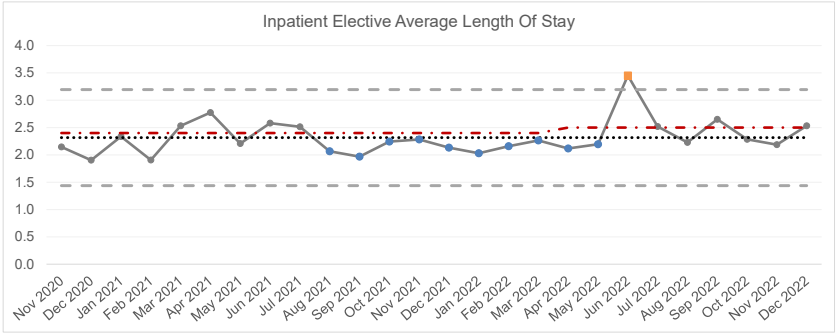
- Patients are triaged on the ambulances if there is a delay to ambulance handover to ensure patient safety
- New structure in place within ED with senior decision makers now identified on a daily basis for EPIC, Resus/Majors, Initial Assessment and Ambulance Triage
- Tier system is in place to ensure that escalation is taking place where appropriate to support patient flow to ensure a swift resolution to issues
- Fast track paediatric process in place
- Increased staffing in ED
- Alternatives to trolleys – beds, recliner chairs. Choice of meals for patients during prolonged ED stays



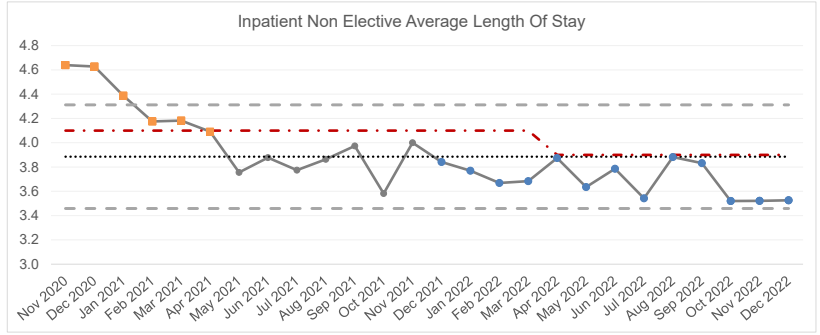
Dec 2022	Target	Variance	Assurance
41.2%	40.0%	Special cause of improving nature or lower pressure due to higher values	Inconsistently hitting passing and falling short of the target



Dec 2022	Target	Variance	Assurance
13.43%	12.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



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



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

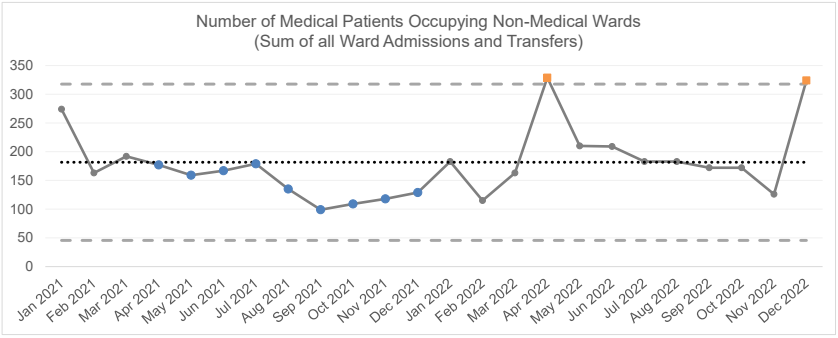
Data Analysis:
Discharged same day as admission: Note: Local target increased from 32% to 40% from April 22. Performance shows sustained improvement with recent data points showing the highest performance since 2020. The target can be expected to achieve and fail at random.
% Extended stay 21+ days: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

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

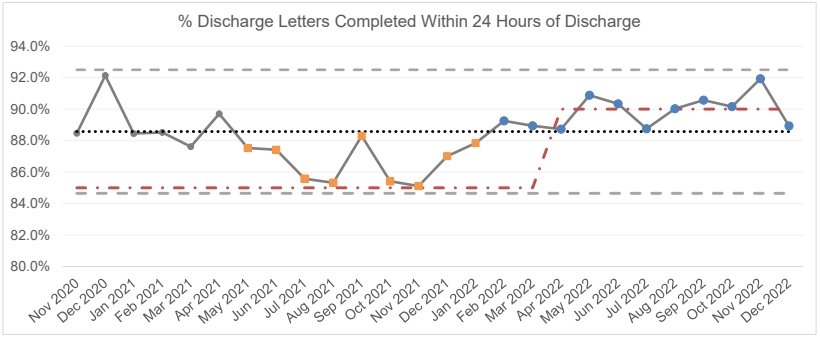
Key Risks:
- Space and capacity issues within SDEC/IAAU
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- Covid-19 impacting phsyical capacity within the current footprint
- Lack of patient flow through the system resulting in a lack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

Actions:
- Review of Demand and Capacity across specialties to quantify current context and identify any imbalances and required remedial action, (January 2023)
- Virtual Ward for both Acute Respiratory Illness & Frailty to go live on 9th January (January 2023)
- Increase capacity within OPAT (January 23)

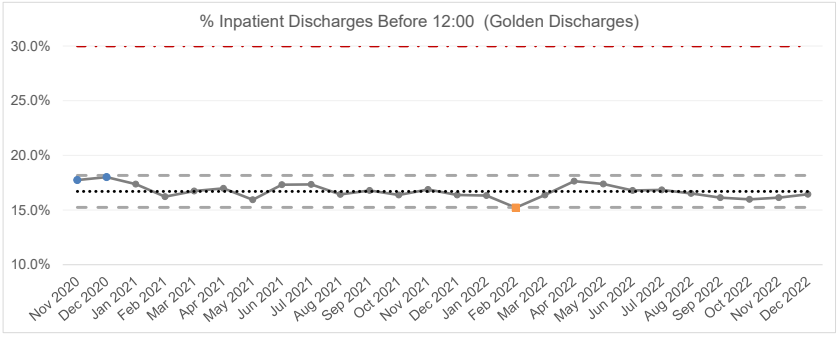
Mitigations:
- Home Care: Discharge Programme in place
- 2 hour community Response
- Single Point of Access
- Acute and Community joint work group established between Medicine and Community & Therapies
- CRT GP suporting Category 3 & 5 calls
- Work taking place with system partners to understand the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



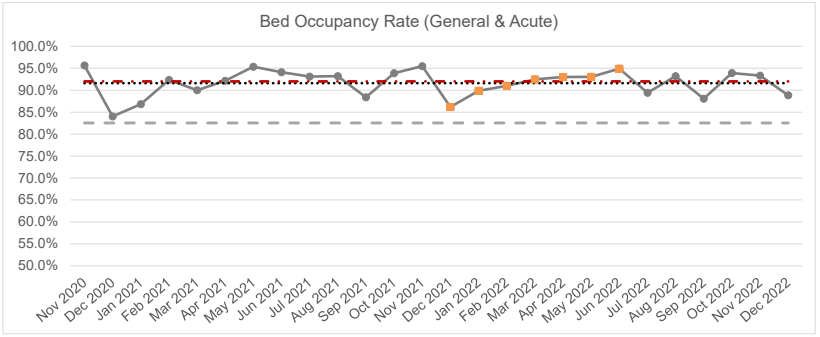
Dec 2022	Target	Variance	Assurance
324	No Target	Special cause of concerning nature or higher pressure due to higher values	There is no target, therefore target assurance is not relevant



Dec 2022	Target	Variance	Assurance
88.9%	90.0%	Special cause of improving nature or lower pressure due to higher values	Inconsistently hitting passing and falling short of the target



Dec 2022	Target	Variance	Assurance
16.4%	30.0%	Common cause - no significant change	Consistently falling short of the target



Dec 2022	Target	Variance	Assurance
88.8%	92.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target

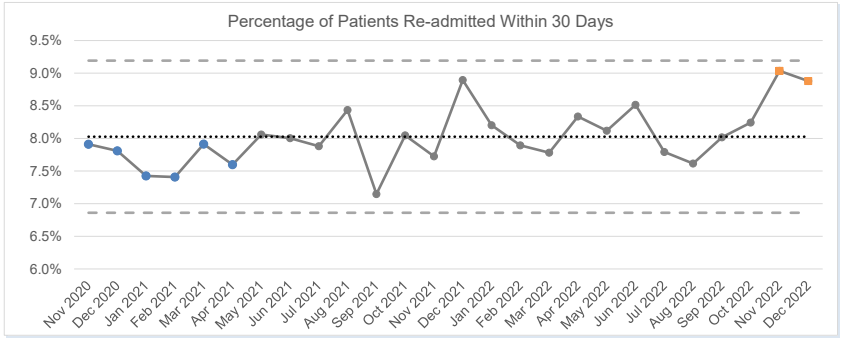
Data Analysis:
Medical Outliers: Following a period of stability for 7 months, Dec 22 has recorded a sharp increase in numbers which has triggered special cause concern. The analysis of this indicator is very sensitive to ward re-categorisations including any temporary agreed usage of wards out of usual scope.
Inpatient discharge letters: Note: the local target of 85% has been increased to 90% in April 22. The data is falling within the expected range and has recorded improvement for the past 8 months. The indicator can be expected to achieve and fail the target at random.
Inpatient discharges before 12:00: Performance is currently stable and as expected. In terms of assurance, current data indicates that the target will not be met without action, planned actions outlined below.
G&A Bed Occupancy: Performance remains stable within the expected range for the data. The target can be expected to achieve and fail at random.

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

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

Actions:
- Review of Demand and Capacity across specialties to quantify current context and identify any imbalances and required remedial action, (January 2023)
- Virtual Ward for both Acute Respiratory Illness & Frailty to go live on 9th January (January 2023)
- Increase capacity within OPAT (January 23)

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



Dec 2022
8.9%

Target
No Target

Variance

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

Assurance

There is no target, therefore target assurance is not relevant

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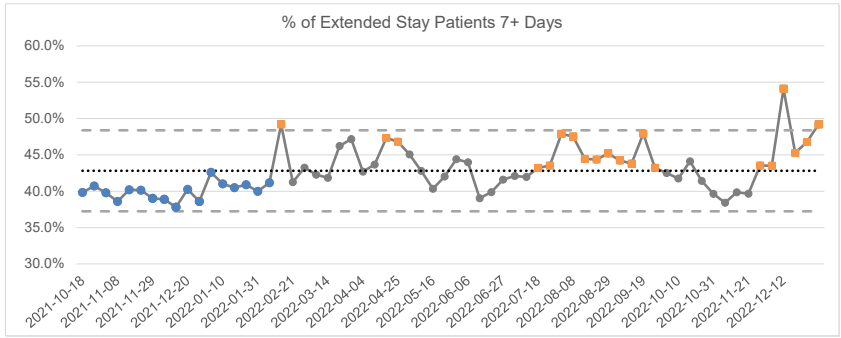


Dec 2022
49.2%

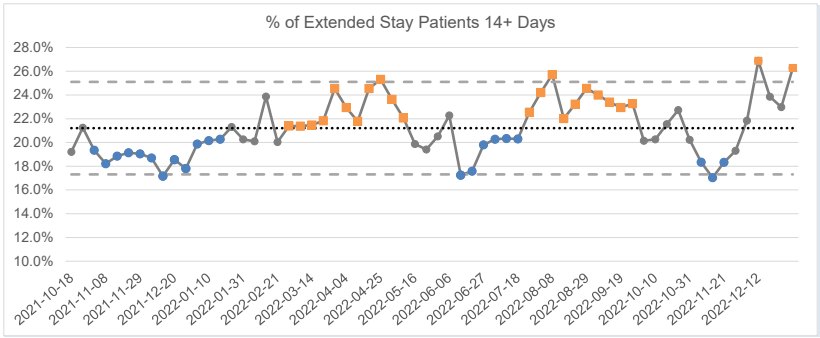
Target
No Target

Variance

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

Assurance

There is no target, therefore target assurance is not relevant



Dec 2022
26.3%

Target
No Target

Variance

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

Assurance

There is no target, therefore target assurance is not relevant

Data Analysis:

Emergency Re-admissions 30 days: Performance is currently within the expected range, however the last 2 months have shown an increase, registering special cause concern. For context, the national benchmark figure for the 12 months to July 22 is 7.19%. NLAG's figure for July 22 was 7.79%.
Extended stay 7+ days: Recent performance has been above the mean for the past 6 months, with Dec 22 exceeding the upper process limit for the expected range, and is currenlty a cause for concern. See Flow page 1 for the 21+ day position.
Extended stay 14+ days: Performance remains largely within the expected range, however Dec 22 is recording special cause concern. See Flow page 1 for the 21+ day position.

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

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

Actions:
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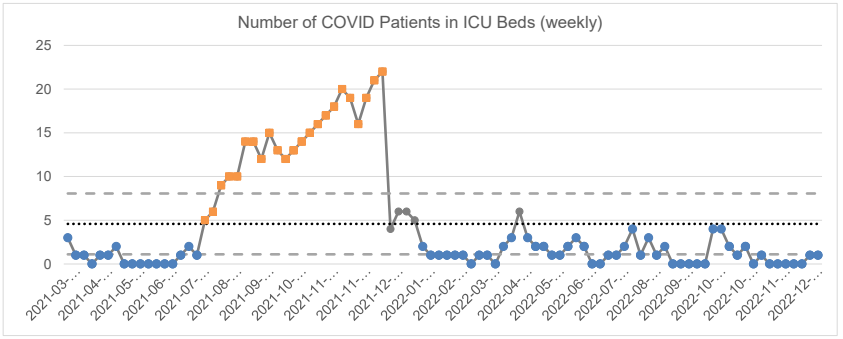
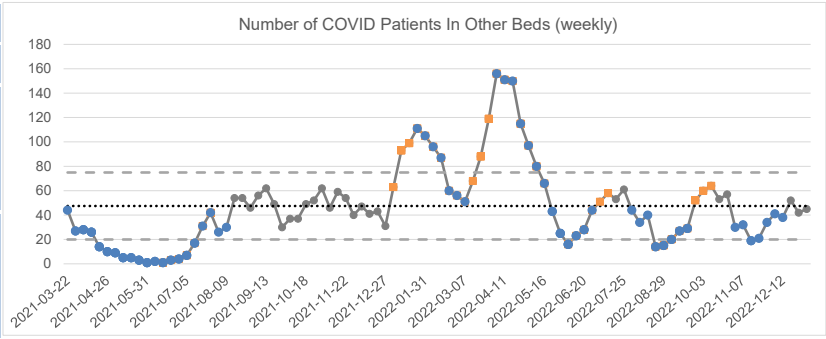
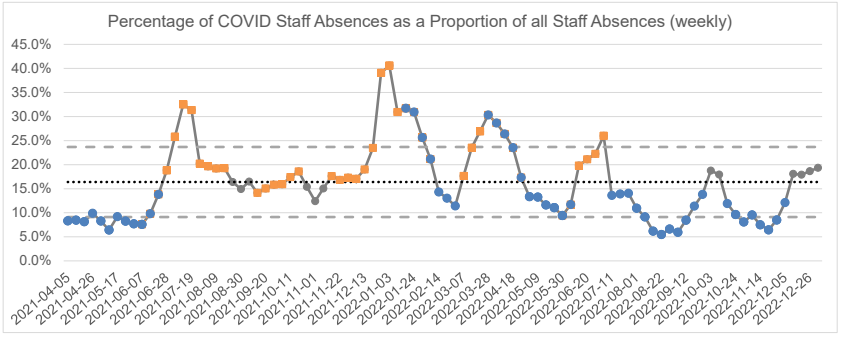


Dec 2022	Target	Variance	Assurance
1	No Target	Special cause of improving nature or lower pressure due to lower values	There is no target, therefore target assurance is not relevant



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



Dec 2022	Target	Variance	Assurance
19.3%	No Target	Common cause - no significant change	There is no target, therefore target assurance is not relevant

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Data Analysis:

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

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

COVID Staff Absences: The rate has been volatile since 2021 with repeated changes between concerning and improving performance. Data for the last 4 months has been approaching the mean, registering no cause for concern.

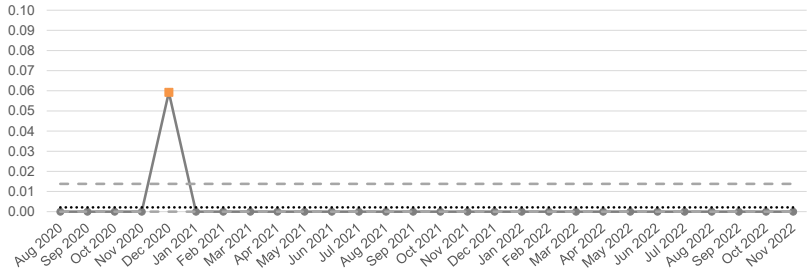
Challenges:

Key Risks:

Actions:

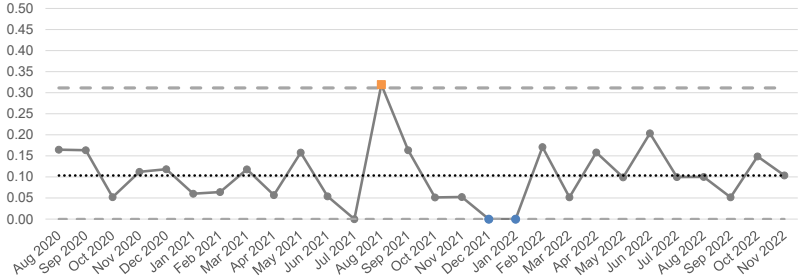
Mitigations:

Number of MRSA Infections (Rate Per 1000 Bed Days)



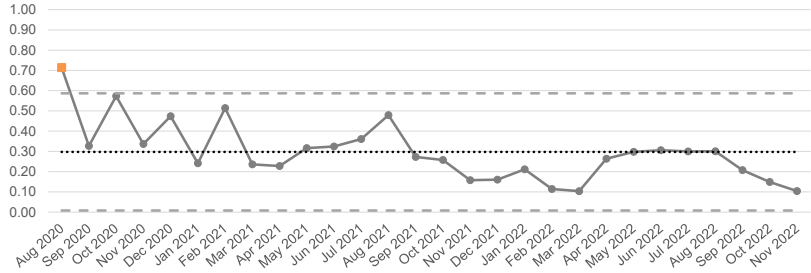
Nov 2022
0.00
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Number of Trust Attributed C-Difficile Infections (Rate Per 1000 Bed Days)



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

Number of E Coli Infections (Rate Per 1000 Bed Days)



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

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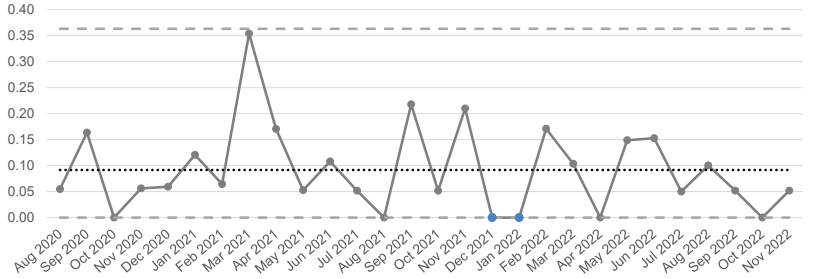
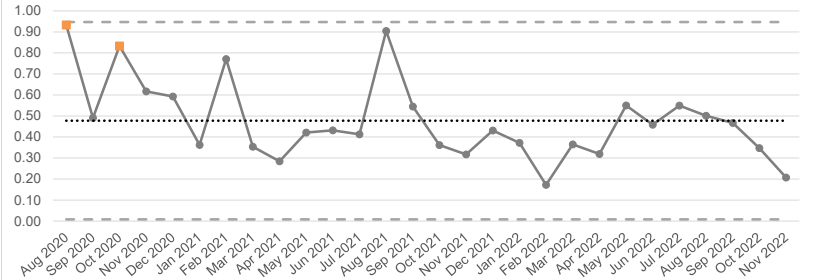
Data Analysis:
MRSA: Performance is stable and within the expected range of the data. The YTD figure is 0 against an annual target of 0.
C Diff: Performance is stable and within the expected range of the data. The YTD figure is 19 against an annual target of 21.
E Coli: Performance is stable and within the expected range of the data. The YTD figure is 38 against an annual target of 65.

Commentary:
Cdiff, MSSA and Ecoli reportable cases are as expected. There has been no MRSA case for 2 years



Nov 2022
0.05
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Nov 2022
0.21
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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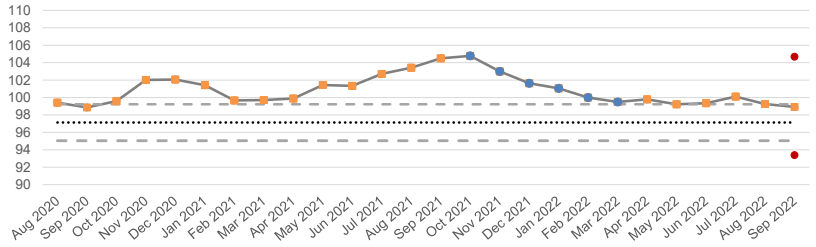
Data Analysis:
MSSA: Performance is stable and within the expected range of the data. The YTD figure is 11, there is no annual target.
Gram Neg: Performance is stable and within the expected range of the data. The YTD figure is 67 against an annual target of 97.

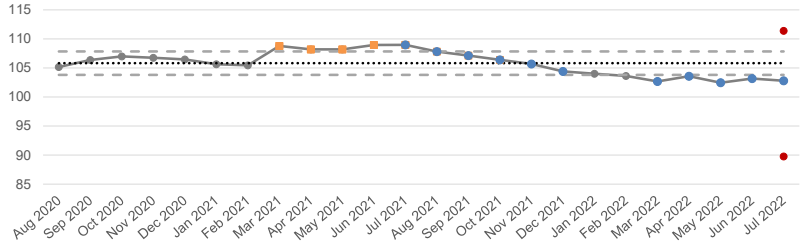
Commentary:
MSSA and Gram Negative cases are stable and within expected range. There has been no MRSA Bacteraemia case for 2 years

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



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

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



Jul 2022
102.8
Target
As expected
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Within 'as expected' range

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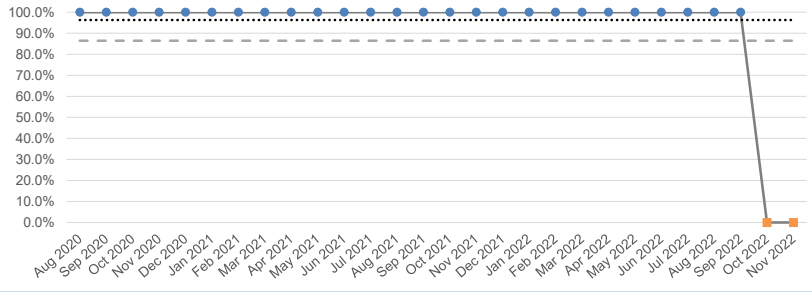
Data Analysis:
HSMR: Our contract with HED has come to an end. Until we have a new supplier it is not possible to update this chart. The data represents a rolling 12 month position.
SHMI: Performance continues to record improvement. The data represents a rolling 12 month position.

Commentary:

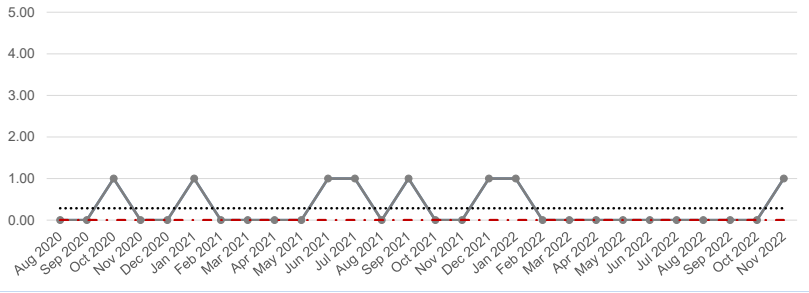
Northern Lincolnshire and Goole NHS Foundation Trust

Patient Safety Alerts to be actioned by specified deadlines



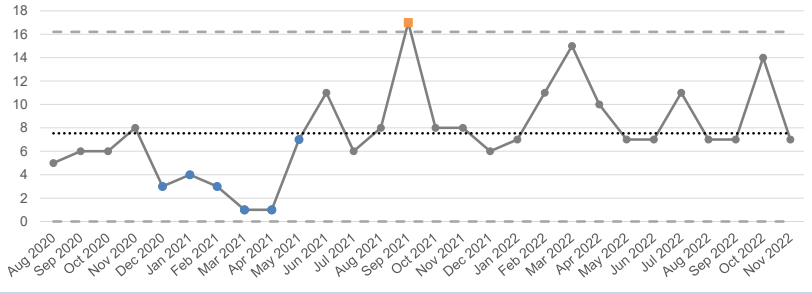
Nov 2022
0.0%
Target
No target
Variance
Special cause of concerning nature or lower pressure due to lower values
Assurance
There is no target therefore target assurance is not relevant

Occurrence of 'Never Events' (Number)



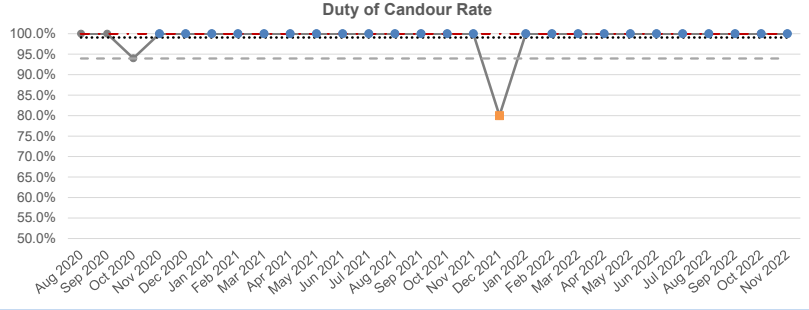
Nov 2022
1
Target
0
Variance
The data are not appropriate for an SPC chart, therefore varaince is not relevant
Assurance
The data are not appropriate for an SPC chart, therefore assurance is not relevant

Number of Serious Incidents Raised in Month



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

Duty of Candour Rate



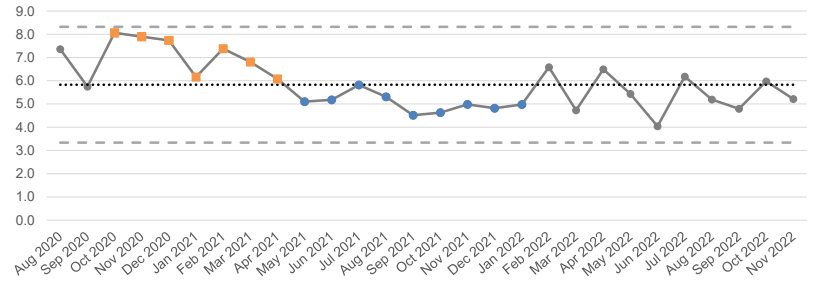
Nov 2022
100.0%
Target
100.0%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target

Data Analysis:

Patient Safety Alerts: Patient Safety Alerts are at zero per cent for the past two months. However, both months have a denominator of 1.
Never Events: Due to the infrequency of never events an SPC is not appropriate. Never events data are a subset of the serious incidents data.
Serious Incidents: Note this data is updated retrospectively to reflect any de-escalated incidents. The data is within the expected range of variation.
Duty of Candour: With the exceptions of October 2020 and December 2021 performance has achieved the target consistently for over two years.

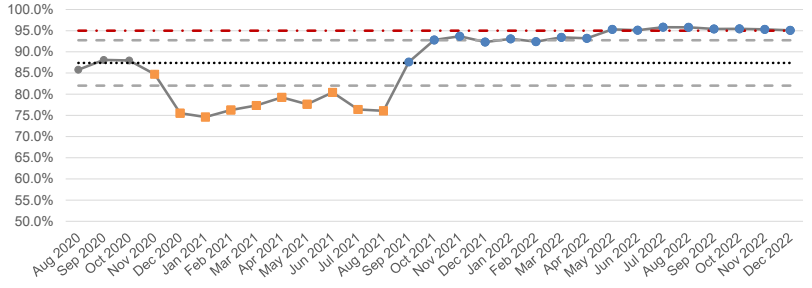
Commentary:
A National Patient Safety Alert in relation to insulin pumps and the potential risk of insulin leakage was due to be closed by 26 November 2022. All the actions were completed and assurance was provided for the Paediatric patients from the Family Services division. However, there was insufficient assurance provided to allow the closure of the alert from the Medicine division in relation to the adult patients at DPoW. We have clinical reassurance from the diabetes clinical nurse specialists that they have taken the necessary actions, but we took the decision not to close the alert until full assurance of completion has been provided. We have been working closely with the diabetes clinical nurse specialists and the division's Clinical Governance Lead to provide education and support to enable the division to provide robust evidence to allow the alert to be closed.

Falls on Inpatient Wards (Rate Per 1000 Bed Days)



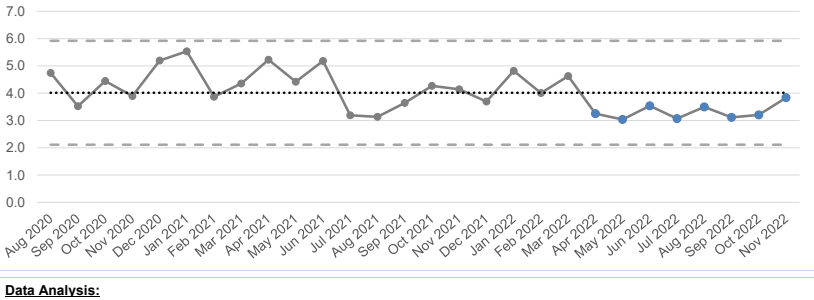
Nov 2022
5.2
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant

Venous Thromboembolism (VTE) Risk Assessment Rate



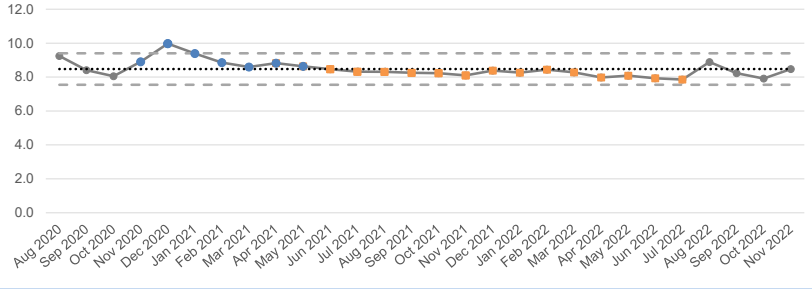
Dec 2022
95.1%
Target
95.0%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Consistently failing the target

Hospital Acquired Pressure Ulcers on Inpatient Wards (Rate Per 1000 Bed Days)



Nov 2022
3.8
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

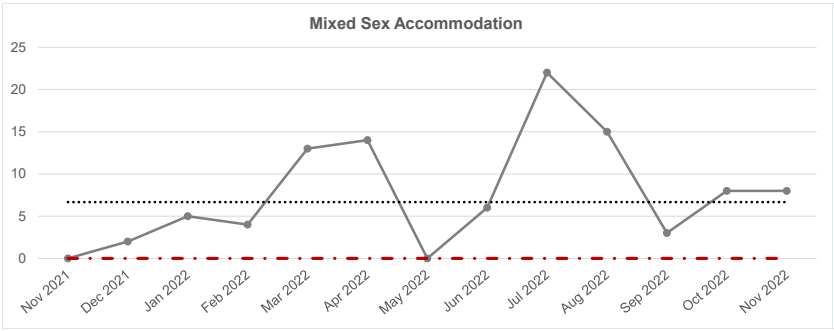
Care Hours Per Patient Day (CHPPD)



Nov 2022
8.5
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 within the expected range.
VTE Risk Assessment: Performance has shown a significant improvement over the past 16 months. For the past eight months the target has been met. However, more data is needed to provide assurance that the target will consistently be met.
Hospital Acquired Pressure Ulcers: Performance is consistently within the expected range. The indicator has recorded below average figures for the past eight months triggering improvement.
Care Hours Per Patient Day: Performance continues within the expected range for the data.

Commentary:
Falls - the number of reported falls remain within the "as expected" range. Pressure Ulcers - there has been a small increase in reported pressure ulcers in November. The numbers reported continue to suggest an improvement. CHPPD - the overall Trust CHPPD was 8.5 in November. The latest model hospital data for October 2022 indicates a provider value of 7.9 (quartile 2 mid-low 25%) against a peer median of 8.1 and provider median of 7.9.



Nov 2022
8
Target
0
Variance
There is currently insufficient data, therefore variance is not relevant
Assurance
There is currently insufficient data, therefore assurance is not relevant

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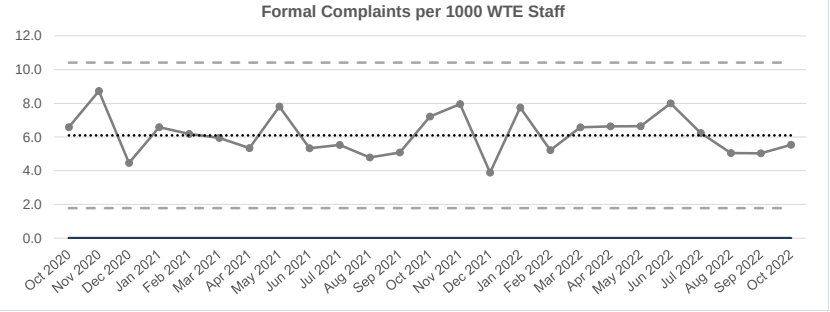
Data Analysis:
Mixed sex accommodation: There is insufficient data for SPC presentation.

Commentary:



Oct 2022
5.5
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore assurance is not relevant

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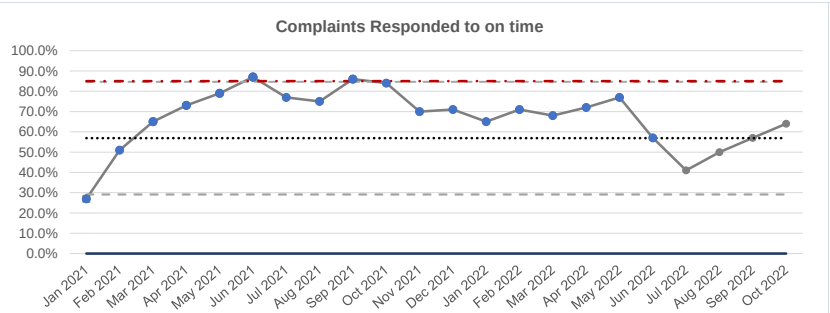

Oct 2022
64.0%
Target
85.0%
Variance
Common cause - no significant change
Assurance
F
Consistently failing the target

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Data Analysis:

Formal Complaints: The data continues within the expected range.

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

Commentary:

Complaints responded to on time: The Data continues within the expected range but is not currently meeting the target. We have seen 3 months of improvement due to the agreed actions now being undertaken by Divisions. Progress

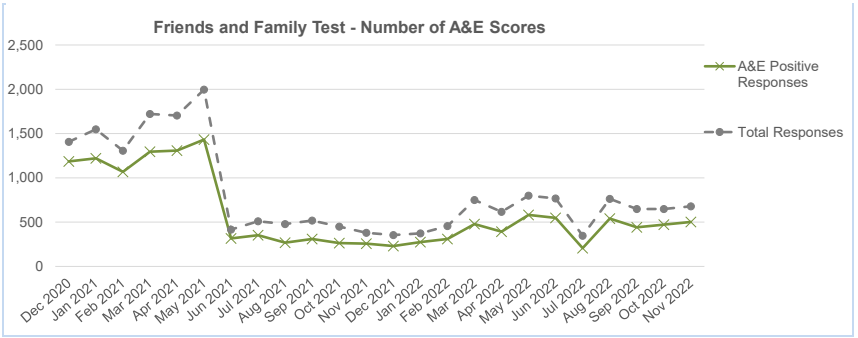
> Continued improvement seen in responses in timescale
> Reduced new complaint numbers - providing some additional support time from central team
> Weekly meetings now all in place with divisions and Complaint Manager
> Temp PALs Manager able to reduce translation of concerns to complaints through interventions
> Delays in development of learning module in Ullysses but learning captured in responses of all upheld complaints

Risks

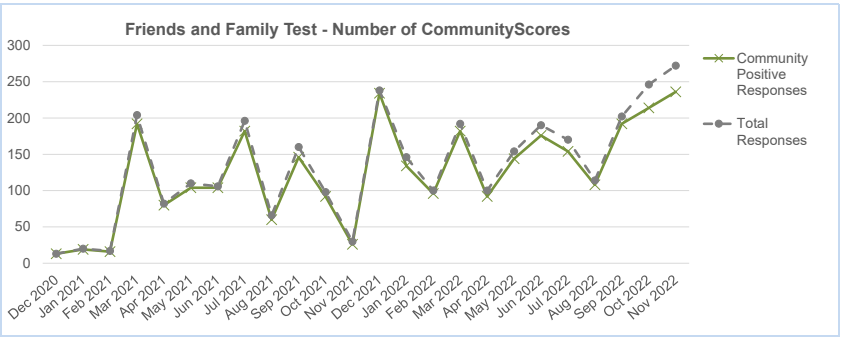
> Increased time required by clinical staff to manage complex complaint investigations remains an ongoing concern
> Sustained compliance against KPI of 85% closed complaints managed in timescale , ongoing risk
> Reputational risk to Trust , ongoing risk

Mitigation

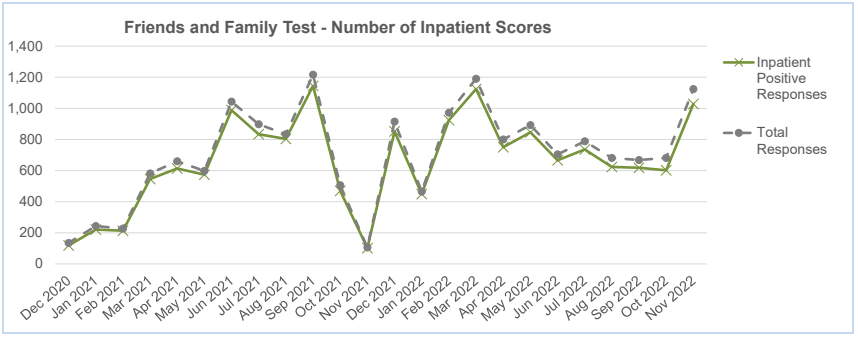
> Weekly Central Team Support and Challenge Meetings
> Chief Nurse Reporting
> PRIMS
> Monthly and weekly complaint report and feedback
> Escalation processes
> Divisional meetings with PALs and Complaint Manager



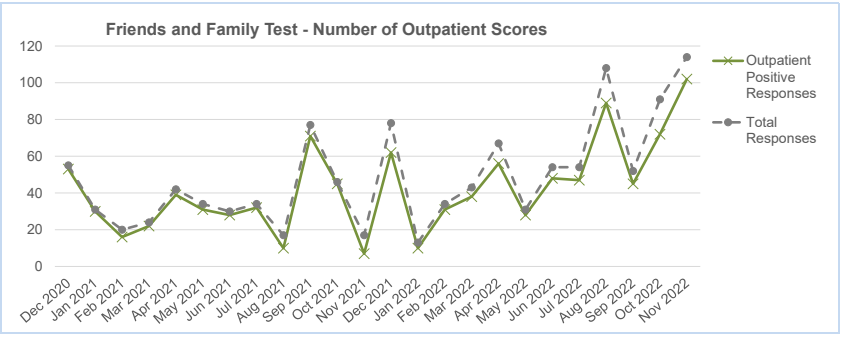
Nov 2022
502 out of 678
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Nov 2022
236 out of 272
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Nov 2022
1028 out of 1124
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



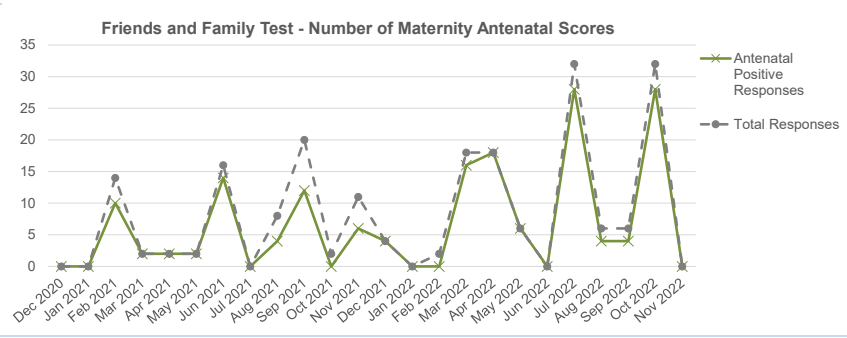
Nov 2022
102 out of 114
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

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

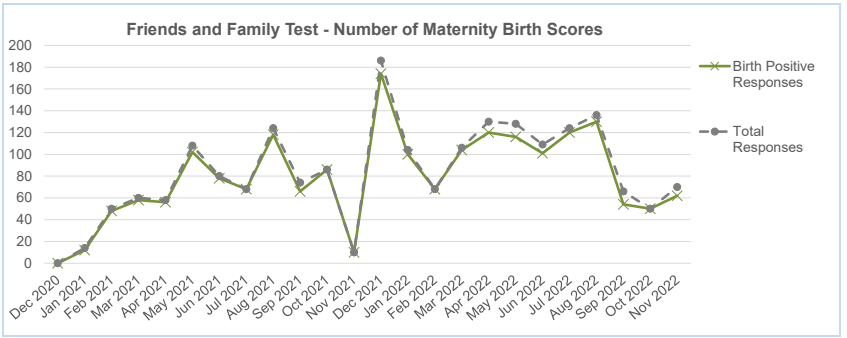
Commentary:
Progress
> Increase in responses across Trust
> Patient Experience Manager engagement meetings with ward managers/dept leads continue
> Draft FFT report under first review
> Patient Experience Manager undertaking quality checking of response data by IWGC to determine error translation rate
> Kiosks and SMS developments continue to be explored

Risks
> Temporary Patient Experience Manager post due to complete March 31st 2023
> Increased clinical activity and priorities means that FFT conversations are challenging
> Lack of representative feedback responses meaning reduced oversight of patient insights
> Staff engagement levels mean that response collection is impacted in many areas
> Methodologies are limited in some areas meaning accessibility is reduced

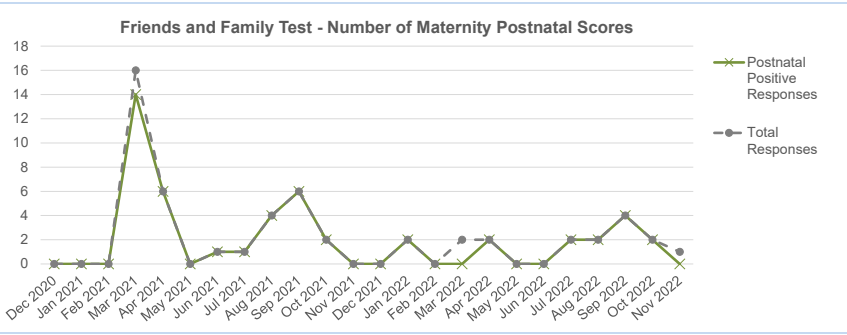
Mitigation
> Weekly meetings with IWGC
> Temporary Patient Experience Manager has priorities
> Divisional Patient Experience Meetings highlighting issues
> Quarterly Divisional reported shared with PEG
> Utilisation of new patient experience dashboard to share FFT data divisionally via Metrics
> Widespread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



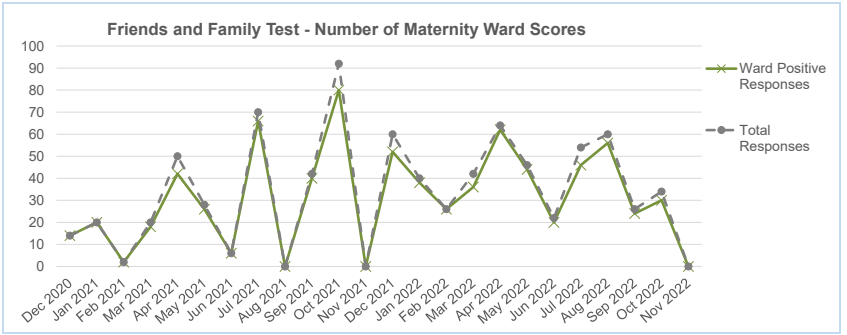
Nov 2022
0 out of 0
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Nov 2022
62 out of 70
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



Nov 2022
0 out of 1
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC



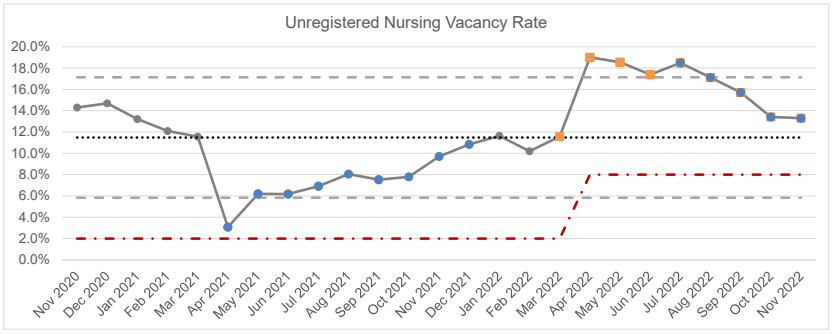
Nov 2022
0 out of 0
Target
No target
Variance
Inappropriate chart format for SPC
Assurance
Inappropriate chart format for SPC

Data Analysis:
Maternity Antenatal FFT: There were no responses received in November
Maternity Birth FFT: The majority of respondents continue to provide positive feedback.
Maternity Postnatal FFT: There was one response received in November and it was not positive.
Maternity Ward FFT: There were no responses received in November

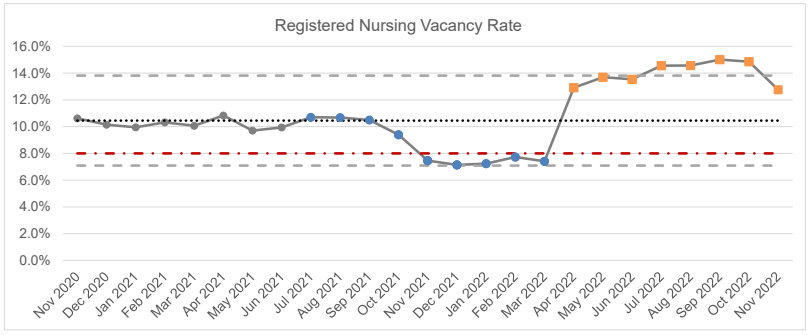
Commentary:
Progress
> Continued variation in response numbers
> Badgernet option unable to provide quality data outputs and therefore not to be used
> IWGC continue to work to improve maternity platform for responses still ongoing
> Patient Experience Manager meeting with ward managers for engagement purposes
> SMS and online options to be reviewed to see if any factors inhibiting completion

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

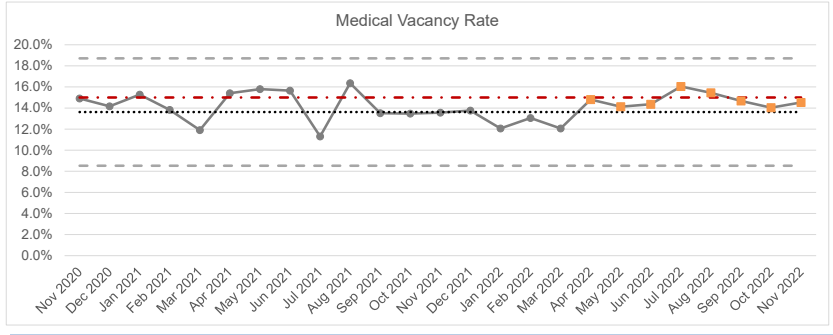
Mitigation
> Weekly meetings with IWGC
> Release of Patient Experience Manager to focus on FFT
> Divisional Patient Experience Meetings highlighting issues
> Quarterly Divisional reported shared with PEG
> Utilisation of new patient experience dashboard to share FFT data divisionally via Metrics
> Other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



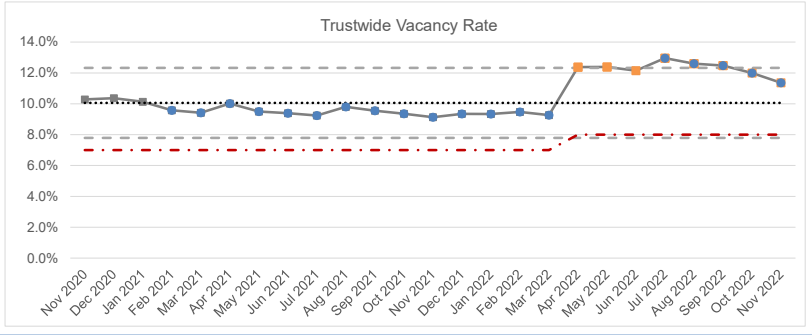
Nov 2022
13.3%
Target
8.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target



Nov 2022
12.8%
Target
8.0%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target



Nov 2022
14.5%
Target
15.0%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target



Nov 2022
11.4%
Target
8.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target

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

Commentary:
Unregistered Nursing Issues/Risks: Retention of HCAs, current high vacancy rate.

Mitigations: A project group led by the Chief Nurse's office to oversee activity and consider mitigating actions. Successful mass recruitment events took place in September which exceeded plans, with 142 appointments made. HCA induction capacity has been increased to allow quicker onboarding of new HCAs from recruitment events. Mass recruitment of HCAs implement as BAU, with events planned each quarter. Next recruitment events scheduled for January 2023, with a large uptake from candidates, with circa 100 confirmed to attend. Theapproach taken by NLAG regarding sourcing and new to care has been recognised by NHSi/e as good practice and the Trust has been asked to present this approach to the North East and Yorkshire region.

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

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

Actions: Continue sourcing of nursing candidates via the Talent Acquisition Team - Domestic and international. Continued engagement with both Chief Nurse Directorate and Operations to review existing recruitment practices. Implementation of a nursing workforce plan as part of the Nursing Strategy inclusive of all pipelines including apprenticeship development and a strengthened domestic presence in the existing market place. Commence local/regional/national recruitment campaign in anuary 2023.

Mitigations: A project group led by the Chief Nurses office to oversee all activities. Newly qualified nurse (NQN) recruitment for 21/22 exceeded target with 89 appointments. Plans for International Nurses have been exceed with 91 started by January. Further 10 planned for Q4. Nursing career frameworks and introduction of nursing apprenticeships currently being recruited to will will see reliance on international nurse sourcing reduce longer term. Invitations to be bid for further funding for 2023 have been communicated, this is being considered by the Chief Nurse's Office project group.

Commentary Vacancies Cont/d:
Medical Issues/Risks: Availability of accomodation can delay recruitment processes.

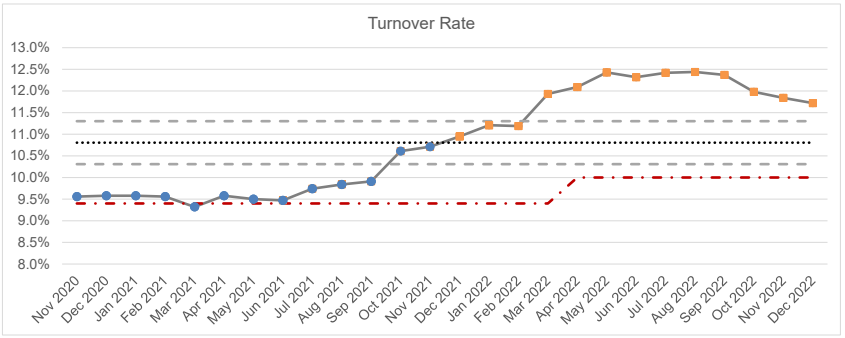
Actions: Ongoing recruitment activity across specialties. Commence UK based sourcing via Talent Acquisition Team.

Mitigations: Recruitment team continuing to engage with candidates.. A pipeline of 59 medical staff has been established awaiting start. A network of private landlords has been established to support accomodation needs where the Trust is unable to accommodate locally, and work undertaken by the onsite accommodation team to free up onsite accommodation. Accommodation team have given notice to long term tenants to free up on-site accommodation for new starters and a change of policy relating to length of stay. Recruitment team are meeting the accommodation team weekly to review priorities and identify accommodation needs. Issues have been resolved with Royal College of Physicians, opening up the MTI pipeline again. UK sourcing via Talent Acquisition Team commencing January 2023.

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

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

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



Dec 2022
11.7%
Target
10.0%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently failing the target

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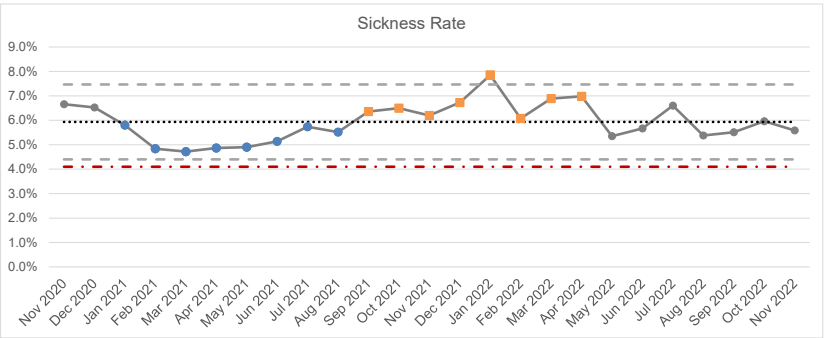

Nov 2022
5.6%
Target
4.1%
Variance
Common cause - no significant change
Assurance
Consistently failing the target

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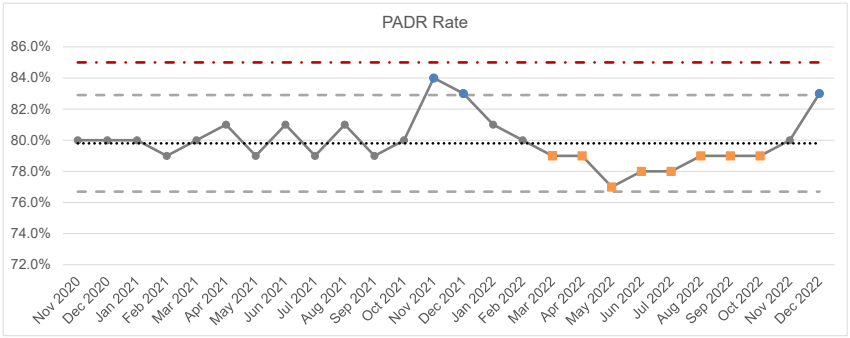
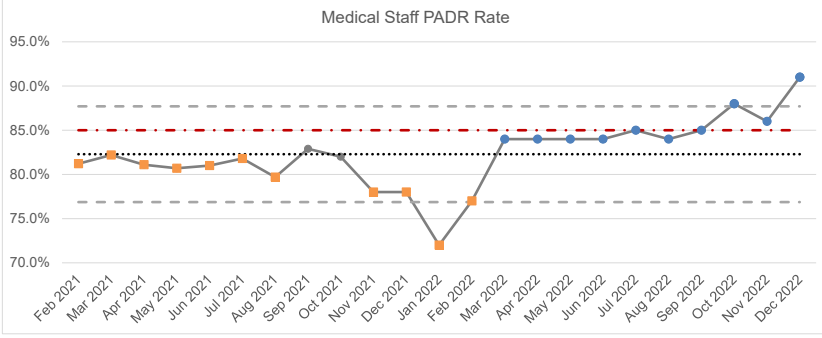
Data Analysis:
Turnover Rate: After having stayed fairly stable during the peak of pandemic, the turnover rate has been steadily increasing since the end of summer 2021 and has recorded concerning performance for the past year
Sickness Rate: This indicator has recorded a general increase in sickness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

Commentary:

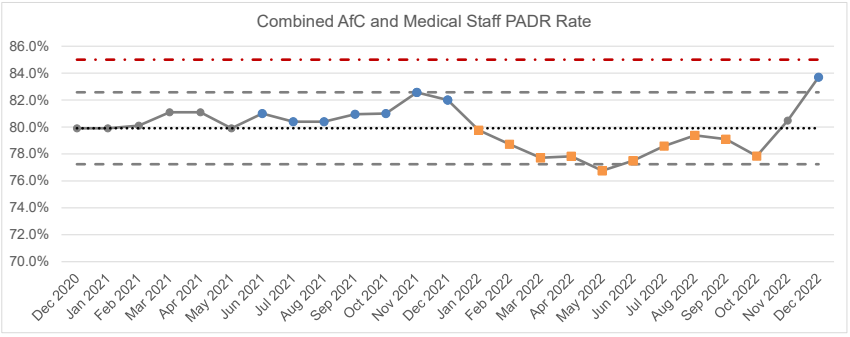
The HR teams have been providing line manager training to divisional areas to ensure managers are fully equipped to manage their staff in relation to sickness absence. There has been a strong focus on staff on long term sickness to ensure they are managed to enable a successful return to work, consideration of redeployment options or to progress to case review. We are experiencing a high volume of staff progressing to case review as a result of correct management. We continue to achieve the KPI set out in the MAP policy for any employee off work for 6 months with no expected RTW date to be progressed to a case review. The HR team continue to promote all the wellbeing support as a preventative measure around keeping staff in the workplace with a mental health condition working closely with the Trust well-being and occupational health teams. Further work around the sickness management process is being reviewed within the team to streamline any documentation required for managers.



Dec 2022	83.0%
Target	85.0%
Variance	Special cause of improving nature or lower pressure due to higher values
Assurance	Consistently failing the target



Dec 2022	91.0%
Target	85.0%
Variance	Special cause of improving nature or lower pressure due to higher values
Assurance	Inconsistently hitting passing and failing the target



Dec 2022	83.7%
Target	85.0%
Variance	Special cause of improving nature or lower pressure due to higher values
Assurance	Consistently failing the target

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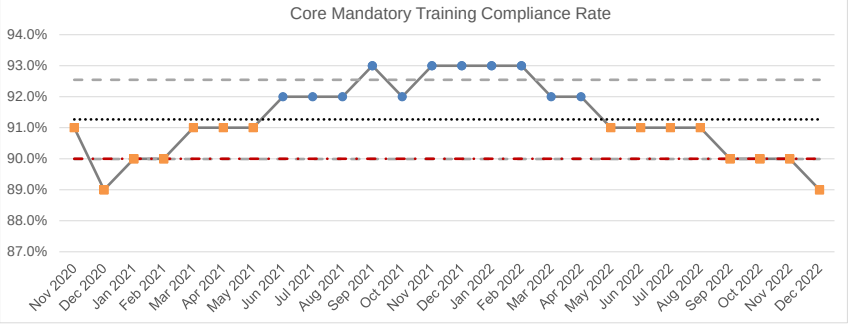
Data Analysis:
PADR Rate: After a period of deterioration, significant improvement has been seen in the last two months, PADR rate is steadily increasing towards the target.
Medical Staff PADR Rate: Performance has been predominantly within the expected range for the past two years with an improvement seen over recent months.
Combined AfC and Medical Staff PADR Rate: Following eighteen months of stable or improving figures, performance has deteriorated in recent months and is now recording concern since January 22. Current data indicates an improvement towards to the target.

Commentary:
The ETD team continue to communicate with individual line managers where PADRs are out of compliance. This has proven successful in improving compliance rates across the Trust.
The ETD team continue to work closely with the ESR team to monitor compliance through Power BI for PADR. This allows managers to access real time data and implement relevant actions to ensure / improve compliance. The ETD team are reviewing SOPs to ensure accuracy of data reports utilised to produce Power BI infographics and information

Commentary:
CMOD continues to support medical staff in completing their appraisal. Those who are late, are contacted by the CMOD team with support from Associate Medical Directors of the relevant division and from the Appraisal Clinical Lead. CMOD uses POWER BI to identify areas that need extra and targeted support to ensure appraisal completion. CMOD also ensures that the medical staff on POWERBI match the doctors on the appraisal system and any discrepancies have been highlighted (i.e missing staff on PowerBI)



Dec 2022
89.0%
Target
90.0%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target

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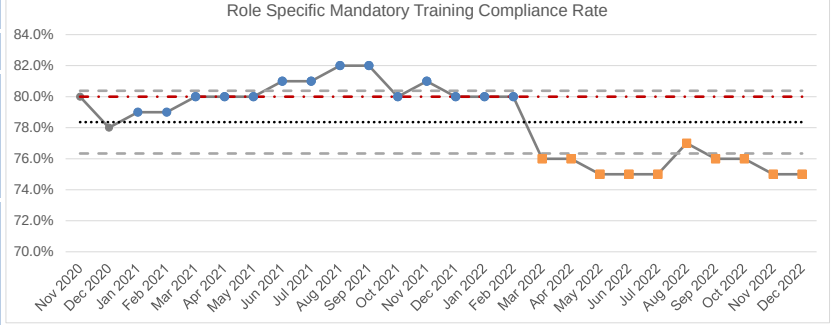

Dec 2022
75.0%
Target
80.0%
Variance
Special cause of concerning nature or higher pressure due to lower values
Assurance
Inconsistently hitting passing and failing the target

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Data Analysis:
Core Mandatory Training: The target has been achieved for the past three months; however, the current data has seen a reduction meaning the indictor has now moved out of the expected range
Role Specific Mandatory Training: After a long run of stable and improving performance, this indicator has deteriorated over the past six months and is now outside of the expected range, recording a concern.

Commentary:

Though OPEL 4 and pressures within the Trust have impacted on some recent non-attendance at classroom-based core and role specific mandatory training, several measures continue to address the decrease in compliance over recent months. The new Corporate Induction was trialled in December 2022 providing clear communication on the importance of completing and maintaining core and role specific mandatory training. Developmental feedback was provided on the programme and amendments have been made in preparation for roll out across 2023. The Corporate Induction will be delivered at DPOW and SGH on a monthly basis beginning on 23.1.23 and 6.2.23 respectively.
All new staff with people leader responsibilities will also be required to attend the People Leader Induction (in addition to the Corporate Induction) in 2023. This will further strengthen understanding of the importance of managing compliance of core and role specific mandatory training within each department. The People Leader Inductions will be delivered on a monthly basis, alternating between DPOW and SGH.
The ETD team are responsible for booking all new starters onto both Corporate and People Leader Inductions and are currently working with recruitment and ESR to agree a process of identifying those with leadership responsibilities and base sites to ensure all staff are invited to the correct sessions.
Corporate Induction competencies have been applied to ESR and the ETD team are currently working with the ESR team to develop a new starter dashboard where managers will be able to access induction and mandatory training compliance of their new staff.
The ETD team continue to work with HRBPs as part of their deep dive processes to target areas of low compliance for core and role specific mandatory training. This deep dive process will also focus on non-attendance moving forward to support a joined-up approach to improving overall attendance and compliance.
The ETD team have also targeted individuals who are out of compliance, emailing relevant links and workbooks to support timely completion of non-classroom-based core and role specific mandatory training.
The Training Needs Analysis (TNA) as been completed for all core and role specific mandatory training. Safety and Resuscitation / Clinical Simulation Leads are now reviewing 2023 Training Delivery Plans to ensure full utilisation of resources (staffing and room capacity) to improve compliance moving forwards.

The ETD team continue to work closely with the ESR team to monitor compliance through Power BI for mandatory training. This allows managers to access real time data and implement relevant actions to ensure / improve compliance. The ETD team are reviewing SOPs to ensure accuracy of data reports utilised to produce Power BI infographics and information.

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

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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Planned	Percentage Under 18 Weeks Incomplete RTT Pathways*	Dec 2022	63.8%	92.0%	Alert			Board
	Number of Incomplete RTT pathways 52 weeks*	Dec 2022	450	0	Alert			Board
	Total Inpatient Waiting List Size	Dec 2022	11,571	11,563	Alert			Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Dec 2022	38.8%	1.0%	Alert			Board
	Number of Incomplete RTT Pathways*	Dec 2022	35,355	No Target	Alert		n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Dec 2022	18,871	No Target			n/a	FPC
	% of Inpatient Live Waiting List Risk Stratified	Dec 2022	100.0%	99.0%				FPC
	% of Inpatient Live Waiting List Overdue Risk Strat Date	Dec 2022	44.5%	37%	Alert			FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Dec 2022	33,317	9,000	Alert			Board
	Outpatient Did Not Attend (DNA) Rate	Dec 2022	7.7%	5.00%	Alert			Board
	% Outpatient Non Face To Face Attendances	Dec 2022	26.9%	25.00%	Alert			Board
	% Outpatient summary letters with GPs within 7 days	Dec 2022	31.8%	50.0%	Alert			FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Dec 2022	83.1%	99.0%	Alert			FPC
	% of Outpatient Waiting List Overdue Risk Strat Date (New and Review)	Dec 2022	28.8%	23.0%			n/a	FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Dec 2022	59.1%	85.0%	Alert			Board
	Cancer Waiting Times - 104+ Days Backlog*	Dec 2022	45	0	Alert			Board
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Dec 2022	25.0%	75.0%	Alert			Board
	Cancer Request To Test In 14 Days*	Dec 2022	80.5%	100.0%	Alert			Board
	Cancer Waiting Times - 2 Week Wait*	Dec 2022	95.5%	93.0%				FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Dec 2022	90.9%	93.0%				FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Dec 2022	67.6%	75.0%				FPC
	Cancer Waiting Times - 31 Day First Treatment*	Dec 2022	94.6%	96.0%				FPC
	Cancer Waiting Times - 31 Day Surgery*	Dec 2022	100.0%	94.0%				FPC
	Cancer Waiting Times - 31 Day Drugs*	Dec 2022	90.0%	98.0%	Alert			FPC
	Cancer Waiting Times - 62 day Screening*	Dec 2022	75.0%	90.0%				FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Dec 2022	53.1%	95.0%	Alert			Board
	Number Of Emergency Department Attendances	Dec 2022	13,313	No Target	Alert		n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Dec 2022	883	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Dec 2022	960	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Dec 2022	615	0	Alert			Board
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Dec 2022	41.2%	40.0%				Board
	% of Extended Stay Patients 21+ days	Dec 2022	13.4%	12.0%				Board
	Inpatient Elective Average Length Of Stay	Dec 2022	2.5	2.5				Board
	Inpatient Non Elective Average Length Of Stay	Dec 2022	3.5	3.9				Board
	Number of Medical Patients Occupying Non-Medical Wards	Dec 2022	324	No Target	Alert		n/a	Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Dec 2022	88.9%	90.0%				Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Dec 2022	16.4%	30.0%	Alert			Board
	Bed Occupancy Rate (G&A)	Dec 2022	88.8%	92.0%				Board
	Percentage of patients re-admitted as an emergency within 30 days	Dec 2022	8.9%	No Target	Alert		n/a	FPC
	% of Extended Stay Patients 7+ days	Dec 2022	49.2%	No Target	Alert		n/a	FPC
	% of Extended Stay Patients 14+ days	Dec 2022	26.3%	No Target	Alert		n/a	FPC
COVID	Number of COVID patients in ICU beds (Weekly)	Dec 2022	1	No Target			n/a	Board
	Number of COVID patients in other beds (Weekly)	Dec 2022	45	No Target			n/a	Board
	% COVID staff absences (Weekly)	Dec 2022	19.3%	No Target			n/a	Board

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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Nov 2022	0.00	see analysis			n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Nov 2022	0.10	see analysis			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Nov 2022	0.10	see analysis			n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Nov 2022	0.05	see analysis			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Nov 2022	0.21	see analysis			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Sep 2022	98.9	As expected	**Alert**	H	As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	Jul 2022	102.8	As expected		L	As expected	Board
	Number of patients dying within 24 hours of admission to hospital	Dec 2022	20	No target			n/a	Q&S
	Number of emergency admissions for people in the last 3 months of life	Dec 2022	212	No target			n/a	Q&S
	Out Of Hospital (OOH) SHMI	Aug 2022	140.1	110.0	**Alert**	H	F	Q&S
	Structured Judgement Reviews - Rate Completed of those required	Aug 2022	76.0%	100.0%	**Alert**	L	?	Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Nov 2022	0.0%	No target	**Alert**	L	n/a	Board
	Number of Serious Incidents raised in month	Nov 2022	7	No target			n/a	Board
	Occurrence of 'Never Events' *(Number)*	Nov 2022	1	0		n/a	n/a	Board
	Duty of Candour Rate	Nov 2022	100.0%	100.0%		H	?	Board
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Nov 2022	5.2	No target			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Nov 2022	3.8	No target		L	n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Dec 2022	95.1%	95.0%	**Alert**	H	F	Board
	Care Hours Per Patient Day (CHPPD)	Nov 2022	8.5	No target			n/a	Board
	Mixed Sex Accommodation Breaches	Nov 2022	8.0	0		n/a	n/a	Board
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Oct 2022	5.5	No target			n/a	Board
	Complaints Responded to on time	Oct 2022	64.0%	85.0%	**Alert**		F	Board
	Friends and Family Test (FFT)							
	Number of Positive Inpatient Scores	Nov 2022	1028 out of 1124	No target			n/a	n/a	Board
	Number of Positive A&E Scores	Nov 2022	502 out of 678	No target			n/a	n/a	Board
	Number of Positive Community Scores	Nov 2022	236 out of 272	No target			n/a	n/a	Board
	Number of Positive Outpatient Scores	Nov 2022	102 out of 114	No target			n/a	n/a	Board
	Number of Maternity Antenatal Scores	Nov 2022	0 out of 0	No target			n/a	n/a	Board
	Number of Maternity Birth Scores	Nov 2022	62 out of 70	No target			n/a	n/a	Board
	Number of Maternity Postnatal Scores	Nov 2022	0 out of 1	No target			n/a	n/a	Board
	Number of Maternity Ward Scores	Nov 2022	0 out of 0	No target			n/a	n/a	Board
Observations	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Dec 2022	89.8%	90.0%			?	Q&S
	Percentage of Child Observations Recorded On Time (with a 30 min grace)	Nov 2022	90.0%	90.0%			?	Q&S
	Escalation of NEWS in line with Policy	Oct 2022	0.0%	No target			n/a	n/a	Q&S
	Clinical assessment undertaken within 15 minutes of arrival in ED	Nov 2022	48.0%	90.0%			n/a	n/a	Q&S
Sepsis	Rate of Adults Screened for Sepsis using the Adult Sepsis Screening and Action Tool *(based on Manual Audit)*	Oct 2022	50.0%	90.0%			n/a	n/a	Q&S
	Rate of those who had the Sepsis Six completed within 1 hour for patients who have a Red Flag - Adults *(based on Manual Audit)*	Oct 2022	0.0%	90.0%			n/a	n/a	Q&S
	Rate of Children Screened for Sepsis using the Sepsis Screening and Action Tool	Nov 2022	17.1%	90.0%			n/a	n/a	Q&S
	Rate of Children who had the Sepsis Six completed within 1 hour for patients who have a Red Flag - Children	Nov 2022	40.0%	90.0%			n/a	n/a	Q&S
Prescribing	Percentage of patients admitted to IAAU with an actual, estimated or patient reported weight recorded on EPMA or WebV *(based on Manual Audit)*	Nov 2022	77.5%	No target			n/a	Q&S
	Percentage of patients admitted to IAAU with an ACTUAL weight recorded on EPMA or WebV *(based on Manual Audit)*	Nov 2022	47.5%	No target	**Highlight**	H	n/a	Q&S
	Percentage of patients admitted to IAAU whose weight was 50kg (+/- 6kg) who complied with prescribing weight for dosing standard	Nov 2022	100.0%	No target			n/a	Q&S
	Reduction in patients prescribed an antibiotic	Sep 2022	56.9%	50.0%		n/a	n/a	Q&S
	Percentage of Medication Omissions for Ward Areas Using EPMA	Nov 2022	1.8%	No target		L	n/a	Q&S
	Antibiotic prescriptions have evidence of a review within 72 hours	Sep 2022	68.8%	70.0%		n/a	n/a	Q&S

Scorecard - Workforce (Workforce 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
Vacancies	Unregistered Nurse Vacancy Rate	Nov 2022	13.3%	8.0%	Highlight	L	?	Board
	Registered Nurse Vacancy Rate	Nov 2022	12.8%	8.0%	Alert	H	?	Board
	Medical Vacancy Rate	Nov 2022	14.5%	15.0%	Alert	H	?	Board
	Trustwide Vacancy Rate	Nov 2022	11.4%	8.0%	Highlight	L	?	Board
Staffing Levels	Turnover Rate	Dec 2022	11.7%	10.0%	Alert	H	F	Board
	Sickness Rate	Nov 2022	5.6%	4.1%	Alert		F	Board
Staff Development	PADR Rate	Dec 2022	83.0%	85.0%	Highlight	H	?	Board
	Medical Staff PADR Rate	Dec 2022	91.0%	85.0%		H	?	Board
	Combined AfC and Medical Staff PADR Rate	Dec 2022	83.7%	85.0%	Highlight	H	F	Board
	Core Mandatory Training Compliance Rate	Dec 2022	89.0%	90.0%	Alert	L	?	Board
	Role Specific Mandatory Training Compliance Rate	Dec 2022	75.0%	80.0%	Alert	L	?	Board
Disciplinary	Number of Disciplinary Cases Live in Month	Dec 2022	8	No Target			n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Dec 2022	0	12		L	?	WFC
	Number of Suspensions Live in Month	Dec 2022	4	No Target	Alert	H	n/a	WFC
	Average Length of Suspension (Weeks)	Dec 2022	0	No Target		L	n/a	WFC

Appendix B - National Benchmarked Centiles

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

NHS Northern Lincolnshire and Goole NHS Foundation Trust

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 20/01/2023

* 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	Dec 2022	63.8%	92.0%	60	68 / 168	Nov 2022
	Planned	Number of Incomplete RTT pathways 52 weeks	Dec 2022	450	0	65	59 / 167	Nov 2022
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Dec 2022	38.8%	1.0%	30	110 / 156	Nov 2022
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Dec 2022	59.1%	85.0%	21	106 / 134	Nov 2022
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Dec 2022	53.1%	95.0%	31	90 / 130	Nov 2022
	Urgent Care	Number Of Emergency Department Attendances	Dec 2022	13,313	No target	49	74 / 144	Nov 2022
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Dec 2022	960	0	19	124 / 152	Nov 2022
	Flow	Bed Occupancy Rate (General & Acute)	Dec 2022	88.8%	92.0%	51	77 / 157	Q2 22/23
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Dec 2022	7.7%	5.0%	58	67 / 159	Nov 2022
	COVID	Number of COVID patients in ICU beds (Weekly)	Dec 2022	1	No target	26	151 / 203	Nov 2022
	COVID	Number of COVID patients in other beds (Weekly)	Dec 2022	45	No target			

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Quality & Safety	Infection Control	Number of MRSA Infections	Nov 2022	0.000	No target	100	1 / 137	Oct 2022
	Infection Control	Number of E Coli Infections	Nov 2022	0.100	No target	93	10 / 137	Oct 2022
	Infection Control	Number of Trust Attributed C-Difficile Infections	Nov 2022	0.100	No target	93	10 / 137	Oct 2022
	Infection Control	Number of MSSA Infections	Nov 2022	0.050	No target	72	39 / 137	Oct 2022
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	Jul 2022	102.8	As expected	48	63 / 121	Aug 2022
	Safe Care	Number of Serious Incidents Raised in Month	Nov 2022	7	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Nov 2022	8.5	No target	32	123/181	Sep 2022
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Nov 2022	95.1%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Oct 2022	5.5	No target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Number of Positive Inpatient Scores	Nov 2022	1028 of 1124	No target	23	104 / 135	Nov 2022

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Nov 2022	5.6%	4.1%	45	119 / 214	Aug 2022

Appendix C - Glossary

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

NLG(23) 009

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	7th February 2023
Director Lead	Fiona Osborne, Non-Executive Director and Chair of Quality and Safety Committee
Contact Officer/Author	As above
Title of the Report	**Quality and Safety Committee Highlight Report (covering December & January)**
Purpose of the Report and Executive Summary (to include recommendations)	The Trust Board is: • to note the Quality and Safety Committee highlight report • recommended to pursue a digital solution for recording sepsis data • recommended that seven day working in pathology is given consideration in the 2023/24 business planning, based on reports from Path Links, the Cancer Transformation Programme and cancer tumour site reports • to receive assurance regarding the actions to prevent reoccurrence of the never event in relation to a retained foreign body
Background Information and/or Supporting Document(s) (if applicable)	None
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)	There will be a financial implication if seven day working in pathology is given consideration in the 2023/34 business planning and approved.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	

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

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1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
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5.	**To provide good leadership**
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Highlight Report to Trust Board

Report for Trust Board Meeting on:	7 February 2023
Report From:	Incorporating Quality & Safety Committees held on 20 December 2022 & 24 January 2023

Highlight Report:

The new Care Quality Commission (CQC) inspection report was published in December 2022 with an overall 'requires improvement' assessment. Within the report a significant number of improvements were noted. There are 87 actions identified in the new report. The Trust is preparing an initial response to the CQC listing each action to be addressed, sustainability, resources and impact of non-achievement. This document was shared with Trust Management Board (TMB) and the Non-Executive Director (NED) Committee chairs. A review is being undertaken to compare the open actions from the existing action plan with the new action plan and a paper will be developed stating the treatment of these to ensure sustainability and reduce duplication.

Three new maternity Serious Incidents (SIs) have been declared and investigations are ongoing. The Committee received further information around the never event declared in November, reported in our last highlight report. This surrounded a retained foreign body following surgery in 2021 which was removed one year later. Due to the recommendations within the ergonomist report published in 2022, the Committee are assured that actions have already been implemented to prevent re-occurrence.

All actions in the first Ockendon action plan have been completed with four exceptions. The remaining actions relate to audits and one Standard Operating Procedure. It is anticipated these will be complete by the end of February 2023 due to waiting for further guidance regarding suitable evidence from the East Kent report.

Birth rate plus and the Chief Nurse establishment review have been completed. This surrounds an increase in the complexity of care required. Recent recruitment has resulted in securing students and international midwives in a challenging skillset market reducing the vacancies to 25.

There are inconsistencies in sepsis data that concern the Committee as this is currently a manual data collection task by clinicians. Sepsis management features on the long list as a Trust Quality priority for 2023/24 however we ask the Board to support investigation of digital solutions to allow a robust and accurate management.

The Committee have received reports from Path Links and cancer tumor site pathways in regard to diagnostic delays. In December the Committee highlighted a recommendation to give consideration in the 2023/24 Business Planning process to seven day working and we wish to underline this recommendation.

Path Links reported to the Committee a risk to its UKAS accreditation in regard to the cellular pathology directorate. Accreditation surveillance is planned for March 2023, action plans are in place to mitigate the risk.

The Nursing Assurance Report highlighted:

- The high number of escalation beds currently open combined with the higher acuity of patients and additional demand for 1:1 care throughout the Trust.
- The Committee have referred a query in regard to delays in recruitment process to the Workforce Committee after a high number of offers had been made for roles and vacancy levels remained fairly static after a three-month period.
- The Board are asked to note that it's unlikely the Trust will achieve the C. difficile infection target despite being having one of the lowest infection rates in the country.

Confirm or Challenge of the Board Assurance Framework:

Cancer Pathways are mentioned in both Strategic Threats and Gaps in Assurance however the Chief Operating Officer has ownership of any actions. It is recommended that the BAF discussion SO1-1.1 reviews are expanded to include the Chief Operating Officer for completeness.

Action Required by the Trust Board:

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

- Pursuing a digital solution for recording sepsis data.
- Based on reports from Path Links, the Cancer Transformation Programme and cancer tumour site reports, a reiteration of our recommendation that seven-day working in Pathology is given consideration in the 2023/24 Business Planning.

Fiona Osborne
Non-Executive Director

NLG(23)010

Northern Lincolnshire and Goole NHS Foundation Trust

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 7 February 2023
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jane Warner, Associate Chief Nurse – Midwifery, Gynaecology & Breast Services
Title of the Report	**Maternity/Ockenden Update**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this report is to provide an update on progress with The Ockenden Report (2020, 2022), Quality Improvement projects, Continuity of Carer and East Kent Report – Reading the Signals, 2022. The Trust Board is asked to note progress against the actions to be met within the Ockenden Reports.
Background Information and/or Supporting Document(s) (if applicable)	https://www.donnaockenden.com/downloads/news/2020/12/ocken den-report.pdf https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report
Prior Approval Process	✓ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Quality & 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.

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NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Board of Directors – 7 February 2023

Maternity / Ockenden update

Introduction

The purpose of this report is to provide an update on progress with the Ockenden Reports (2020, 2022) recommendations; Maternity Improvement Advisor support, Clinical Negligence Scheme for Trusts – year four, Continuity of Carer provision and the recent 'Reading the Signals' - East Kent Report (2022).

Ockenden report, 2020

Of the 12 Immediate and Emerging actions, there are now 11 completed actions. The outstanding action is 'Risk Assessment throughout pregnancy' which is currently being completed with an audit to ensure compliance following the ratification and embedding of the Standard Operating Procedure. It was anticipated that this would be completed by 31 January 2023 however there has been some slippage with the audit and so it is now planned to complete and ratify by 28 February 2023.

There are 11 outstanding actions from the wider action plan. These are actively being worked on. It is anticipated that these are completed by 28 February 2023.

Ockenden report, 2022

As reported previously there continues to be no requirement at this time to provide evidence of compliance or assurance. NHS England will publish a single delivery plan for maternity and neonatal services in early 2023, it is understood that this is likely to be March/April 2023. This will consolidate the improvement actions committed in Better Births, the NHS Long Term Plan, The Neonatal Critical Care Review and reports of the independent investigations at Shrewsbury and Telford Hospital NHS Trust and the independent investigation into maternity and neonatal services at East Kent NHS Trust.

Currently there are 41 of the 92 actions met with an additional 12 actions in progress. The 2022 report is much larger with 92 actions within it and many actions are at a national and regional level.

There has been a successful bid for funding to support Clinical Leadership with the Ockenden work, bereavement training and support enhanced training for midwifery support workers.

Local universities are designing an academic course to support labour co-ordinators

A Humber and North Yorkshire LMNS wide policy to manage conflict of clinical opinion has also been ratified.

Maternity Improvement Advisor(s)

Support continues to be provided by the Maternity Improvement Advisor (MIA) programme and the midwife and obstetric advisors regularly join maternity meetings and visit the sites.

It support is on-going including suggested improvements to various elements of the service with an aim for the maternity service to no longer be on the programme.

Continuity of Carer teams

There is no further progress with Continuity of Carer teams however there is a commitment to continue to expand the teams as midwifery staffing allows.

Maternity Incentive Scheme (CNST), year four

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

Safety Action	Compliance met
1 Perinatal Mortality Review Tool	Yes
2 Maternity Services Data Set	Yes
3 Avoiding Term Admissions to Neonatal Unit	Yes
4 Clinical Workforce	Yes
5 Midwifery Workforce	Yes
6 Saving Babies Lives v2	Yes
7 Service User Feedback	Yes
8 Mandatory Training	Yes
9 Safety Champions	Yes
10 NHS Resolution	Yes

Maternity Incentive Scheme, year five, is awaited.

Quality Improvement – maternity services

We are continuing at pace with 3 Quality Improvement projects –

- Maternity Triage – 3 staged approach across both maternity units. Stage 2 currently with telephone triage 08:00 – 01:00. Benefits are consistency of information being provided to women and signposting to most appropriate place i.e. community midwife, Antenatal Day Unit or inpatient area. Stage 3 - Complete triage service to commence mid-February at both sites; Jasmine ward area, DPOW and Ward 26, SGH.

- Induction of Labour – QI team including midwives and obstetric medical staff, reviewed and updated guideline to ensure consistency across both maternity

units. Next stage to implement out-patient induction of labour via Antenatal Day Unit and consistent care delivery within in-patient areas.

- Thermoregulation of neonates – Roll out of thermoregulation project which is expected to reduce neonates being transferred for neonatal care / transitional care – early February. Clinical guidelines updated and involvement of both maternity and neonatal staff within QI project.

Jane Warner
Associate Chief Nurse – Maternity, Gynaecology and Breast Services

NLG(23)011

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	Tuesday 7 February 2023	
Director Lead	Ellie Monkhouse, Chief Nurse	
Contact Officer/Author	Debbie Bray, Associate Chief Nurse – Neonates, Children & Young People	
Title of the Report	**Neonatal, Children & Young People's Strategy**	
Purpose of the Report and Executive Summary (to include recommendations)	The Board are asked to approve the launch of the Neonatal, Children & Young People's Strategy to deliver the key priorities for the Trust in relation to neonatal, children and young people's services over 2023 - 2025	
Background Information and/or Supporting Document(s) (if applicable)	Neonatal, Children & Young People's Strategy 2023 - 2025	
Prior Approval Process	✓ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ✓ Reducing Health Inequalities ☐ Collaborative and System Working	✓ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
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Financial implication(s) (if applicable)	There will likely be some financial requirements relating to service developments and/or reconfigurations via usual business planning routes	
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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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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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

Neonatal, Children & Young People's Strategy

2023 -2025

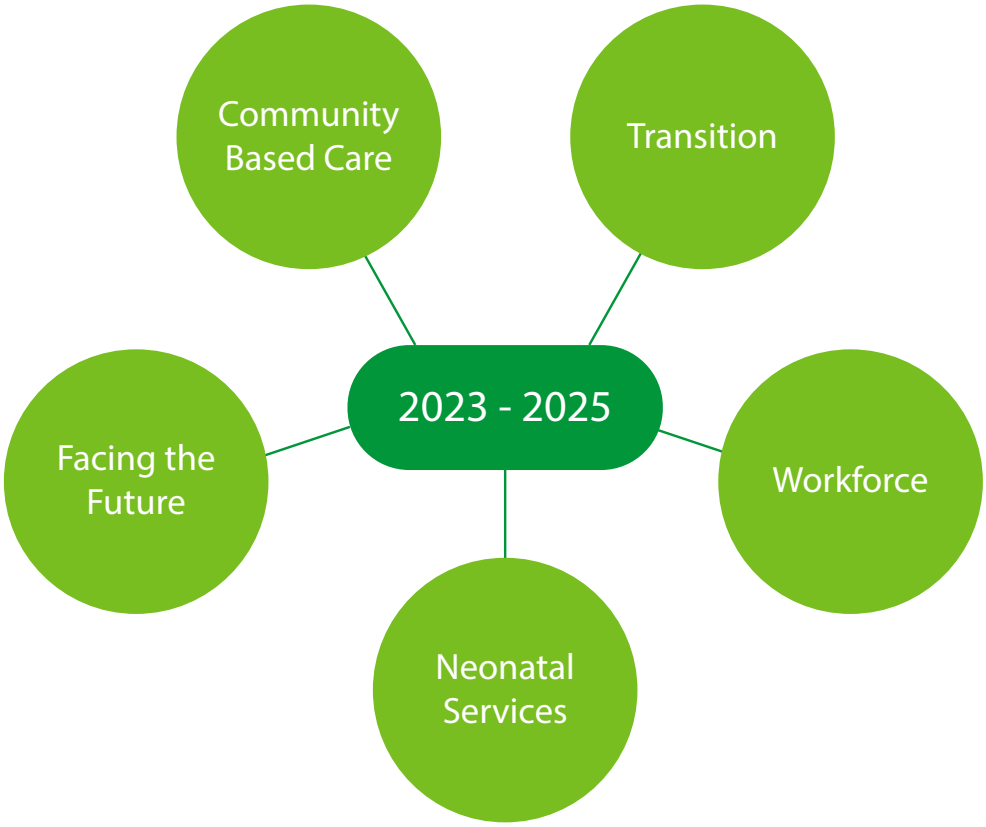
Kindness • Courage • Respect

INTRODUCTION

Our first Neonatal, Children & Young People Strategy will set out key priorities for the next 2 years and highlight what we can achieve by 2025.

Our babies, children and young people of today are our adults of the future - we need to give them the best start in life by providing services that meet their holistic health needs and ensure they are given the best opportunity to maximise their potential in life.

Over the next 2 years we will focus on 5 areas:



The children, young people and their families who use our services will help us shape them for the future and we will ensure we hear their voices by engaging through the development of service user groups as we move through our Strategy work programmes.

This Strategy has been developed with our staff and we have listened to their views and ideas around our Key Priorities. Our staff will be the very people who deliver the Strategy so throughout the next 2 years as we work through our plan will continue to listen to shape and influence our decisions.

TABLE OF CONTENTS

All photography included in this document was taken pre-Covid.

A MESSAGE FROM THE CHIEF NURSE

Welcome to the first strategy for Neonates, Children and Young People for Northern Lincolnshire and Goole NHS Foundation Trust.

Our local services provided for our youngest service users and their families are undergoing a period of intense evaluation as part of the Humber Acute Services Reviews which over the next few months will set out a clear vision for our local and regional neonatal and paediatric services and the changes required to turn the vision in to reality.

This interim strategy will focus on our 5 Key Priorities for the next 2 years which will simultaneously allow services to transition and develop in accordance with the outcome of the HAS Review, whilst we continue to re-design, develop and progress locally provided services to ensure good health outcomes, access to locally based services and positive patient experiences.

Our 5 Key Priorities are:

- Transition to Adulthood
- Compliance with the Facing the Future and Paediatric Intensive Care Society Standards
- Workforce retention and development
- Home or 'Close to Home' Based Care
- Transformation of Neonatal Services.

Throughout the next 2 years we will ensure our 'Golden Threads – our patients, their families and our staff - are at the forefront of the work programmes established to enable us to deliver our priorities and see tangible improvements in our service delivery. As the executive lead for Neonates, Children and Young People I will commit to continue to raise the profile of our services and ensure that the voice of the child and those that advocate for them is heard at all levels within the Trust.

I look forward to working alongside you all and continuing to support the Division to achieve delivery of the Strategy and feel confident that we are able to achieve the ambitious priorities we have set ourselves.

Over the 4 years I have been working at the trust I have seen many improvements and a real difference in the way in which our youngest patients are cared for across all areas of the organisation, however there is much more we can do to improve our services further and I will continue to work with you all to make those improvements happen.

Thank you for your on-going commitment to the improvement and development of neonatal and children, young people's services and for providing excellent care to them and their families, I look forward to working with you all to deliver our first ever Neonatal, Children and Young People's Strategy, 2023 – 2025.

Ellie Monkhouse
Chief Nurse

WHY DO WE NEED A NEONATAL, CHILDREN & YOUNG PEOPLE'S STRATEGY

Over the next 2 years through the delivery of the Strategy we will:

- Raise the profile of Neonates, Children & Young People across the Trust
- Embed the voice of the Child in everything we do
- Design & Deliver exemplar services in line with local, regional and national CYP Transformation Programme
- Have clear priorities and robust workstreams to support them
- Achieve robust leadership & ownership of the CYP Agenda
- Transform, Innovate & Improve
- Maintain collaborative work streams and a robust Governance reporting structure
- Achieve 'GOOD' and work towards 'OUTSTANDING' in our CQC Rating for Neonatal, Children and Young People Services.

A BIT ABOUT US...

We currently provide a range of services for our youngest patients across both our hospital sites:

- Our Emergency Departments (ED) treat approx. 35,000 young patients every year and are supported by our Paediatric Emergency Nursing Team who provide in-reach care within the ED setting
- Our Level 2 Neonatal Units have a combined 22 Cots and 8 Transitional Care Cots and provide care for over 600 babies per year
- The in-patient paediatric wards have a combined 20 beds, each with an 8 bedded 24/7 Paediatric Assessment Unit and 4 High Observation Beds
- Community Nursing and Specialist Nursing services operate on both sites and provide care in the hospital, at home, school and social care settings
- Working closely with regional Children's Hospitals we provide local care for specialities including allergy, asthma, cardiology, cystic fibrosis, dental, diabetes, endocrine, ear, nose and throat, epilepsy, gastroenterology, general paediatrics, neurology, oncology, ophthalmology, renal and orthopaedics.

OUR GOLDEN THREADS

Our golden threads throughout the delivery of our strategy are our babies, children, young people, their families and our staff

Our commitment to them is that we will ensure they are fully involved in the decisions made about them and our services upholding the principle of 'No decision about me…without me'.

OUR GOLDEN THREADS

Service User Feedback

- We will continue to gather feedback from our children and young people and their families by using our 'Tops & Pants' and 'I want great care' tools
- We will continue to learn from parental complaints and ensure that we say sorry when things don't go well
- We will engage with children, young people and their parents/carers when developing or making changes to our services to ensure their experiences and needs are fully considered and incorporated into any change

Voice of the Child

- We will advocate for our babies, children, young people and their families to ensure their voices are heard
- We will put the child and young person at the heart of all we do
- We will ensure children and young people have the opportunity to describe things from their point of view
- We will ensure children and young people are continually involved and have information fed back to them in a way that they can understand
- We will ensure that the child or young person's voice has influenced the decisions that professionals have made

Our Staff

- We will ensure our staff are listened to and involved in decisions that affect them and the services they deliver
- We will value our staff, treat them with kindness and respect and empower them to have the courage to speak up and make changes to their practice and the services they deliver
- We will value our staff, treat them with kindness and respect and empower them to have the courage to speak up and make changes to their practice and the services they deliver
- We won't make decisions about our staff without listening to their views – 'No decision about me - without me'

KEY PRIORITIES

Our 5 Key Priorities and how we will deliver them 2023 - 2025	
Priority 1	We will have a Transition to Adults Strategy
How will we do this?	• We will develop and embed robust speciality led pathways for all young people who require transition to adult services by 2025
Priority 2	We will achieve compliance with Facing the Future and Paediatric Intensive Care Society Standards by 2025
How will we do this?	• We will work collaboratively across all specialities to ensure 75% compliance with applicable Facing the Future/PICS standards by 2024 & 100% of applicable standards by 2025
Priority 3	We will develop and maintain an innovative, highly skilled work-force across
How will we do this?	• We will review and develop a 5 year plan for both our medical and nursing workforce in line with agreed service delivery models and national standards • We will increase the RSCN provision to ED to meet FTF & CQC requirements by 2025 • We will introduce the Nurse Associate and Advanced Clinical Practitioner roles to Paediatrics and Neonates as part of a 5 year workforce plan and commence training posts by 2025
Priority 4	We will provide care within homes or closer to home to avoid or reduce the need for hospital-based care where possible
How will we do this?	• We will secure funding and implement Hospital@Home/ Tele-medicine Services in NE & North Lincolnshire by 2025 • We will carry out a comprehensive review of community and specialist nurse service to ensure our workforce is fit for the delivery of future service models by 2025
Priority 5	We will transform our neonatal services in line with the Humber Acute Services Review and Neonatal Critical Care Transformation Programme
How will we do this?	• Reviewing and re-modelling our neonatal nursing and medical workforce to ensure we meet BAPM standards • Re-configuring our neonatal services in line with the recommendations of the Neonatal Critical Care Transformation Programme and the Humber Acute Services Review to ensure we deliver safe, local neonatal services.

DELIVERING OUR STRATEGY

The Neonatal, Children & Young People's Strategy will be delivered by established workstreams overseen by the Associate Chief Nurse for Children's Services supported by the Chief Nurse and the wider Divisional Senior Management Team.

Through the next 2 years we will:

- Monitor progress of the workstreams led by the Associate Chief Nurse for Children's Services supported by the Lead Nurse for Children and the Clinical Lead Paediatricians
- Review and challenge progress on a bi-monthly basis during the Children & Young People's (CYP) Transformation Board led by our Chief Nurse
- Update on the current position in relation to the various workstreams at the CYP Transformation Board, identifying risks to deliver
- Review actions and timelines, refreshing them annually to ensure delivery of key actions
- Raise the profile of Neonatal and Children & Young People's services across our organisation and both regionally and nationally
- Work hard to ensure we promote the work of the Division and individuals within it across local, regional, and national forums
- Work with our QI colleagues to embed a culture of QI across all our work-streams
- Keep our young people and their families involved in the delivery of the strategy and ensure their voices are heard
- Keep our teams up to date via our Family Chat, Looking Forward and Senior Leadership Forums.

Contact Us:

Telephone: **03033 303035**
Email: **nlg-tr.comms@nhs.net**
Visit: **www.nlg.nhs.uk**

NHSNLaG

NHSNLaG

Kindness · Courage · Respect

NLG(23)012

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	February 7, 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. Finalized recruitment of the Group Digital Senior Leadership Team 3. Current focus on a single Electronic Patient Record (EPR) for acute Trusts in the ICS 4. Collaboration of Business Intelligence across the ICS to reduce duplication, support Pop Health Management, Elective Recovery, Mutual Aid and system working, and measuring outcomes 5. IT Infrastructure assessment is underway to map options to to join up the infrastructure for seamless working
Background Information and/or Supporting Document(s) (if applicable)	Attached slides – Highlight report
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 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, 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.
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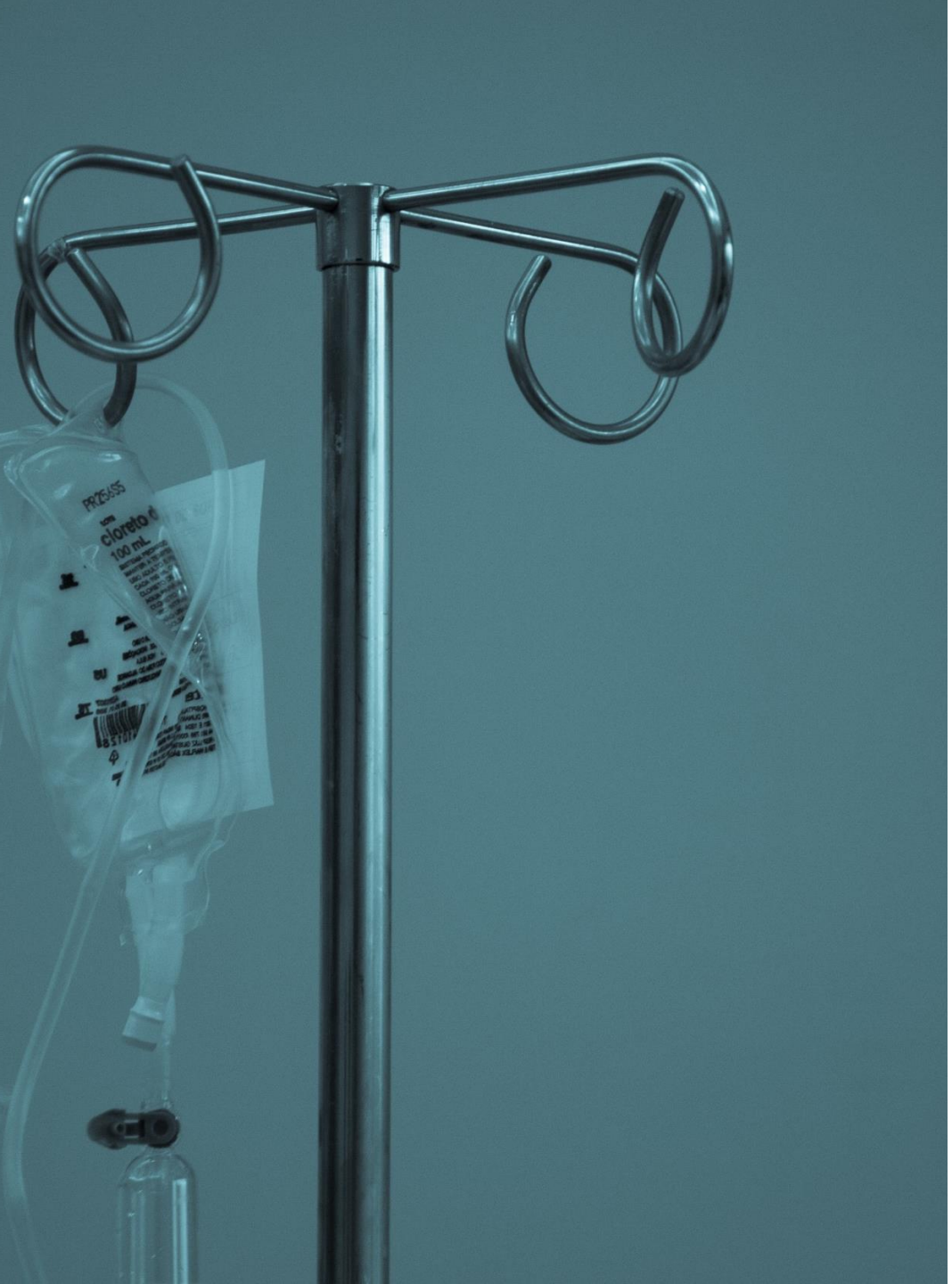
Board Highlight Report
Digital Services
Feb. 7, 2023

Co-Creating a Consolidated (Group) Digital Service

Shauna McMahon, CHCIO, FedIPLdgPra, FBCS, CHE, MA Leadership
Group Chief Information Officer
(NLaG & HUTH)

Northern Lincolnshire and Goole NHS Foundation Trust

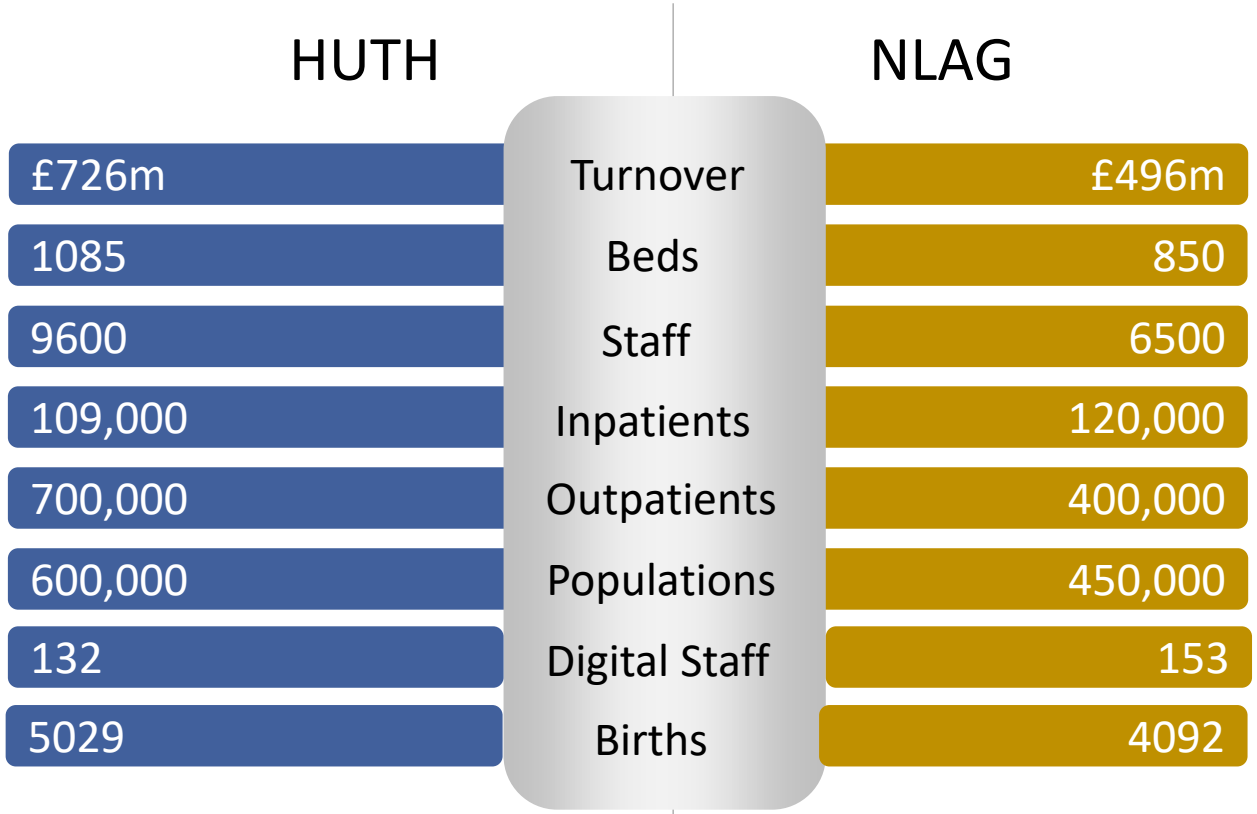
Hull University Teaching Hospitals NHS Trust



Transforming Digital Services Timeline

- Nov. 2020 – CIO / Executive on Board at NLaG
- Dec. 2021 – approached by CEOs from NLaG & HUTH to consider Joint Role
- April 2022 – started as Joint CIO /Executive Team/Board member
- Agreement: Join up the two Departments, consolidate as much as we can to have one Digital service, supporting the 2 Trusts
- May – Dec – Recruit single leadership team (not site assigned)
- Co-Design the future department. Workshops being scheduled for employees and leadership team to co-create the new structure to deliver the vision

NLAG & HUTH PROFILE



HUTH specialises in neurology and trauma covering a densely populated city region.

NLAG provide services across district hospitals covering a wider geographical area.

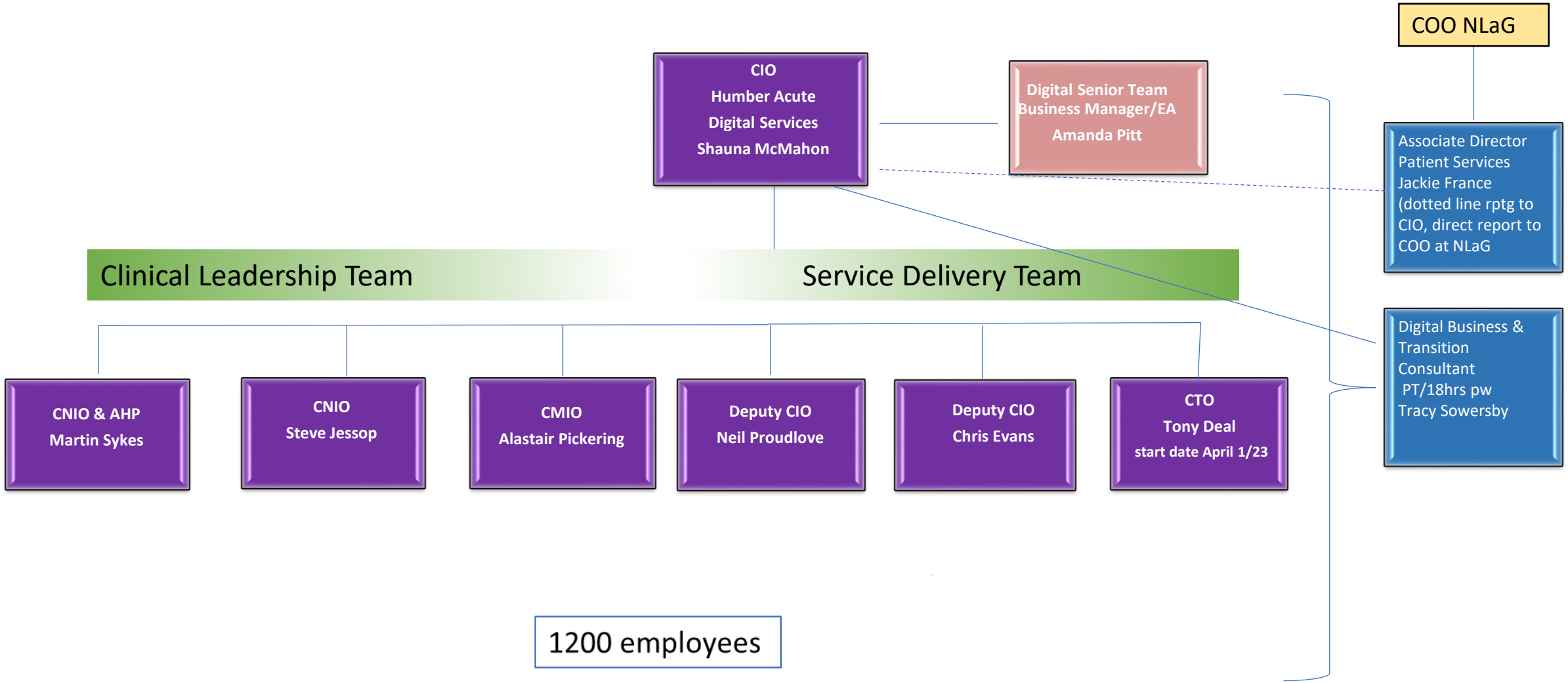
NHS Northern Lincolnshire and Goole NHS Foundation Trust

NHS Hull University Teaching Hospitals NHS Trust

NLAG & HUTH DRIVERS

- Deliver quality and sustainable services to our patients
- Play our part in delivering locally the national NHS agenda
- Be “Anchor Institutions” within our locality, maximising our role in improving the lives of local patients and residents.
- Maximise the potential of partnerships for education, research and innovation
- Maximise the skills and strength of our workforce through:
  - Shared resources
  - Developing local where possible
  - Improved training and development opportunities for all staff
  - Integrated pathways of care across community and primary care reducing reliance on hospital services
  - Reduce inequalities of provision and access across our local communities
  - Increased use of technology to support self help, prevention, early intervention, remote diagnosis and treatment where appropriate
  - Ensure that our infrastructure maximises the use of technology in service delivery including use of robotics and Artificial Intelligence

NLaG and HUTH Group Digital Services: Senior Leadership Team



Finances

Site	WTE	Operating 22/23 (000)	Capital 22/23 (000)
HUTH	132 (656 Pt A)	£10, 438.0	£2.5
NLaG	153 (592 Pt A)	£ 11,111.0	£2.4

Pt Admin budget sits in another Portfolio
~ 15-20 M at each site

NHS Northern Lincolnshire and Goole NHS Foundation Trust

NHS Hull University Teaching Hospitals NHS Trust

APPROPIATE FUNDING

% IT Spend of Revenue

HUTH

2.88%

% IT Spend of Revenue FY21/22

HUTH

2.11%

% IT Spend of Revenue 4 Year Average

NLAG

1.71%

% IT Spend of Revenue 4 Year Average

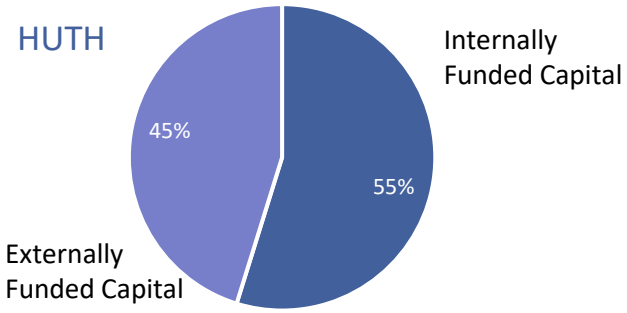
NLAG

1.56%

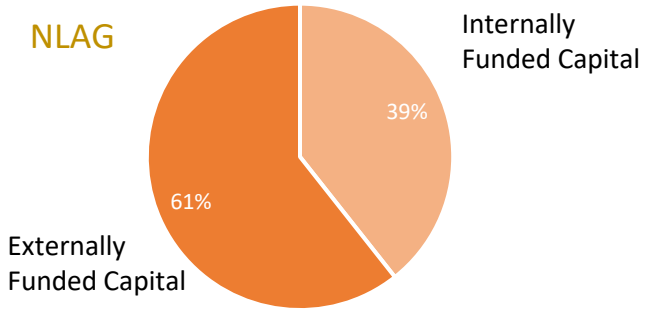
% IT Spend of Revenue FY21/22

Capital Funding Source

HUTH



NLAG



8.2%

% IT Spend of Revenue Industry Average

The NAO report on digital transformation states 5 recent investments in digital transformation has **not been sufficient to deliver the national ambitions**.

At a local level, trusts' expenditure on IT varies widely and collectively they spend less than the recommended level: NHSE&I estimates **that less than 2% of trusts' expenditure is on technology, compared with a recommended 5%.**

NHSE&I acknowledged the **funding was not enough to deliver everything**, but felt it was enough to make a good start.

Trust Priority 9 – Digital - NLAG

We will implement the second phase of our **Digital Strategy**, including:

Priority	Updates
Completing **digital projects** initiated in 2021-22 – 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 live over the next two quarters (Q4 2022/23 and Q1 2023/24) including Lorenzo PAS, RPA and the new Data Warehouse
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 2022-23 and 2023-24).	• Agreement to stop printing copies for electronic letters/results approved by Digital Strategy Board (2022/23) • Joint EDMS Business Case being finalised (Q4 2022/23), procurement and implementation Q1/2 23/24.
Working with national and regional teams to implement **mandated system level digital solutions** (e.g. Maternity IT system, Eye Referral System, Diagnostic Hubs, ICS Electronic Patient Record).	• Maternity Badgernet implementation underway at both Trust's. Go-live being agreed for 2023/24 • EPR Convergence Programme entering procurement phase (May 2023) subject to Trust approvals. Procurement to conclude December 2023.
Collaborating with acute partners in the ICS to improve access for clinicians to clinical information through **digital interoperability between trusts** and by supporting digital processes.	• Both 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 CHCP • NLAG have seen the first data provision (discharge summaries) go-live, with ED 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 (Q4 2022/23) • Further work to continue to develop Clinical Engagement for Digital Literacy. Delays Limited progress with release of HEE Digital Literacy Assessment. The tool is currently proceeding through the assurance process and will be available for rollout early spring 2023.

Trust Digital Priorities - HUTH

An update on key strategic digital objectives including:

Priority	Updates
Undertake Lorenzo Cloud Migration (incl ORMIS) to move system infrastructure off site	Work has been completed to move system infrastructure to a supplier hosted cloud environment and remove ageing local infrastructure to mitigate service sustainability risks.
Undertake the Lorenzo Contract Renewal, extending the services to cover NLaG's use of Lorenzo PAS	Lorenzo contract have been extended for a 7 (5+2) year term including NLaG's use of the PAS components of the Lorenzo Care Management suite.
Complete deliverables for Year 2 Digital Aspirant programme including the successful delivery of projects projects including Joint PAS/EPR development with NLaG	Both HUTH/NLaG are working jointly on a number of projects including PAS replacement, Datawarehouse migration and RPA. These projects form part of the joint delivery plan and expected to go live over the next two quarters (Q4 2022/23 and Q1 2023/24).
Review of some of back office services to move towards a shared service model with NLaG	Work to redesign services has already been completed on shared Information Governance (IG) and Clinical Coding functions. Further organisational development will occur in 23/24 to review wider Digital structures and align these between the two Trusts
Provide Digital Support for the Interim Clinical Plan and Humber Acute Services Review	Fortnightly workstream meetings for digital report to the ICP delivery board. Any change management requests and digital optimisations are being reviewed between both Trusts Digital Teams and implemented to support clinical specialty alignment.
Migrate the maternity system to an ICS Single Maternity System (Badgernet)	The programme to implement BadgerNnet maternity system across the ICS is underway and expected to deliver in 2023/24
Continue to support and deliver Shared Care Record related developments	HUTH has successfully delivered Integration with the Yorkshire and Humber shared care record including the new provision of appointments data and support of the first-of-type subscriptions project with CHCP. 2023/24 will see continued development of integration as part of phase two of the programme.

Digital and IT Infrastructure Executive Team Report

NHS Northern Lincolnshire and Goole

NHS Hull University Teaching Hospitals

- **IM Resources** (amber) vacancies a challenge in Business Intelligence. Balance increasing and often short notice demands from ICS, NHS. Increasing data collection demands.
- **IT Infrastructure (**amber)– meeting with suppliers to determine cost effective way to update network, improve seamless working, and currently have 1 x Network Technician, 1 x End User Computing Manager and 1 x IT Technician vacancy.
- **Digital Programme Performance** (amber) – balance the increasing demand vs capacity, largely due to ICS and NHS demands.
- **ICT Performance** (**red**) - Backlog tasks to process, excluding SysAdmin, is **312**. Current tasks breaching SLA stands at **223,** due to unfilled vacancies
- **ICT Resources (red**) 3x positions in Support and 1x Voice Analysts out for re-advertisement
- **IG Performance** (green) –overall performance green
-
- **HCR Performance** (green)

Digital Directorate Financial Position M9 - Joint

	Budget YTD (£K)	Actual (£K) YTD	Variance (£K) YTD	Comments
Revenue	15,888	15,480	425	
Capital (internal)	4,927	3,560	245	
Capital (External Agreed)	84	64	20	Front-line Digitisation funding not impacting YTD position

Risk/Issues/ Messages to escalate

- IG Incident reported to the ICO in January 2023 – Awaiting ICO response.
- IG – New 22/23 Data Security Protection Toolkit (DSPT)
  - Launched August 2013 with 36 assertions consisting of 142 evidence items,113 mandator.
  - Baseline submission will take place 28th February 2023
  - DSPT Audit to be undertaken on 13 assertions. 6th March and 2nd May 2023
- Cyber Security – as part of the IT Infrastructure review, we are currently costing any work to fill gaps that will then enable us to me Cyber Essentials + standard. Overall our Cyber Security is good and covered both internally and with external support. It is a continuous and evolving area – we are never done.

Key Highlights/achievements this reporting period

- **PAS –** Trial testing of data one cycle completed.
- **RPA –** Access gained to NHSE/I Infrastructure to develop the RPA bots, development
- **Clinic Letters:** 2 x testing rounds of remain phase 2 areas completed in January, and all issues found resolved or in hand except one which has been sent to supplier
- **Information Management/BI:** NLaG's DW community uploads completed. New ICP KPI reports developed.
- **Clinical coding:** HUTH introduced the new Site Lead and Clinical Coding Liaison Roles in December and successfully recruited, internally, to all positions. NLAG will begin recruiting, internally, for these positions at the end of February.
- **System Admin:** Work has been focused on the PAS Migration programme delivery. Additional support has been provide to projects such has Lung Health Checks and CHN activities

ICS System Collaboration

Humber North Yorkshire ICS	
Topic	**Update**
Business Intelligence	BI and Data Analytics group working across the ICS to reduce duplication of data collection. Currently: Axiom, RAIDR, SCC, Frontrunner (Optical Palantir) all in progress.
Optimising Health Services	**Digital Imaging Radiology** Both HUTH and NLaG now on the same Radiology Information System (RIS). HUTH are upgrading PACS Next phase will be a solution to link up the systems – workflow for access to reports at both sites. **Maternity** A single Maternity Information System (MITS) will be implemented across the local regional over the course of 2023/24. HUTH and NLAG will be moving to this solution in the next 6-9 months. Go-live dates are being agreed subject to interdependencies on the wider Digital plan.
Interim Clinical Plan	Short term and tactical optimisations are continuing to occur to support the ICP short term plans. These will allow services to operate effectively while strategic solutions are bought in over the next 12-24 months. The Lorenzo PAS go-live (May 2023) will be the first large strategic change to support this.
EPR Convergence	Major programme to procure a single EPR across the ICS Acute Sector, with the intention of having open system to enable future GP and Community integration. This is a very complex piece of work, however the outcome will be a single system that will then require more standard patient pathways, improve collection of information for more accurate reporting, make it easier for patients to see their health information journey.

IT Operations – Performance Metrics

Digital Services Desk calls

Month	Inbound Calls Queued	Max Queue Entry Position	Answered	% answered	Abandoned	% Abandoned	Average time to answer	Longest time to answer
Nov 2022	5238	34	3911	74.7	1327	25.3	00:06:00	00:35:31
Dec 2022	3653	20	3089	84.6	564	15.4	00:03:04	00:22:27
Jan 2023	4178	11	3745	89.6	433	10.4	00:02:07	00:15:49

Out of Hours call in January = 34

WebV Support number calls

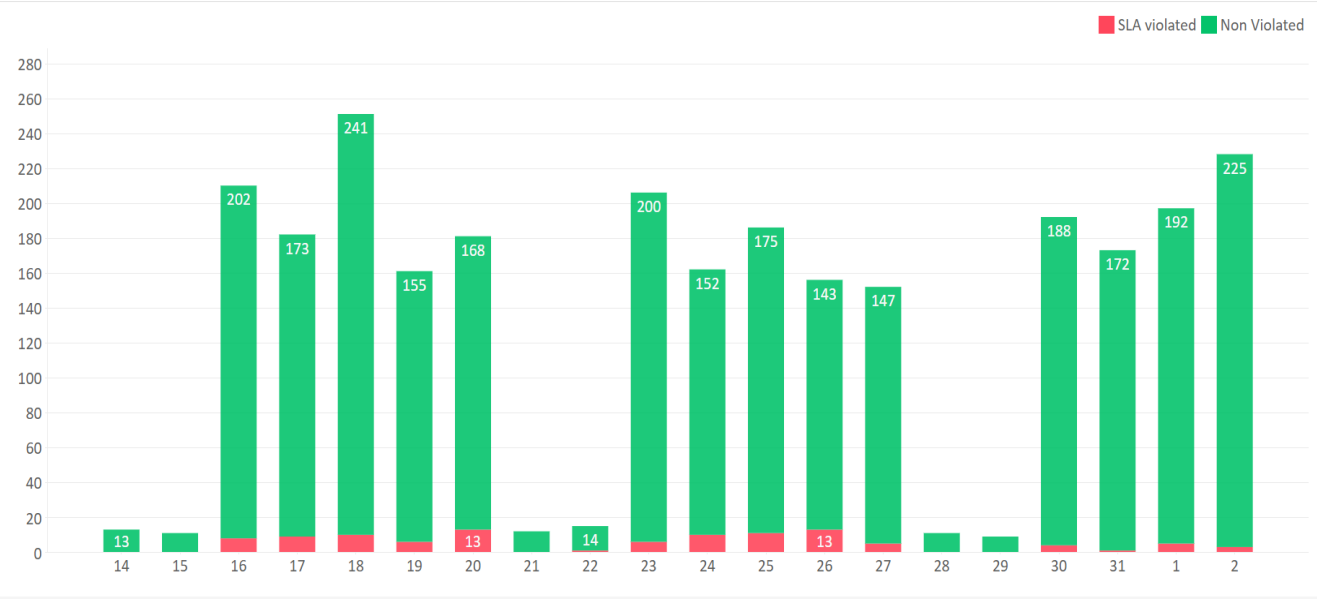
Month	Inbound Calls Queued	Max Queue Entry Position	Answered	% answered	Abandoned	% Abandoned	Average time to answer	Longest time to answer
Nov 2022	495	2	480	97	13	2.6	00:00:22	00:04:06
Dec 2022	310	2	301	97.1	8	2.6	00:00:19	00:04:46
Jan 2023	364	3	343	94.2	21	5.8	00:00:21	00:19:00

IT Operations Call Stats

Oldest Digital Jobs

Month	Count still outstanding	Area
July 2022	1	Networks
Aug 2022	2	Networks
Sept 2022	1	Networks
Oct 2022	9	Networks/ Data Centre/ IT Asset
Nov 2022	12	Networks/ Data Centre/ IT Asset/ Telecoms

Requests Received via the Service Desk Plus in the last 20 days



Service Desk Plus Jobs in Dec 2022
Raised: 3197 Resolved 3440

Service Desk Plus Jobs in Nov 2022
Raised: 4615 Resolved 4480

IT Operations Call Stats

Northern Lincolnshire & Goole NHS Foundation Trust

Requests Status by priority

Generated by Cath Butterill on : Feb 2, 2023 06:03 PM

Created Time : From Nov 1, 2022 12:00 AM To Jan 31, 2023 11:59 PM

	1. New / Pending	2. Assigned	3. Active	4. On Hold	Cancelled	Closed	Resolved	Count
Not Assigned	0	2	0	0	0	0	0	2
P1 - Critical (4 hrs)	1	0	1	2	0	27	232	263
P2 - High (1 day)	21	23	29	25	2	240	3024	3364
P3 - Medium (3 days)	11	20	24	24	1	89	1369	1538
P4 - Low (5 days)	30	74	43	67	5	449	4350	5018
P5 - No SLA	2	24	21	72	0	124	236	479
Preventive Maintenance	0	0	0	0	0	0	6	6
Count	65	143	118	190	8	929	9217	10670

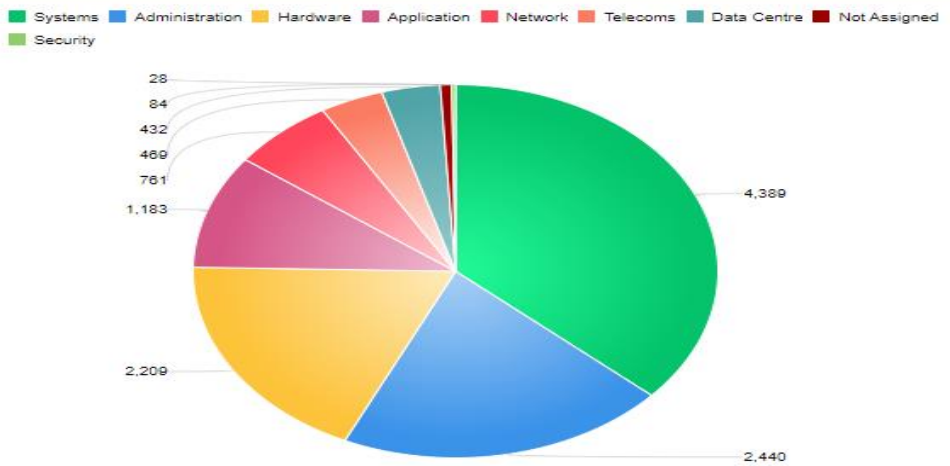
Northern Lincolnshire & Goole NHS Foundation Trust

Requests by Category

Generated by Cath Butterill on : Feb 2, 2023 06:07 PM

Total records : 11995

Created Time : From Nov 1, 2022 12:00 AM To Jan 31, 2023 11:59 PM



HUTH/NLAG Clinical Coding Shared Service Executive Team Report

Performance Indicator	Target	Shared Service	HUTH	NLAG
% Coded flex	100	67 %	58 %	80.5%
% Coded freeze	100	97.2 %	95.3 %	100 %
SHMI (latest Sept 21 – Aug 22)	As Expected	N/A	1.1051 As Expected	1.0148 As Expected
Performance Indicator	**England Av.**	**Shared Service**	**HUTH**	**NLAG**
Depth elective (higher is better)	5.7	N/A	6.6	5.5
Depth non-elective (higher is better)	5.7	N/A	5.9	5.5
% sign or symptom code in primary (lower is better)	13.6 %	N/A	6.9	16.7

Coding Depth – the avg number of diagnosis codes in each type of activity. The total # diagnosis codes/total number of episodes. Anything around the national avg is considered to be good.

Risks and Issues

- **Medicode 360** – HUTH have been using Medicode 360 since November 2022 and making use of it's new capabilities. NLAG are not yet able to move to Medicode 360 as testing the integration between 360 and the data warehouse has not yet been completed.
- **Coding Re-structure** – HUTH introduced the new Site Lead and Clinical Coding Liaison Roles in December and successfully recruited, internally, to all positions.
- NLAG will begin recruiting, internally, for these positions at the end of February.

Staffing

- Both Trusts are carrying vacancies (HUTH 4.5 and NLAG 2.4)
- Both currently have a significant proportion of inexperienced staff
- New starters are being given in-depth training sessions on a weekly basis as well as day-to-day on the job training with mentors.
- Further new starters will be recruited in March 2023
- Current new staff will have passed their initial training phase in March 2023

Key Initiatives

Programme	Digital Enabling Work	Benefits to be Realized
Connect Patient Information	Single PAS (Lorenzo) (May 2023)	Care Providers can access same Patient Information at NLaG or HUTH Risk Stratification Improve PTL Management
Reduce Paper	Enterprise Content/Document Management System	Eliminate use of paper charts Eliminate paper in Corporate Services (HR, Finance) Archive management – doc retention
Improve Pt Flow	ICS EPR	Improve patient workflow Improve alerting and flow for care providers Improve data collection Reduce number of systems in use Single patient record HUTH & NLaG Re-assign Admin staff to more critical tasks
Reduce Wait Lists	Soliton RIS System	Same Imaging systems at the Trusts
	Healthcare Communications	Digital Patient appt / PIFU/ Digital letters
	PKB/SystmOne	Integration with SDEC and UAC
	CDC	Community access to Imaging*
Improved Performance Reporting	New Data Warehouse (Insource)	Improved quality data Increase auto collection of data
Apps review	Review all applications in the estate against clinical and corporate priorities and the future view of the EPR systems	Reduce complexity, reduce wasted cost and enable enhanced and targeted infrastructure change. Enhanced multi sourced operating model, reducing complexity and increased capacity in the team.

Key Initiatives

Programme	Digital Enabling Work	Benefits to be Realized
Infrastructure Performance	Upgrade Network OBC – Cloud Migration Replace / Level up end user devices Single Sign on Single Service Desk / Service Centre	Stable Wifi Performance Reduce 4 Server rooms/ meet green agenda Automate datacentre operations Improve end user experience – multiple devices – fit for purpose Easy access to systems (reduce number of passwords)/improved auditing of access/IG Standardize ITSM processes, KPIs and track workload
Supply/Safety Management Scan 4 Safety	RFID – equipment & Supplies tracking Bar code scanning	Manage costs by tracking equipment Immediate audit and tracking of any recalled devices used in surgery Real Time inventory tracking
Digital Nursing Notes	NerveCentre (HUTH)	Nursing notes documented in EPR
Joining up Care	Integrated Care Programme (ICP) PAS/ WEBV & Lorenzo	10 specialties being combined (Cardio, GI, Oncology, Haem, Neuro, ENT, Derm/plastics, Urology, Respiratory, Ophthalm.)
Community Care	Augmented Reality Glasses	Reduce recording notes, and improve efficiency
Improve Efficiency and Productivity	Automation of repetitive tasks (RPA)	Reduce manual admin tasks using RPA
Consolidated service management, including investing in people, process and tooling to develop an effective joined up service.	Consolidated Service Introduction of Business relationship management Introduction of CTO Office and Solutions Design Function Technical & Service Governance introduced and aligned to IG and Programme change control processes.	Strategically aligned workforce with the right culture, skills and capacity to help deliver an innovative world class and modern Digital Service for the future. Aligned workforce in conjunction with modernizing processes will provide opportunities for the staff to further broaden their development & skills. Improving & modernizing processes should provide productivity improvements and the ability to get more value from our budget Sharper engagement with IT at a business level leading to greater focus in delivery of Trusts needs and regional priorities.

Improving the Work Experience

- The Single Sign On (SSO) project is on track for delivery. We have had a clinical discovery visit by Imprivata in January where a few issues were identified which have now been resolved. Key clinical systems have been profiled, including WebV, Symphony, ePMA, SystmOne and Xero. Others will be profiled as they become live, including Lorenzo, Badgernet and the Endovault upgrade. We will have the ability to tap on to a PC with our trust ID badges or NHS Smartcards, to easily log in to the device, and all our usernames and passwords will be remembered for us. For staff who are connecting to information on the NHS Spine, we can virtualise their Smartcard, so they do not need to insert it into the PC every time they need to see data on the Spine, improving access to vital information and streamlining the workflows.
- We have our next Imprivata on site visit booked in for the week commencing 27*th* Feb where we will train the service desk team, and clinical 'power users' who will be able to help with enrolment and troubleshooting. We will run a series of 'enrolment fairs' to register as many of our colleagues as we can before we go live, and we will also have a trial run of Single Sign On in the ED at DPoW to ensure that all systems are working as expected with the platform, before we start the full deployment.
- We are working with our vendor who has been developing a few methodologies that take frontline insights (from the clinical walkthroughs), combined with anonymous analytics from the Imprivata platform (Imprivata Insight reporting) that enables us to scale ROI calculations for an organization-wide view. We are participating in this to track our ROI.

We know that you know that virtual smartcards provide many benefits for clinicians and the Trust alike, including:

- Quick, seamless access to Spine applications
- Time savings of an estimated 20 minutes per person, per shift
- No need to collect a physical card and is instead delivered direct to PC/device
- Onboard new intakes of students in just minutes
- Replace lost and stolen cards instantly

But what about the business case? **How much money will your Trust actually save?**

There's no need to guess, because our ROI calculator can give you a better idea of how much money you'll save with the solution – all while getting the benefits above!

Try it now – you might be surprised at how much you could save! And for a demonstration of just how quick and easily the Imprivata Virtual Smartcard is set up, watch this video.

Successes….

- Digital Group Structure is evolving, Senior Team recruitment is complete
- Employee workshops for designing new joined up service currently being scheduled
- Data Warehouse build is progressing which will improve our reporting, further automate the manual tasks
- Continue to improve the integrated performance report, and performance review & improvement reporting for operations
- Joining up the reporting and standardizing across the 2 Trusts. Currently working on the same IPR format with comparison of the 2 Trusts
- Paperless working - Progressing the Electronic Patient Record (EPR) and Electronic Content/Document Management Business Cases
- Completed external review of IT & Infrastructure dept. Currently implementing some of the recommendations.
- Currently refining to a single Digital Governance Structure for Decision Making
- Increasing engagement with end users a focus on end user design and process improvement
- We now have access to patient records in both Trusts via Lorenzo and WebV click view
- Digital Letters Programme has a 3% reduction in do not arrives (DNA) and to date a £ 212k Savings

Challenges….

- In Group model it can be a challenge navigating different policies in place at the Trusts. Things take longer.
- Demand vs Capacity - Navigating the multiple demands is our biggest challenge at the moment
- Managing internal change with team; + ICS and NHS unplanned work
- Governance - Establishing a single Governance Structure for Decision Making
- Contract Consolidation - same suppliers, or systems that do same function
- Clinical & Operational Depts Joined up working - Communicating to departments at both Trusts that services work together. I.e.., Join up service plans and articulate their needs in BP. We cannot afford to support different systems, processes
- We have an Integrated Clinical Plan across the 2 Trusts, 10 specialties are joining together. We must align our processes to support that, and the accompanying business processes.
- Electronic Patient Record (EPR) ICS Convergence and HUTH and NLaG Enterprise Content/Document Management System (EDMS) – major business transformation programme across 2 Trusts

What I am asking from you...

- Understand the Digital Enabling Program and the leadership role you have
- Have shared clarity on where we want our investments to go – we must make every investment and spend make a measurable difference
- To understand the amount of change that is required to get the benefits from the changes that digital can support
- The time scales to implement are often longer than we would like
- Managing internal change with team; + ICS and NHS unplanned work
- Governance - Establishing a single Governance Structure for Decision Making, we must support the integrity of that process
- We need to invest more effort on business analysis for improvements and include that in operational division reports. "We spent this and the benefits we delivered are this."
- Our next piece of work is creating our joined up Digital Strategy –this is where the governance will be critical for our success and must have organizational level goals our highest priority

NLG(23)013

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7 February 2023	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance & Performance Committee Highlight Report**	
Purpose of the Report and Executive Summary (to include recommendations)	To highlight to the Board the main Performance and Estates & Facilities areas where the Committee was assured and areas where there was a lack of assurance resulting in a risk to the delivery of the Trust's strategic objectives. • Emergency Care performance and ambulance handovers remain a concern • A deep dive into Cancer performance at tumour site level took place • Lack of capital to address the risks to Critical Infrastructure	
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Executive Leads
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ✓ Review ☐ Other: Click here to enter text.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	7 February 2023
Report From:	Finance & Performance Committee – 21-12-22 and 26-01-23

Highlight Report:

Unplanned Care Month 8

There continued to be an increased number of patients attending Accident & Emergency (A&E) that required admission and flow issues through the hospital continued to contribute to long waits and ambulance handover delays. The recent Perfect Fortnight had delivered impressive results at Scunthorpe, but less at Grimsby and the good practices from that were being embedded across the system, including increased support in the community. There were 55-60 escalation beds open, with only 2 of those funded to the end of March, but closure looked unlikely given the current level of pressure. Urgent Care Service (UCS) performance was 98% in 4 hours and 73% in 2 hours and 40% of patients were discharged on the same day from Same Day Emergency Care (SDEC), well above the 28% achieved nationally, but SDEC was only open until 10.00pm. After that, patients went into A&E.

Unplanned Care Month 9

The Committee were informed that a set of actions had been taken recently and because of these the number of 60+ minute Ambulance Handovers had decreased. The Committee queried the work going on at Place and asked if that was helping with discharges. It was confirmed that some benefits had been seen in the East Riding and Hull and that some additional funding had been made available to improve support in the community and the use of discharge lounges.

Planned Care Month 8

The Committee requested assurance around the Overdue Follow Ups and Risk Stratification and was assured that there were no increased patient safety risks, as both areas were discussed at Performance Review and Improvement Meetings (PRIMs) and were being monitored at specialty level. The total waiting list size had reduced slightly, but mutual aid had resulted in more patients that had waited over 52 weeks. It was also confirmed to the Committee that the Cancer Deep Dives were taking place within the Planned Care Improvement and Productivity (PCIP) meetings, but there remained delays due to oncology, tertiary capacity, diagnostics and reporting. The Committee queried the delays due to cancer 'patient non-compliance' and were informed that conversations were being held at the Primary Care Interface Group to ensure that patients were aware of the need to attend appointments.

Magnetic Resonance Imaging (MRI) capacity issues impacted on DM01 performance. Surgery High Intensity Theatre (HIT) lists resulted in improved theatre productivity. Plans were in place to embed HIT to enable more patients to have surgery each day, but theatre capacity was at 83% due to refurbishments that were due to be completed in June 2023.

Planned Care Month 9 - Planned Care Improvement Programme

The Committee received deep dive reports into Cancer and Diagnostics. The Committee questioned the performance shown by the trend lines for Breast Cancer as the paper showed improvement work but deteriorating performance on the charts. It was confirmed that Breast was the best performing tumour site with a backlog of less than 6%. The Committee were assured by the Diagnostic report and the site level deep dive Cancer paper, as they outlined all the work taking place to improve performance against constitutional standards in each separate pathway.

It was confirmed to the Committee that not all the principles used during the recent HIT lists would be continuing due to cost versus benefits decisions.

Patient Administration Transformation Delivery

The Committee received a presentation which detailed the improvements in Patient Initiated Follow Ups (PIFU), Did Not Attend (DNA's), Virtual Appointments, Patients Know Best (PKB), Advice and

Guidance (A&G), Digital Communications and the growth of the Connected Health Networks (CHN). The Committee were advised that PIFU and CHN were the 2 biggest enablers to outpatient transformation to improve the backlog of patient follow-ups.
The Committee questioned the funding for CHN and was informed that it was still an issue as it needs to be system funded, but costs were offset by reduced need for funding for secondary care to manage bigger waiting lists.

Operational and Business Planning Timetable and Progress Update
The Committee received an update on planning which stated that the Trust was utilising the Capacity and Demand National Health Service England/Improvement (NHSE/I) tool for 2023/24. Baseline analysis was complete and work had started on workforce and finance plans, with a triangulation process agreed. The Trust was providing frequent updates to the Integrated Care System (ICS) with the biggest challenges being in Theatre, Follow Ups and Discharges.
It was confirmed that the first submitted draft of the plan would come to the Committee in February.

Low Voltage/High Voltage (LV/HV)
The Committee were presented with a paper on LV/HV that showed that the previous gap in LV/HV Authorised Persons had been covered, thereby mitigating that risk. The Committee were informed that there was a 5-year maintenance contract in place that also came with good opportunities for future joint Procurement with Hull University Teaching Hospitals (HUTH). The Committee queried the recent power issues at the Trust and were informed that the faulty generator fuel gauge and the electrical cable failure in Information Technology (IT) that caused the server issues were separate incidents, the latter not being connected to the Uninterrupted Power Supply (UPS) issues with the generator. It was also confirmed that improvements to the UPS had been approved at Capital Investment Board (CIB) and would be funded that year for the Theatres, Intensive Therapy Unit (ITU) and Neonatal Intensive Care Unit (NICU). The Committee requested a deep dive into the two incidents to have a full understanding of what had happened, the lessons learnt and how those lessons would result in improved resilience and reduced future risks.

Estates Strategy Update
The Committee received a paper and presentation which demonstrated some good work in the past few years to mitigate the Estates and Facilities risks. The Trust had also received c£101m of capital funding over the past three years for projects but that still left a Critical Infrastructure Risk currently valued at c£117m (£71m Scunthorpe General Hospital (SGH), £31m Diana, Princess of Wales (DPoW), £15m Goole District Hospital (GDH)). That was increasing at a rate of c10% each year, with the biggest risk being the boilers at SGH. An application for SGH to the New Hospital Program had been submitted but no response had been received yet.
Other programs of work were continuing such as the A&E/Integrated Acute Assessment Unit (IAAU) builds and the regional Community Diagnostic Centre's (CDC's). A Board discussion had been planned to discuss the options available and potential sources of funding, as the internally generated capital was small in comparison to the funds needed over the next 5 years.

Confirm or Challenge of the Board Assurance Framework:

A deep dive into SO1-1.6 took place and the Committee queried the ability of the operational teams to enact contingency plans at short notice in the light of the recent power and IT systems cable issues. The Committee also queried the risk score as it was unclear how the target score would be achieved from the controls and actions and there appeared to be no attributable high level risks on the risk register. It was agreed the Chair would raise these questions on behalf of the Committee.

Action Required by the Trust Board:

The Trust Board is asked to note the key points made and consider whether any further action is required by the Board at this stage.
Gill Ponder
Non-Executive Director / Chair of Finance and Performance Committee

Northern Lincolnshire and Goole NHS Foundation Trust

Agenda Item: NLG(23)014

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	07 February 2023
Director Lead	Simon Nearney, Interim Director of People
Contact Officer/Author	Karl Portz, Equality, Diversity and Inclusion Lead
Title of the Report	**Gender Pay Gap Report**
Purpose of the Report and Executive Summary (to include recommendations)	To gain approval of the Trust's Gender Pay Gap data which legally the trust must publish by 30 March 2023 and to agree an action plan to address identified gap. It is recommended that the Trust Board: • Note the contents of this report • Approve the results, as set out in Section 3, to be published on the Trust's website • Support the next steps and actions to reduce the Trust's gender pay gap • Report back to the Workforce Committee with progress on the Gender Pay action plan
Background Information and/or Supporting Document(s) (if applicable)	Included within the report.
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)	None
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	To meet our Public Sector Equality Duty

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 FT
Gender Pay Gap Report 2022/2023

1. PURPOSE/AIM

1.1 The purpose of this report is to provide an overview of the data that the Northern Lincolnshire & Goole NHS Hospital Trust (NLaG) statutorily needs to publish on its website and report to the Government on the gender pay gap. The report covers data for 2020, 2021 and 2022.

2. BACKGROUND/CONTEXT

2.1 The introduction of the Government regulations in April 2017 saw the requirement for public sector bodies in England with 250 or more employees to publish their gender pay and bonus gap. The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 bring in the gender pay gap reporting duty as part of the existing public sector equality duty (PSED).

2.2 The main requirements are for public sector employers to carry out six calculations based on annual data and to publish those figures on their organisation's website and upload on the Government website, annually, by 30 March, with a rationale for the pay gap. This report provides data for three years: 2020, 2021 and 2022. The Trust's Electronic Staff Record system has a specific standard report for this purpose.

2.3 There are two sets of nationally mandated regulations. The first is mainly for the private and voluntary sectors and the second is mainly for the public sector. Employers have up to 12 months to publish their gender pay gap, on their own website and on the government's online reporting service https://www.gov.uk/report-gender-pay-gap-data. This means that the gender pay gap will be publicly available, including to commissioners, patients, employees and potential future recruits.

2.4 The purpose of a gender pay gap audit is to focus on reducing any gaps in the pay of male and female employees by comparing and evidencing the difference in their average earnings.

2.5 The Gender Pay Gap Indicators

The legislation requires employers to publish the results of six calculations, as set out below. This report provides information on each of these six calculations, the formulas for which are explained below:

1. **Mean gender pay gap in hourly pay -** adding together the hourly pay rates of all male or female full pay and dividing this by the number of male or

female employees. The gap is calculated by subtracting the results for females from results for males and dividing by the mean hourly rate for males. This number is multiplied by 100 to give a percentage.

2. **Median gender pay gap in hourly pay -** arranging the hourly pay rates of all male or female employees from highest to lowest and find the point that is in the middle of range.

3. **Mean bonus gender pay gap -** add together bonus payments for all male or female employees and dividing this by the number of male or female employees. The gap is calculated by subtracting the results for females from results for men and dividing by the mean hourly rate for men. This number is multiplied by 100 to give a percentage.

4. **Median bonus gender pay gap -** arranging the bonus payments of all male or female employees from highest to lowest and find the point that is in the middle of the range.

5. **Proportion of males and females receiving a bonus payment -** total males and females receiving a bonus payment divided by the number of relevant employees.

6. **Proportion of males and females in each pay quartile -** ranking all of our employees from highest to lowest paid, dividing this into four equal parts ('quartiles') and working out the percentage of men and women in each of the four parts.

2.6 Gender pay reporting is different to equal pay. The gender pay gap is the average difference between the gross hourly earnings for all men and women which is expressed as a percentage of men's earnings (as set out at 2.5 calculation 1). Equal pay refers to men and women being paid the same for like work; work rated as equivalent or work of equal value as set out in the Equality Act 2010. It is unlawful to pay people unequally purely because they are a man or a woman.

2.7 It should be noted that whilst current pay structures support equal pay for men and women, factors such as length of service can affect the gender pay gap.

2.8 The majority of the Trust's staff are on national terms and conditions of employment. These are recognised as being an excellent example of equal pay for work of equal value. This will significantly assist in reducing our pay gap.

3. NLaG TRUST DATA TO BE PUBLISHED BY 30TH MARCH 2023

3.1 This section provides the breakdown of the statutory information the Trust is required to publish by 30th March 2023; all 2022 data provided in the tables below is a snapshot of a month's data as at 31st March 2022. The report also includes data from the same point in 2020 and 2021 to provide comparative information.

3.2 All data provided has been internally verified by NLaG HR Systems and Finance departments.

3.3 The data for reporting is as follows:

Average gender pay gap as a mean average for years 2020, 2021 and 2022 (Mean is calculated as the sum of all the values (hourly rates) divided by the number of staff)

Table 1

Average Hourly rate	2020	2021	2022
Male:	**£19.72**	£20.23	£21.17
Female:	**£13.04**	£13.68	£14.28
Gap:	**33.84%** ↓	**32.36%** ↓	**32.54%** ↑

3.4 The Average Hourly Rate (in table 1 above) is the figure that is used to calculate our gender pay gap nationally. The Average Hourly Rate calculation for all employees includes any unsocial payments made i.e., unsocial hours and weekend allowances.

3.5 The average pay gap increased marginally by 0.18%, from 32.36% in 2021 to 32.54% in 2022. Men's Average Hourly Rate (pay) increased by £0.94 and women by £0.60 over the two-year reporting period 2020 - 2022, therefore a slight increase in male and female Average Hourly Rates respectively. The slight increase in the pay gap is due to a slightly higher increase in men's Average Hourly Rate compared to the Average Hourly Rate for women. Further analysis of Average Hourly Rates shows the increase in the pay gap is due to an increased proportion of males in the upper pay quartile (as can be seen in 3.15).

3.6 **Median average gender pay gap for years 2020, 2021 and 2022**

Table 2

Median Hourly rate	2020	2021	2022
Male:	£14.89	£15.35	£16.21
Female:	£10.78	£11.55	£12.28
Gap:	**27.59%** ↑	**24.74%** ↓	**24.24%** ↓

3.7 The median average gender pay decreased by 0.5% (men's median average hourly pay increased by £0.86 and women by £0.73 over the two years).

3.8 The pay gap is as a result of less women being at the top of their pay scale, with a greater percentage of women compared to men with headroom to move up the pay scale. A greater percentage of men have already reached the top of their pay scale due to longer length of service.

3.9 **Average bonus gender pay gap as a mean average**

Table 3

Average Bonus	2020*	2021	2022
Male:	£6,757.46	£7,280.07	£5,842.67
Female:	£2,374.18	£3,677.42	£2,792.77
Gap:	**64.87%** ↓	**49.49%** ↓	**52.20%** ↑

3.10 The table above shows the average bonus payments for the last 3 years. Bonus payments include 'Refer a Friend' incentives paid to staff for helping to fill 'hard to fill' posts as well as Clinical Excellence Awards (CEAs). CEAs are awarded to consultants who perform their role 'over and above' the expected standard and can be in the form of both national and local CEAs. In 2022, the average bonus payment made to females decreased by £884.65. Male bonus payments also decreased by £1,437.40. This resulted in the average bonus pay gap increasing from 49.49% to 52.20%. The gap is largely due to a large proportion of bonus payments made in 2022 attributable to CEAs, 36 to females and 132 to males.

*Please note during the reporting year (2020-21) bonus payments include back pay for CEA payments from 2014-18 and 2018-21; therefore 2021 saw a higher number of CEAs awarded compared to previous reporting years.

3.11 **Average bonus gender pay gap as a median**

Table 4

Median Bonus Payment	2020	2021	2022
Male:	£3,015.96	£5,037.00	£3,126.48
Female:	£351.43	£1,841.00	£403.20
Gap:	**88.35%** ↑	**63.45%** ↓	**87.10%** ↑

3.12 The median average bonus pay increased in 2022 by 23.65%, from 63.45% in 2021 to 81.10% in 2022. In 2021, the median bonus payment to females decreased by £1,437.80. The median male bonus payment also decreased by £1,910.52. The median bonus pay gap has worsened due to a greater decrease in median bonus payments made to female employees.

*Please note during the reporting year (2020-21) bonus payments includes back pay for CEA payments from 2014-18 and 2018-21; therefore 2021 saw a higher number of CEAs awarded compared to previous reporting years.

3.13 **Proportion of males and proportion of females receiving a bonus payment**

Table 5

Proportion of bonus Payment	2020	2021	2022
Male:	6.45%	9.89%	9.00%
Female:	0.86%	0.79%	0.90%
Gap:	**5.59%** ↑	**9.1%** ↑	**8.1%** ↓

3.14 Table 5 shows the proportion of male and female staff who received bonus payments during the financial year 2021-22. In 2022, the gap between male and female decreased by 1%, from 9.1% to 8.1% with more male staff receiving bonus payments, than females. The decrease is due to a slightly higher proportion of females receiving a bonus payment as well as a reduction in the proportion of male employees receiving a bonus payment. The gap is mainly due to a higher number of male consultants in the workforce than females who qualify for CEA payments. CEA's awards range from values of £2,183 up to £36,886. This is the main reason for the bonus pay gap.

3.15 The data below ranks our full pay employees' hourly rates from highest to lowest, divided into four equal parts (quartiles) and then calculates the percentage of men and women in each of the four groups. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries.

Table 6

No. of Staff				
2020				
Quartile	**Female**	**Male**	**Female %**	**Male %**
Upper Quartile	1117.00	600.00	65.06%	34.94%
Upper Middle Quartile	1441.00	275.00	83.97%	16.03%
Lower Middle Quartile	1476.00	241.00	85.96%	14.04%
Lower Quartile	1484.00	230.00	86.58%	13.42%
Total	**5518.00**	**1346.00**	**80.39%**	**19.61%**
2021				
Quartile	**Female**	**Male**	**Female %**	**Male %**
Upper Quartile	1176.00	596.00	66.37%	33.63%
Upper Middle Quartile	1443.00	324.00	81.66%	18.34%
Lower Middle Quartile	1531.00	239.00	86.50%	13.50%
Lower Quartile	1542.00	228.00	87.12%	12.88%
Total	**5692.00**	**1387.00**	**80.41%**	**19.59%**
2022				
Quartile	**Female**	**Male**	**Female %**	**Male %**
Upper Quartile	1175.00	626.00	65.24%	34.76%
Upper Middle Quartile	1491.00	313.00	82.65%	17.35%
Lower Middle Quartile	1543.00	257.00	85.72%	14.28%
Lower Quartile	1564.00	233.00	87.03%	12.97%
Total	**5773.00**	**1429.00**	**80.16%**	**19.84%**

3.16 The data in the upper quartile, shows that NLaG have a higher proportion of men in the upper quartile compared to all other quartiles. In contrast, there are fewer women in the upper quartile compared to the remaining quartiles. From looking at the data in the upper quartile, men saw an increase from 596 to 626 which is why the percentage of male employees in the upper quartile has increased to 34.76%, up from 33.63% last year. In comparison, the number of females in the upper quartile decreased by 1.

3.17 Looking at the data in the upper middle quartile, men saw a decrease from 324 to 313. The number of females in the upper middle quartile increased by 48.

3.18 The lower middle quartile for females increased by 12. The number of males in this quartile increased by 18.

3.19 In 2022, men in the lower quartile increased by 5. In comparison, the number of women in this quartile increased by 22.

3.20 Overall, men's representation increased by 42 and the overall male percentage increased by 0.25% from 19.59% representation in 2021 to 19.84% in 2022. There remains more women in the middle and lower quartiles. This is due to a high number of female staff applying for and being appointed to HCA and administration and clerical roles.

3.21 The table below illustrates NLAG gender pay gap scores compared to peer median (other acute trusts) and national median (Model Hospital). In common with the Acute Healthcare Sector, there is a higher number of female to male ratio. Males represent 19.84% of our workforce and females represent 80.16%. This disproportionality in the upper quartile is one of the main reasons for both the mean and median gender pay gap. As can be seen in the comparator table below, NLaG has a higher proportion of males in the upper quartile compared to our peer groups.

Metric	Trust value	Peer average	National value
Average gender hourly pay gap	26.1%	22.8%	20.6%
Median gender hourly pay gap	16.8%	15.5%	9.4%
Proportion of males in lower quartile of hourly pay	16%	17.5%	20.2%
Proportion of females in lower quartile of hourly pay	84%	82.5%	79.8%
Proportion of males in top quartile of hourly pay	32.6%	31.7%	31.5%
Proportion of females in top quartile of hourly pay	67.4%	68.3%	68.5%

*Model Hospital recommended peer groups have been used as a comparator. Data period 2021/22.

4. WHAT HAVE WE DONE TO DATE

4.1 In recognition of the importance workforce data plays in understanding the performance of the Trust we have an established Associate Director of Workforce Systems and Recruitment. This role ensures the accuracy and consistency of workforce data, and together with the Trust Equality, Diversity and Inclusion Lead further interrogates our gender pay gap data to identify areas for improvement.

4.2 We have fully implemented Agenda for Change with the national job evaluation scheme in place to ensure our roles are evaluated against criteria that has been rigorously tested. The pay system is well-recognised as being an excellent example of equal pay for work of equal value.

4.3 As a follow up to our Trust Board development session last year which focussed on Equality, Diversity, and Inclusion. This year the Trust Board also received a session delivered by Eden Charles a nationally accredited Organisational Development and Leadership specialist. This session explored the importance of equity across all equality groups and challenged the Trust Board on their understanding of individual and collective responsibilities in relation to our Public Sector Equality Duties. In addition, Equality, Diversity, and Inclusion awareness was promoted as part of our Culture Transformation launch event. We also delivered a series of engagement events in partnership with our Trade Union colleagues which focused on gender equality, and health and wellbeing.

4.4 All of our job advertisements and associated literature are inclusive, and our interview panels now have an identified equality representative who is responsible for ensuring equality and inclusive practice is maintained during the interview.

4.5 To celebrate International Women's Day on 8th March 2022 the Trust held its first International Women's Day event. This event was very successful and involved a cross section of staff. A number of our females in senior leadership roles gave some powerful presentations on their lived experience and the challenges they overcame to become female leaders. These speakers included our Director of People, our Medical Director, and our Chief Nurse.

4.6 We have updated and refreshed our equality impact assessment process to ensure our policies and service changes do not discriminate; we advance equality of opportunity and we foster good relations between all equality groups. In particular, we have a number of family friendly policies which support flexible working, maternity and paternity, parental and adoption leave. Our Health and Wellbeing Strategy, implementation plan continues to support our staff.

4.7 The Trust has a very successful virtual Menopause staff equality network which has more than 200 members of staff.

5. NEXT STEPS

5.1 Gender Pay Gap report will be published, once approved by Trust Board, on the Trust's website and the government's online reporting service as legally required.

5.2 We will continue to implement the Trust's Equality, Diversity and Inclusion work plan to ensure we meet our legal and contractual responsibilities, and to meet our social and fairness responsibilities as a large employer and healthcare provider. This work plan will incorporate the actions identified within this report.

5.3 The EDI Lead will monitor the diversity workforce data in relation to recruitment, retention, employee relations, access to training and the overall make-up of the Trust's workforce in relation to diversity. This data will be reported into the forthcoming Culture Transformation Working Group (CTWG) which will meet monthly to facilitate the Trust-wide culture change agenda. The CTWG will report quarterly to the forthcoming Culture Transformation Board, accountable to the Trust Workforce Committee for the delivery of our Culture Transformation agenda. Proactive action will be taken where the data is disproportionate.

5.4 We will continue to work with other NHS Trusts via the Humber and North Yorkshire Health and Care Partnership and the Yorkshire and Humber regional equality, diversity and inclusion leads group to learn from best practice and explore opportunities to develop joint activities.

5.5 The gender equality action plan, as can be seen in Appendix 1, has been reviewed and refreshed in line with our 2022 gender pay gap data and will be monitored by the forthcoming Equality, Diversity, and Inclusion lead/EDI steering group. The EDI steering group will feed its reporting into the CTWG.

6 CONCLUSION

6.1 Whilst we can see small changes in the Average and Median pay compared to the last three years these are relatively small. It can be seen that we have a large female workforce (80.16% female), but the upper pay quartile disproportionately favours male staff. This suggests we need to do more work in the area of female staff progression and recruitment.

6.2 Due to a disproportionally high number of male consultants compared to female consultants, we made 132 Clinical Excellence Awards (CEAs) to males, compared to only 36 CEAs to female consultants. As stated at 3.10 above, a large proportion of bonus payments made in 2022 were in relation to CEAs.

7 RECOMMENDATIONS

It is recommended that the Trust Board:

1. **Note** the contents of this report;
2. **Approve** the results, as set out in Section 3, to be published on the Trust's website;
3. **Support** the next steps and actions to reduce the Trust's gender pay gap;
4. **Report back to the Workforce Committee** with progress on the Gender Pay action plan.

Appendix 1

Gender Action Plan 2022/23

Introduction

Northern Lincolnshire and Goole NHS FT is committed to reducing our gender pay gap and this is our 6th publication against this standard. April 2017 saw the introduction of the Government regulation setting out the requirement for public sector bodies in England with 250 or more employees to publish their gender pay and bonus gap. Northern Lincolnshire and Goole NHS FT, as an organisation that employs more than 250 people, has met our legal requirement of submitting gender pay gap data to the Government for five consecutive years.

For the 2021 result's we have produced an action plan that builds on some progress but also recognises that more work is required to narrow the gender pay gap. It provides detail on work planned to advance gender equality more generally. The action plan below has been developed into three themes to reflect the Trust's People Strategy.

NLaG People Strategy

- Workforce
- Culture
- Leadership

Monitoring and Evaluation

The action plan will be monitored by the Equality, Diversity and Inclusion Work Plan and the Culture Transformation Working Group on a quarterly basis, and through the Trust Board for end of year assessment and evaluation.

Gender – Action Plan 2022/23

No	Objective	Specific action	Lead	Timeline	Relevant Workforce Gender Data 2022	Indicators of improvement	Progress
1.0	**Workforce**						
1.1	**Ensure that recruitment and selection practices are inclusive for all prospective applicants regardless of gender**	Analyse recruitment data to explore drop-out rates by roles and service areas Identify reasons and trends for drop outs (all equality groups) Review and analyse inclusivity of recruitment materials (including where adverts are placed).	EDI Lead EDI Lead EDI Lead / Head of Employment	August 2023 August 2023 August 2023	Average gender pay gap (mean): 32.54% Men: £21.17 Women: £14.28	Following EDI and Unconscious Bias training, all selection panels will be inclusive and EDI compliant. We aim to have gender representation on all Recruitment and Selection panels. Workplace Disability Equality Scheme (WDES) Workplace Race Equality Scheme (WRES) Equality & Diversity System 22 (EDS22) Gender pay gap report.	EDI and Unconscious Bias training in place as part of leadership training. Recruitment data is being reviewed to ensure that meaningful analysis can be undertaken. Adverts have been updated to include an inclusive statement. All job descriptions and person specifications are reviewed to ensure that criteria are inclusive. All recruitment literature has been reviewed to ensure it is inclusive. All recruitment panels include an equality representative.

<table>
<tr><th>No</th><th>Objective</th><th>Specific action</th><th>Lead</th><th>Timeline</th><th>Relevant Workforce Gender Data 2022</th><th>Indicators of improvement</th><th>Progress</th></tr>
<tr><td>1.2</td><td>Ensure policies are in place to support a diverse and inclusive culture – linked to gender equality</td><td>For all newly created jobs and for all individual requests we will commit to exploring opportunities for more flexible or alternative shift working across the organisation.

For all newly created jobs and for all individual requests we will commit to exploring whether flexible working could be introduced into a wider range of roles, including at a senior level.</td><td>EDI Lead

EDI Lead</td><td>On-going

On-going</td><td>Average gender pay gap (mean): 32.54%

<table><tr><th>Men</th><th>Women</th></tr><tr><td>£21.17</td><td>£14.28</td></tr></table></td><td>Flexible working policy usage monitoring.

Equality Impact Assessment</td><td>Flexible working policy in place.

New Equality Impact Assessment policy and procedure in place.</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Specific action</th><th>Lead</th><th>Timeline</th><th>Relevant Workforce Gender Data 2022</th><th>Indicators of improvement</th><th>Progress</th></tr>
<tr><td>1.3</td><td>To hold comprehensive workforce data on all protected characteristics for staff</td><td>The intention is for the Equality, Diversity and Inclusion Steering Group to monitor the workforce data in relation to:
Applications/ Shortlisting/ Recruitment
Pay and reward
Employee relations case work
Access to training & development
Staff satisfaction. In addition WRES and
WDES data will continue to be presented at Workforce Committee

Monitor the make-up of the Trust’s workforce in relation to all protected</td><td>EDI Lead

EDI Lead</td><td>April 2023

August 2023</td><td>Average gender pay gap (mean): 32.54%
<table><tr><th>Men</th><th>Women</th></tr><tr><td>£21.17</td><td>£14.28</td></tr></table></td><td>The following mandated and published work programmes benefit from equality monitoring data

Workplace Disability Equality Scheme (WDES)

Workplace Race Equality Scheme (WRES)

Equality & Diversity System 2 (EDS2)

Gender pay gap report

NHS staff survey</td><td>Standard reporting templates under development</td></tr>
</table>

<table>
<tr><th>No</th><th>Objective</th><th>Specific action</th><th>Lead</th><th>Timeline</th><th>Relevant Workforce Gender Data 2022</th><th>Indicators of improvement</th><th>Progress</th></tr>
<tr><td></td><td></td><td>characteristics via the annual Equality and Diversity Report and to complete mandated reports to NHS England

To explore equality of access to leadership programmes for clinical / medical staff (all equality groups)</td><td>

EDI Lead</td><td>

August 2023</td><td>Average bonus gender pay gap (mean): 52.20%

<table><tr><th>Men</th><th>Women</th></tr><tr><td>£5,824.67</td><td>£2,792.77</td></tr></table></td><td></td><td></td></tr>
<tr><td>2.0</td><td>Culture</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>2.1</td><td>Staff work in an environment free from bullying, harassment and discrimination</td><td>Develop a culture of dignity and respect for all staff which includes any behaviour considered to be disrespectful as a result of gender

Design and deliver a range</td><td>EDI Lead

EDI Lead</td><td>Monthly events

April 22</td><td></td><td>Fewer cases of conflict/ harassment going through formal processes (WDES, WRES)

Staff are aware of Health and Wellbeing support and feel comfortable accessing it
Staff feel confident about reporting</td><td>Monthly staff engagement events to support equality, health and wellbeing, and FTSU.</td></tr>
</table>

No	Objective	Specific action	Lead	Timeline	Relevant Workforce Gender Data 2022	Indicators of improvement	Progress
		of knowledge, skills and awareness programmes focussed on strengthening inclusion and reducing exclusion, equipping staff with the skills to explore and understand difference. These modules will be included in the culture transformation and leadership development work 2022/23.				incidences of bullying and harassment regardless of gender (NHS staff survey)	
2.2	**Examine gender issues experienced by staff to improve staff experience and increase retention**	Launch a Women's Staff Equality Network	EDI Lead	May 2023		NHS staff survey	Menopause virtual network in place 200+ members

No	Objective	Specific action	Lead	Timeline	Relevant Workforce Gender Data 2022	Indicators of improvement	Progress
3.0	**Leadership**						
3.1`		Create an Equality, Diversity and Inclusion Steering Group Develop the EDS22 framework in relation to workforce gender equality (assemble evidence)	EDI Lead EDI Lead	May 2023 May 2023		Group in place EDS2 Grades (workforce)	
3.2	**To ensure that the Health and Wellbeing Services reflects the gender specific needs of staff**	Undertake an Equality Impact Assessment on the Health and Wellbeing Services and ensure that the gender specific needs of staff are met	EDI Lead	August 2023			New EIA Policy and Procedure in place.
3.3	**To have enabling strategies that support staff to succeed**	Ensure equality, diversity and Human Rights embedded into all training	EDI Lead	On-going			

No	Objective	Specific action	Lead	Timeline	Relevant Workforce Gender Data 2022	Indicators of improvement	Progress
	regardless of their gender	Monitor take-up of Learning and Development opportunities by protected characteristic, including at events designed to improve learning e.g. conferences, seminars.	EDI Lead	August 2023		WRES and WDES, workforce data metrics	

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	07 February 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) National Policy**
Purpose of the Report and Executive Summary (to include recommendations)	National Freedom To Speak Up (FTSU) Policy developed by the National Guardians Office (NGO) and NHSE with a recommendation that all Trusts adopt it. The policy has been amended to include relevant NLaG contacts. The policy has been to Trust Management Board in December 2022 and is recommending the policy to Trust Board for approval.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	✓ TMB ☐ PRIMs ☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working ☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	✓ Approval ☐ Discussion ✓ Assurance ☐ Information ☐ Review ☐ Other: Click here to enter text.

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

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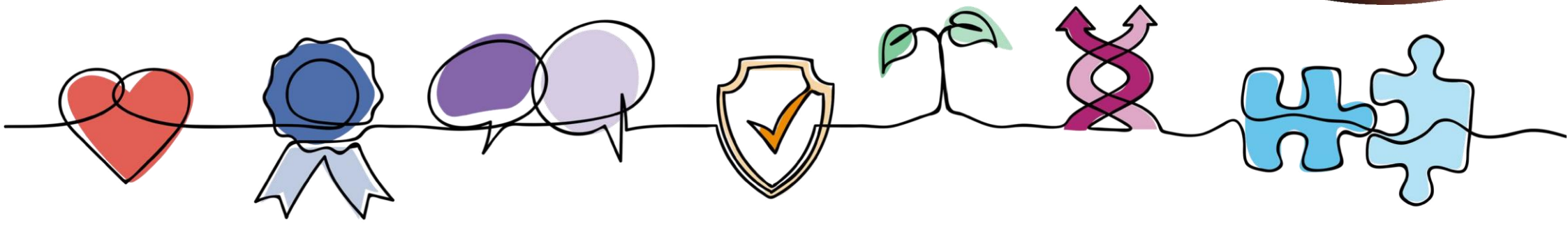
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan.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

Freedom to Speak Up policy for the NHS

Version 2, June 2022. Publication approval reference: PAR1245_i



Contents

Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment, and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Speak up – we will listen

We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all our workers. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.
This policy is for all workers and we want to hear all our workers' concerns.

We ask all our workers to complete the online training on speaking up. The online module on listening up is specifically for managers to complete and the module on following up is for senior leaders to complete.

You can find out more about what Freedom to Speak Up (FTSU) is in these videos

This policy

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

What can I speak up about?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others is affecting your wellbeing, or that of your colleagues or patients.

Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes (for example, HR or patient safety/quality)
That's fine. As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.

We want you to feel safe to speak up

Your speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about.

We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

Who can speak up?

Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.

Who can I speak up to?

Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you and depending on the size of the organisation you work in (some of the options set out below will only be available in larger organisations).

- Senior manager, partner or director with responsibility for the subject matter you are speaking up about.
- The patient safety team or clinical governance team (where concerns relate to patient safety or wider quality) email: nlg-tr.twcorporategovernance@nhs.net
- Our HR team – HR helpdesk number is 03033 306643 (operates Mon-Fri 10-4)
- Our Freedom to Speak Up Guardian – Liz Houchin (Tel: 07892764607 or email : nlg-tr.ftsuguardian@nhs.net), who can support you to speak up if you feel unable to do so by other routes. [Include explanation of the status of the guardian if they sit outside your organisation and/ or are shared with other organisations.] The guardian will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the guardian role here.
- Local counter fraud team (where concerns relate to fraud) Contact Nicki Foley on Tel: 03033 302994 or email: nicki.foley@nhs.net
- Our senior lead responsible for Freedom to Speak Up (Director of People) - they provide senior support for our speaking-up guardian and are responsible for reviewing the effectiveness of our FTSU arrangements.
- Our non-executive director responsible for Freedom to Speak Up

Speaking up externally

If you do not want to speak up to someone within your organisation, you can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.
- NHS England for concerns about:
  - GP surgeries
  - dental practices
  - optometrists
  - pharmacies
  - how NHS trusts and foundation trusts are being run (this includes ambulance trusts and community and mental health trusts)
  - NHS procurement and patient choice
  - the national tariff.

NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

- NHS Counter Fraud Agency for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix B contains information about making a ‘protected disclosure’.

How should I speak up?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity.

You have a choice about how you speak up:

- **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.
- **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.
- **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.

Advice and support

You can find out about the local support available to you at [either link to organisation intranet or reference other locations where this information can be found]. Your local staff networks [include link to local networks] can be a valuable source of support.

You can access a range of health and wellbeing support via NHS England:

- Support available for our NHS people.
- Looking after you: confidential coaching and support for the primary care workforce.

NHS England has a Speak Up Support Scheme that you can apply to for support.

You can also contact the following organisations:

- Speak Up Direct provides free, independent, confidential advice on the speaking up process.
- The charity Protect provides confidential and legal advice on speaking up.
- The Trades Union Congress provides information on how to join a trade union.
- The Law Society may be able to point you to other sources of advice and support.
- The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.

What will we do?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix A.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published and changes made as appropriate.

Senior leaders' oversight

Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardian.

Appendix A:
What will happen when I speak up?

We will:

Thank you for speaking up

•

Help you identify the options for resolution

•

Signpost you to health and wellbeing support

•

Confirm what information you have provided consent to share

•

Support you with any further next steps and keep in touch with you

→

Steps towards resolution:

Engagement with relevant senior managers (where appropriate)

•

Referral to HR process (where appropriate)

•

Referral to patient safety process (where appropriate)

•

Other type of appropriate investigation, mediation, etc

→

Outcomes:

The outcomes will be shared with you wherever possible, along with learning and improvement identified

→

Escalation:

If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter to the senior lead for FTSU or the non-executive lead for FTSU (if you are in an NHS trust)

•

Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body, such as the CQC or NHS England

Appendix B:
Making a protected disclosure

Making a ‘protected disclosure’

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from Protect or a legal representative.

Northern Lincolnshire and Goole NHS Foundation Trust

Agenda item: NLG(23)016

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	07 February 2023	
Director Lead	Simon Nearney, Interim Director of People	
Contact Officer/Author	Karl Portz, Equality, Diversity and Inclusion Lead	
Title of the Report	**Modern Slavery Statement**	
Purpose of the Report and Executive Summary (to include recommendations)	The approval of the Anti-Slavery statement is a legal requirement for Northern Lincolnshire and Goole NHS Foundation Trust and must be annually reviewed and published on the Trust's website.	
Background Information and/or Supporting Document(s) (if applicable)	The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all business with a turnover greater than £36 million per annum, the NHS is obliged to comply with the Act.	
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)	Not applicable	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Component of the Equality, Diversity and Inclusion remit for the Trust that must be renewed annually.	
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
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1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
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Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of People

MODERN SLAVERY STATEMENT

2023

MODERN SLAVERY ACT 2015 – STATUTORY STATEMENT

This statement is to be accepted as Northern Lincolnshire and Goole NHS Foundation Trust's response to the Modern Slavery Act 2015.

Background

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the Act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is obliged to comply with the Act.

The Modern Slavery Act makes provision to prohibit slavery, servitude and forced or compulsory labour and human trafficking and includes provision for the protection of victims.

A person commits an offence if:

- The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude.

- The person requires another person to perform forced or compulsory labour and the circumstances are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour.

Modern Slavery and Human Trafficking Act 2015 Actions Required

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

The aim of this statement is to demonstrate that the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.

Where possible all members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility lead for overall compliance.

This statement will be published externally on the Trust's internet site and internal on the Hub.

Northern Lincolnshire and Goole NHS FT

Northern Lincolnshire and Goole NHS Foundation Trust provides services across North Lincolnshire, North East Lincolnshire, East Riding of Yorkshire and West and East Lindsey. The Trust's total turnover for 2021/2022 was; £510,699,000 (Annual Report). The Trust employs 6892 permanent and fixed term contract staff (ESR data October 2022).

We have zero tolerance of slavery and human trafficking and are committed to maintaining and improving systems, processes and policies to avoid complicity in

human rights violation and to prevent slavery and human trafficking in our supply chain.

The Trust policies, procedures, governance and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. We also conform to the NHS employment check standards within our workforce recruitment and selection practices, including through our managed service provider contract arrangements. This strategic approach incorporates analysis of the Trust's supply chains and its partners to assess risk exposure and management on modern slavery.

In addition, the Trust is meeting its supply chain commitments on slavery and human trafficking by undertaking the following steps during the year:

- For all Terms and Conditions, including specific clauses that reflect our obligations under the Modern Slavery Act 2015
- Including a relevant pass/fail criteria for all Procurement led tender processes and new vendor requests for all goods and services above the OJEU procurement threshold as set out in the Public Contracts Regulations 2015
- The where possible uses procurement frameworks to provide assurance on key supplier metrics which meet our obligations under the Modern Slavery Act 2015
- We treat our employees fairly and consistently across the Trust adhering to UK employment law. The Trust pays above the national living wage i.e. the minimum wage set by the Government
- Risks to Northern Lincolnshire and Goole NHS FT associated with this Act are managed in accordance with the Trust's Risk Management Policy and will be included as appropriate on the Trust's risk register

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2023.

Chair Person Signature

CEO Signature

Equality Act (2010)
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.

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.

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.

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).

Further reading and additional information can be found here:
https://www.gov.uk/government/collections/modern-slavery

NLG(23)017

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	07 February 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. Nursing recruitment and retention strategy. 2. Health Care Support Workers and Medical Support Workers Recruitment exemplar. 3. De-escalation of the Gastroenterology Programme Enhanced Monitoring Status. 4. Industrial action. 5. Approval of: • The Gender Pay Gap Annual Report • NLaG Modern Slavery Statement. The Board is asked to: a) Receive and note the content of this highlight report b) Approve the Gender Pay Gap Report c) Approve the Modern Anti-Slavery Statement
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
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Financial implication(s) (if applicable)	N/A

Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

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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:	07 February 2023
Report From:	Susan Liburd, Non-Executive Director, and Chair of Workforce Committee

Highlight Report: Workforce Committee – 31 January 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. **Nursing Recruitment and Retention Strategy**
   As notified at the last Board meeting, the Workforce Committee has carried out a deep dive into NLaG Nursing recruitment and retention.

   The largest staff group within the Trust comprises of Nursing and Midwifery (25.9% of the total workforce). The Trust's largest nursing age group profile falls between 51 and 55yrs. Age 55yrs is the point at which nurses can choose to retire. Nationally there is a notable increase in nurses aged 55yrs exercising their right to take early retirement. There is a potential disruption to NLaG workforce of early career departure, and the recruitment and retention of Nurses is one of the Trust's key objectives

   The Trust has a Nursing profile made up of Registered Nursing, Midwifery and Unregistered Staff groups, with a headcount of **2,913** staff (2,415.55 full time equivalent) as at 31/12/2022. This is a 4.3% increase in the number of staff employed in these staff groups at the same period last year. The largest of these three staff groups is Registered Nursing. Trust data indicates that if a nurse is retained for a period of 3-5 years this leads to longer service. The average length of service for this retained age group is 17 years. Over the past 12months nursing staff turnover has increased from 0.6% to 11.3%.

   The Workforce committee was assured that comprehensive actions are being taken to recruit and retain nurses these include – career clinics, retire and return, part-time and flexible working initiatives for those able to retire early. In addition, for new starters, pastoral support, listening clinics, enhanced training and development, career planning and feeling valued initiatives are being delivered.

3. **Health Care Support Workers (HCSW) and Medical Support Workers (MSW) Recruitment Exemplar**
   NLaG have been recognised nationally as being a recruitment exemplar notably in the areas of in HCSW and MSW. The HR & OD teams have been invited to share NLaG recruitment methodology and best practice through the delivery of showcase and training events to other NHS Trusts.

4. **De-escalation of Gastroenterology Programme Enhanced Monitoring Status**
   NLaG had been in enhanced monitoring for its training of medical students in gastroenterology since June 2017. The Trust has made significant progress in resolving key areas of concern – clinical supervision, workload, and rota management. Following recommendation from Health Education England to the GMC in December 2022, the GMC is assured the training environment is now at the required levels and has de-escalated monitoring.

5. **Industrial Action**
   The Workforce Committee noted nationally industrial action is still ongoing and to date Nursing & Midwifery thresholds for strike action have not been met.

6. Items for Committee Ratification & Assurance

Workforce Committee approved the Gender Pay Gap Report
The purpose of this report is to provide an overview of the data that the Northern Lincolnshire & Goole NHS Hospital Trust (NLaG) statutorily needs to publish on its website and report to the Government on the gender pay gap. The report covers data for 2020, 2021 and 2022. Since April 2017 public sector bodies in England with 250 or more employees are required to publish their gender pay and bonus gap data. NLaG 2022 data must be published by the 3rd of March 20203. The Trust average pay gap increased marginally from 2021 by 0.18%. Men's Average Hourly Rate (pay) increased by £0.94 and women by £0.60 over the two-year reporting period 2020 – 2022. The report details several contributory factors due to the Trust's male and female professional salary demographic profile, as well as who was in receipt of clinical excellence awards.

Workforce Committee approved the Modern Anti-Slavery Statement
The Modern Slavery Act 2015 makes provision to prohibit slavery, servitude, forced or compulsory labour and human trafficking. It includes provision for the protection of victims. In line with all businesses with a turnover greater than £36 million per annum, the NHS is obliged to comply with the Act. The provisions in the act create a requirement for an annual statement to be prepared demonstrating transparency in supply chains.

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.

NLG(23)018

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	7 February 2023	
Director Lead	Lee Bond, Chief Financial Officer	
Contact Officer/Author	Brian Shipley, Deputy Director of Finance	
Title of the Report	**Finance Report – M09**	
Purpose of the Report and Executive Summary (to include recommendations)	This report highlights the reported financial position of Month 09 of the 2022/23 reporting period. The Trust Board are asked to note: • The Finance Report, Month 09 • The £2.5m year-to-date deficit	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: F&P Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Contained within the report.	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-	
Recommended action(s) required	☐ Approval ✓ Discussion ☐ Assurance	☐ Information ✓ Review ☐ Other: Click here to enter text.

Finance Report Month 9

December – 2022/23

Income & Expenditure - Summary

	£m
Current month Actual I&E Surplus/(Deficit)	0.73
Current month Planned I&E Surplus/(Deficit)	0.53
Current month Variance I&E Surplus/(Deficit)	0.21
YTD Actual I&E Surplus/(Deficit)	(2.49)
YTD Planned I&E Account Surplus/(Deficit)	1.29
YTD Variance from Plan – I&E Surplus/(Deficit)	(3.78)

The Trust had a £0.73m surplus in month, £0.21m better than plan. However, the in-month position was supported through further release of £1.45m of non-recurrent technical reserves. The Trust also received £2.055m additional non-recurrent funding to support the residual pay award pressures not covered by the tariff increase, £1.54m released in month. This funding should have improved the Trust's financial position, but it has been required to cover additional cost pressures in month in non-pay across Clinical Supplies, Drugs, Energy and referred Pathology testing.

The Trust is also behind its improvement trajectory in month by £0.36m, and still has a £2.49m year-to-date deficit, £3.78m worse than plan.

The Trust is formally forecasting a balanced financial position but is highlighting a deficit risk of **£8.04m** if the run rate witnessed in the last two months of November and December continues. The Trust has non-recurrent flexibility of £5.2m, leaving a potential residual un-mitigated deficit of **£2.8m**.

Income & Expenditure - Income

Income - £3.23m Favourable in month, £10.32m favourable year-to-date

• Clinical income was £2.25m above plan in month. £1.54m is due to additional non recurrent pay award funding and is £7.42m above plan year-to-date, £7.06m in total is due to pay award funding. Injury recovery income was £0.37m above plan year-to-date. The Trust received non-recurrent bed capacity funding of £0.22m in month offsetting nurse overspends driven through escalation beds. These favourable variances are partly offset by the shortfall on the Lincs ICB Contract, which totalled £0.51m under plan year-to-date (reduced from £1.1m last month with a final settlement due to be reached imminently). High cost drugs were £0.5m above plan year-to-date offset by CDF drugs being £0.5m below plan. These variances include £0.19m drug challenges year-to-date (improved from £0.29m year-to-date at the end of last month), due to prior approval processes not being followed. The Trust is continuing to over-perform on CCG pathology contracts, but these are block-funded, driving pressures in non-pay consumable costs. The transfer of Neurology services reduced NHS clinical income by £0.53m year-to-date but this is now reported under Non-patient care contract income from HUTH under provider to provider income.

• Elective Recovery Funding was again recognised as fully achieved, per system requirements (except the Lincs ICB misalignment). The Trust did not achieve the 104% activity target in month; performance was 94% in month and now sits at 96% year-to-date. However, core activity is supported by IS capacity of 3% both in month and year-to-date. £4.06m of Elective Recovery Funding received year-to-date would have been at risk if penalties had been enforced.

• Covid outside envelope income is £0.71m below plan year-to-date due to lower testing costs than expected in the plan.

• Education income is £1.06m above plan year-to-date due to increased funding for lead employer payments and additional GP VTS Doctors, both with offsetting expenditure.

• Non-patient care and contracts agreements is £1.33m above plan. £0.53m relating to Neurology, as per above. £0.48m for Grange Beds and £0.5m for Migrant Support Workers are offset with corresponding expenditure.

• Other income variances year-to-date mainly consist of several minor favourable monthly variances, including Donated Asset income (£0.23m) and R&D income (£0.10m) offset by expenditure, and accommodation income (£0.06m).

Income & Expenditure - Pay

Northern Lincolnshire and Goole NHS Foundation Trust

Pay - £1.27m overspent in month, £13.40m overspent year-to-date

• The impact of the pay award is now covered through additional non recurrent support of £2.05m on top of tariff funding and equates to £0.78m in month and £7.06m year-to-date across all staff Groups.

• Medical staff was £1.38m overspent in month and £10.37m year-to-date. £0.12m in month and £1.09m year-to-date was due to the pay award (before additional funding support as above). Increased Non-Elective and Emergency activity continues to drive additional shift bookings across Medicine Acute Care and ED, £0.40m in month and £1.88m year-to-date overspend. Non-delivery of CIP, mostly recruitment, caused a £0.11m overspend in month, £0.56m overspend year-to-date. Premium pay covering vacancies, sickness and on-call exemption cover are the main reasons for £0.43m overspends in month and £3.75m year-to-date across a number of specialities. £1.87m of Waiting List payments for additional capacity are partially offset by slippage on planned Independent Sector contracts.

• Nursing was £0.94m overspent in month and £3.69m overspent year-to-date. £0.32m in month and £2.88m year-to-date was due to the pay award. £0.20m in month and £2.17m year-to-date vacancy underspends across Maternity, Community District Nursing, NICU and Paediatrics obscure cost pressures that would otherwise amount to £0.25m in month and £1.58m year-to-date from at least 40 additional escalation with circa 11,212 more bed days than the equivalent period in 21/22. The escalation beds costs in month are partly offset by non-recurrent bed capacity funding but should be reducing via recent investment in community schemes. Other overspends includes additional duties in ED and SDEC agency premiums (£0.17m in month and £1.30m year-to-date), and Goole Ward 3 agency premiums (£0.14m overspent year-to-date excluding escalation beds). Non-delivery of CIP, mostly recruitment, caused a £0.11m overspend in month and £0.56m year-to-date. Bank incentives introduced part month did not increase bank supply at a cost of £80k.

• Scientific was £0.38m overspent year-to-date. £1.23m was due to the pay awards impact, partly offset by vacancies across Community and Therapy, Blood Sciences and Pharmacy.

• Other Pay was £1.05m underspent in month and £1.04m underspent year-to-date. £0.21m in month and £1.86m overspend year-to-date was due to the pay award. £0.33m Medical Support Worker year-to-date overspends were offset by income. These overspends are obscured by the release of £2.52m of non-recurrent technical reserves year-to-date, and CIP over-delivery within Corporate functions of £1.05m.

Income & Expenditure – Non-Pay, EBITDA, Reserves

Non-pay - £2.0m overspent in month, £1.41m overspent year-to-date

• Clinical non-pay was £1.40m overspent in month £3.57m year-to-date, and again reflected the highest spend in any month this year on clinical supplies despite lower planned care activity in month. Activity caused a Pacemaker overspend of £0.02m in month and £0.12m year-to-date. General Theatre overspends of £0.29m in month and £1.23m year-to-date are being caused by high non-elective admissions. Overall patient admissions were 20.3% higher in month and 13.6% higher year-to-date compared to 19-20 activity. High Cost Drug pressures of £0.94m year-to-date would otherwise be fully offset by additional income under previous PBR rules. Change of supplier and increased activity drive diabetic insulin pump overspends of £0.14m in month and £0.53m year-to-date which would otherwise be funded under PBR as high cost excluded devices. £0.34m cumulative overspends across Community equipment / orthotics and wheelchairs are the other material adverse variances.

• Other non-pay was £0.60m overspent in month and £2.16m underspent year-to-date. Underspends in planned IS activity of £0.05m in month and £2.50m year-to-date partly offset additional WLI payments outlined above. Establishment expenses were overspent by £0.56m year-to-date due to employment screening costs (£0.22m, mostly international recruitment offset by HEE income), postage (£0.10m) and travel and subsistence (£0.21m). Premises and fixed plant were overspent by £0.65m year-to-date due to overspends across several areas including electricity, water, sewerage and computer hardware. These pressures are offset by £1.33m of non-recurrent technical reserve released year-to-date to support the position.

• Pathology overspends of £0.41m year-to-date are driven by CCG over-performance with no corresponding income due to block arrangements although £1.0m is expected as part of the Lincolnshire ICB settlement.

• Post EBITDA - £0.21m underspent in month, £1.29m underspent year-to-date is mainly due to a high cash balances resulting in interest received, and a reduced PDC charge from capital programme delays.

• The position is further supported through slippage on centrally held unallocated reserves of £2.1m.

Income & Expenditure

Income & Expenditure	Annual Plan to 31st March 2023 £'000	Current Month Plan £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
Clinical Income	374,338	31,196	33,442	2,246	280,751	287,364	6,613
ERF Income	0	0	0	0	0	0	0
TIF	0	0	0	0	0	0	0
Block Top Up	58,394	4,866	4,923	56	43,796	44,474	678
Covid Inside Envelope Block	11,387	949	960	11	8,540	8,672	132
Covid Outside the Envelope	1,700	142	35	(107)	1,275	563	(712)
Other Income	39,338	3,286	3,998	711	29,422	32,802	3,379
Donated Income	0	0	311	311	0	232	232
Total Operating Income	**485,157**	**40,439**	**43,668**	**3,229**	**363,784**	**374,106**	**10,321**
Clinical Pay	(256,495)	(21,073)	(23,386)	(2,313)	(192,026)	(206,465)	(14,439)
Other Pay	(65,707)	(5,458)	(4,410)	1,047	(49,265)	(48,223)	1,043
Total Pay	**(322,203)**	**(26,530)**	**(27,797)**	**(1,266)**	**(241,292)**	**(254,687)**	**(13,396)**
Clinical Non Pay	(70,187)	(5,569)	(6,973)	(1,404)	(52,363)	(55,930)	(3,567)
Other Non Pay	(71,403)	(5,940)	(6,540)	(600)	(53,322)	(51,164)	2,158
Total Non Pay	**(141,590)**	**(11,509)**	**(13,513)**	**(2,004)**	**(105,685)**	**(107,093)**	**(1,409)**
Operating Expenditure	**(463,793)**	**(38,039)**	**(41,310)**	**(3,270)**	**(346,977)**	**(361,781)**	**(14,804)**
EBITDA	**21,364**	**2,400**	**2,358**	**(42)**	**16,808**	**12,325**	**(4,483)**
Depreciation	(16,169)	(1,441)	(1,296)	145	(11,628)	(11,463)	165
Interest Expenses & Other Costs	(233)	(19)	84	103	(175)	511	685
Dividend	(6,251)	(520)	(554)	(34)	(4,682)	(4,243)	439
Total Post EBITDA Items	**(22,653)**	**(1,980)**	**(1,766)**	**214**	**(16,485)**	**(15,196)**	**1,289**
Remove Capital Donated I&E Impact	1,289	107	143	35	967	502	(465)
Remove Impairments (allowable)	0	0	0	0	0	0	0
Remove variance on gains on disposals	0	0	0	0	0	(120)	(120)
Remove net impact of consumables donated from other DHSC b	0	0	0	0	0	0	0
Remove net loss on disposal of DHSC donated equipment	0	0	0	0	0	0	0
I&E Surplus / (Deficit)	**0**	**527**	**734**	**208**	**1,290**	**(2,489)**	**(3,779)**

Divisional Financial Position

BUDGETARY PERFORMANCE

	Annual Budget (£000s)	In-month Budget (£000s)	In-month Actual (£000s)	In-month Variance (£000s)	YTD Budget (£000s)	YTD Actual (£000s)	Variance (£000s)
Operations Directorate	(39.2)	(3.2)	(3.5)	(0.2)	(29.5)	(30.0)	(0.5)
Family Services	(47.4)	(4.0)	(4.0)	(0.0)	(35.6)	(35.0)	0.6
Surgery & Critical Care	(120.3)	(10.3)	(11.3)	(1.0)	(91.5)	(98.3)	(6.9)
Medicine	(120.4)	(9.6)	(11.1)	(1.5)	(91.5)	(97.3)	(5.8)
Therapy & Community Services	(35.6)	(2.9)	(3.0)	(0.1)	(26.8)	(26.4)	0.4
Sub Total – Operations	**(362.8)**	**(30.0)**	**(32.8)**	**(2.8)**	**(274.9)**	**(287.0)**	**(12.1)**
Trust Management	(1.5)	(0.1)	(0.1)	(0.0)	(1.1)	(1.1)	0.1
Medical Director's Office	(23.1)	(2.0)	(1.9)	0.0	(17.5)	(17.2)	0.3
Chief Nurses Office	(5.2)	(0.4)	(0.4)	0.0	(3.9)	(3.8)	0.1
Finance	(5.0)	(0.4)	(0.4)	0.0	(3.8)	(3.5)	0.3
People & Organisational Effectiveness	(5.3)	(0.5)	(0.4)	0.1	(4.0)	(3.9)	0.1
Estates & Facilities	(33.4)	(2.9)	(3.1)	(0.2)	(24.9)	(25.1)	(0.2)
Strategic Development	(1.3)	(0.1)	(0.1)	0.0	(0.9)	(0.8)	0.1
Digital Services	(10.7)	(0.9)	(0.9)	0.0	(8.1)	(7.9)	0.2
Central & Capital Charges	(15.6)	(1.4)	(0.6)	0.8	(11.1)	(5.1)	6.0
Central Income	470.2	40.0	40.8	0.8	352.7	351.9	(0.7)
Trust Reserves	(7.5)	(0.9)	0.5	1.4	(2.1)	0.5	2.6
Sub Total – Corporate Directorates	**361.5**	**30.4**	**33.4**	**3.0**	**275.2**	**284.1**	**8.9**
Trust Total	**(1.3)**	**0.4**	**0.6**	**0.2**	**0.3**	**(2.9)**	**(3.2)**
Excluded Items	**1.3**	**0.1**	**0.1**	**0.0**	**1.0**	**0.4**	**(0.6)**
TOTAL	**(0.0)**	**0.5**	**0.7**	**0.2**	**1.3**	**(2.5)**	**(3.8)**

Divisional Financial Position

• Operations Directorate £0.5m overspent year-to-date - £0.68m Pathology overspends (note circa 50% CCG activity on block), £0.21m Operations Centre overspends covering Site are partially offset with Pharmacy vacancy underspends of £0.2m.

• Family Services £0.6m underspent year-to-date - £1.33m year-to-date nursing vacancy underspends across Maternity, NICU and Paediatrics, partly offset by overspend on clinical supplies (£0.39m) from high cost insulin pumps, Medical Staff (£0.16m) due to Gynae over-establishments / additional sessions / exempt on-call.

• Surgery and Critical Care £6.9m overspent year-to-date - £3.6m overspent on Medical Staff mainly due to pay premiums covering 40.5 WTE vacancies alongside restricted duties and on-call cover, £2.2m overspent on Clinical Supplies mainly due activity in Orthopaedics, Urology, Ophthalmology and Audiology and Theatres due to clinical practice changes on energy sealing and heating devices and usage of Urology disposable scopes. £0.3m Scientific staff overspends from premium pay covering Theatre ODP vacancies, £0.25m other staff overspends due to unallocated CIP, £0.1m Nursing overspends mainly due to escalation beds.

• Medicine £5.8m overspent year-to-date - £1.78m Medical Staff mainly due to additional shift bookings across Medicine Acute Care and ED, £1.94m Nursing Staff due to £1.12m escalation beds and £1.3m additional duties in ED and SDEC agency premiums, £1.43m Drugs of which £1.2m were high cost drugs activity, £0.49m Clinical Supplies mainly due to high cost insulin pumps and pacemakers, £0.27m Healthcare Services from HUTH for Haematology and Cardiology.

• Therapy and Community Services £0.4m underspent year-to-date - £1.5m vacancy underspends across many areas including district nursing, neuro rehab and community dental services, £0.37m Goole Medicine overspends due to escalation beds and premium pay covering vacancies, £0.28m overspends due to unallocated CIP and £0.34m overspends across Community equipment / orthotics and wheelchairs.

• Estates and Facilities £0.2m overspent year-to-date - £1.40m pay overspends mainly due to support staff bank usage over budget. £0.9m above income plan due to high private patient activity compared to last year. £0.15m non-pay overspends across several areas including electricity, water, sewerage and building/engineering maintenance and materials.

• Other corporate areas £9.1m underspent – mainly due to non-recurrent release of technical reserves and non-recurrent corporate CIP.

ERF

Elective Recovery Funding was again recognised as fully achieved, per system requirements (except the Lincs ICB misalignment). The Trust did not achieve the 104% activity target in month; performance was 94% in month and now sits at 96% year-to-date. However, core activity is supported by IS capacity of 3% both in month and year-to-date. £4.06m of Elective Recovery Funding received year-to-date would have been at risk if penalties had been enforced.

In Month

		Community and Theraples	Medicine	Surgery and Critical Care	Womens and Childrens	Surgery Endoscopy	Trust Total
DAYCASE	CORE	119%	131%	92%	77%	105%	101%
	ISP						
	TOTAL	119%	131%	92%	77%	105%	101%
ELECTIVE	CORE		40%	85%	65%		76%
	ISP						
	TOTAL		40%	85%	65%		76%
OP FIRST ATTENDANCE	CORE		81%	111%	113%		100%
	ISP		34%	1%			12%
	TOTAL		115%	112%	113%		112%
OP F/UP ATTENDANCE	CORE		84%	97%	111%		94%
	ISP		13%	2%			6%
	TOTAL		97%	98%	111%		100%
OP FIRST PROCEDURE	CORE		44%	77%	113%	160%	90%
	ISP		3%	4%			2%
	TOTAL		46%	81%	113%		93%
OP F/UP PROCEDURE	CORE		57%	99%	105%		90%
	ISP			6%			4%
	TOTAL		57%	105%	105%		94%
Total	CORE	34%	90%	91%	91%	103%	91%
	ISP		9%	1%			3%
	TOTAL	34%	99%	92%	91%	103%	94%

Year to Date

	Community and Theraples	Medicine	Surgery and Critical Care	Womens and Childrens	Surgery Endoscopy	Trust Total
CORE	79%	105%	94%	82%	103%	97%
ISP						
TOTAL	79%	105%	94%	82%	103%	97%
CORE		45%	91%	73%		84%
ISP						
TOTAL		45%	91%	73%		84%
CORE		81%	118%	110%		102%
ISP		40%	2%			15%
TOTAL		121%	120%	110%		117%
CORE		82%	94%	111%		92%
ISP		14%	2%			7%
TOTAL		95%	95%	111%		98%
CORE		72%	78%	106%		93%
ISP		0%	5%			3%
TOTAL		73%	83%	106%		96%
CORE		66%	107%	117%		99%
ISP			6%			4%
TOTAL		66%	113%	117%		103%
CORE	48%	86%	96%	92%	102%	93%
ISP		11%	1%			3%
TOTAL	48%	97%	96%	92%	102%	96%

Included within its plan is an allocation of £7.3m to cover additional capacity expenditure. The Trust has incurred £5.99m of additional expenditure in additional capacity but has not achieved the required activity targets.

	In Month			YTD		
Expenditure	Plan	Actual	Variance	Plan	Actual	Variance
Internal Capacity	0.00	(0.35)	(0.35)	0.00	(2.82)	(2.82)
IS Capacity	(0.61)	(0.36)	0.25	(5.48)	(3.18)	2.30
Total	(0.61)	(0.71)	(0.10)	(5.48)	(5.99)	(0.52)
Variance	(0.61)	(0.71)	(0.10)	(5.48)	(5.99)	(0.52)

ERF

Division	SpecCode	Spec Description	Month 1	2	3	4	5	6	7	8	9
Surgery and Critical Care	100	General Surgery	83%	81%	77%	81%	87%	78%	84%	91%	79%
	101	Urology	101%	100%	90%	100%	103%	107%	108%	129%	87%
	104	Colorectal Surgery	94%	101%	130%	121%	111%	109%	147%	127%	131%
	106	Upper Gastrointestinal Surgery	55%	63%	49%	52%	49%	63%	68%	91%	57%
	110	Trauma & Orthopaedics	91%	111%	99%	90%	90%	75%	92%	83%	82%
	120	ENT	99%	101%	100%	87%	96%	108%	104%	127%	108%
	130	Ophthalmology	112%	108%	102%	108%	110%	96%	100%	118%	106%
	140	Oral Surgery	228%	192%	103%	209%	182%	164%	190%	155%	217%
	190	Anaesthetics	86%	100%	84%	103%	79%	95%	87%	85%	96%
	401	Clinical Neurophysiology	0%	0%	0%	0%	0%	0%	0%	0%	0%
Surgery and Critical Care Total			**95%**	**100%**	**94%**	**94%**	**96%**	**90%**	**100%**	**104%**	**92%**
Medicine	300	General Medicine	148%	174%	149%	109%	103%	153%	121%	124%	99%
	301	Gastroenterology	166%	129%	106%	166%	105%	104%	133%	136%	176%
	302	Endocrinology	159%	130%	151%	161%	146%	142%	121%	126%	177%
	303	Clinical Haematology	67%	62%	68%	67%	65%	72%	73%	67%	62%
	307	Diabetic Medicine	102%	113%	112%	127%	116%	106%	105%	93%	90%
	320	Cardiology	82%	82%	86%	66%	90%	82%	103%	126%	102%
	329	Transient Ischaemic Attack	89%	64%	82%	79%	77%	72%	64%	84%	96%
	330	Dermatology	77%	65%	56%	57%	76%	63%	75%	28%	25%
	340	Respiratory Medicine	128%	126%	115%	97%	100%	108%	104%	108%	121%
	370	Medical Oncology	87%	91%	112%	99%	103%	94%	95%	96%	93%
	400	Neurology	67%	70%	51%	61%	50%	46%	37%	43%	56%
	410	Rheumatology	131%	105%	96%	104%	117%	107%	101%	96%	100%
	430	Geriatric Medicine	106%	112%	94%	131%	101%	113%	89%	98%	117%
Medicine Total			**101%**	**95%**	**95%**	**94%**	**94%**	**93%**	**98%**	**101%**	**99%**
Surgery Endoscopy Total			**98%**	**109%**	**99%**	**104%**	**103%**	**95%**	**109%**	**103%**	**103%**
Family Services	103	Breast Surgery	79%	79%	94%	93%	73%	102%	98%	83%	89%
	223	Paediatric Epilepsy	133%	67%	70%	53%	79%	74%	94%	112%	88%
	263	Paediatric Diabetic Medicine	87%	133%	92%	94%	92%	92%	112%	92%	80%
	290	Community Paediatrics	105%	93%	87%	76%	103%	92%	113%	103%	93%
	420	Paediatrics	107%	109%	122%	89%	100%	97%	107%	103%	106%
	502	Gynaecology	95%	94%	85%	85%	89%	86%	96%	91%	86%
Family Services Total			**94%**	**93%**	**93%**	**87%**	**88%**	**91%**	**99%**	**91%**	**91%**
Trust Total			**96%**	**98%**	**94%**	**94%**	**94%**	**91%**	**100%**	**101%**	**94%**

Activity performance has improved since the Pandemic. However, the in year YTD position is still short against 2019/20 levels as follows and has been heavily reliant on premium IS and additional session capacity:

	Spells / Attendances				
POD	19/20	20/21	21/22	22/23	Variance to 19/20
Elective	5,113	2,662	3,657	3,668	(1,445)
Daycase	40,137	25,100	36,915	40,192	55
OPD New	70,600	32,934	55,111	60,633	(9,967)
OPD New Procedure	20,896	9,355	17,022	16,979	(3,917)
OPD Follow Up	139,544	56,661	85,004	103,552	(35,992)
OPD Follow Up Procedure	40,360	20,765	32,743	37,773	(2,587)
Total	**316,650**	**147,477**	**230,452**	**262,797**	**(53,853)**

	Spells / Attendances								
POD	M01	M02	M03	M04	M05	M06	M07	M08	M09
Elective	345	400	353	399	417	426	482	476	370
Daycase	3,990	4,747	4,248	4,538	4,633	4,356	4,456	4,897	4,327
OPD New	6,529	7,509	6,947	6,388	6,643	7,224	6,812	6,818	5,763
OPD New Procedure	1,718	1,978	1,702	1,795	1,806	2,081	2,021	2,138	1,740
OPD Follow Up	10,364	11,827	11,552	10,633	11,277	11,773	12,191	13,684	10,251
OPD Follow Up Procedure	3,804	4,374	3,790	3,865	3,980	4,419	4,563	5,242	3,736
Total	**26,750**	**30,835**	**28,592**	**27,618**	**28,756**	**30,279**	**30,525**	**33,255**	**26,187**

Forecast

	M8 £m	M9 £m	Change £m
Clinical Income (Lincs CCG)	(1.25)	(0.55)	0.70
Other Income	1.93	2.11	0.18
Pay Award Funding Shortfall	(2.04)	0.02	2.06
Medical Staffing	(10.34)	(10.24)	(0.10)
Nursing – Escalation Beds (M1-6)	(1.29)	(1.29)	0.00
Other Nursing	1.21	1.20	(0.00)
Other Pay	0.20	0.61	0.42
Drugs & Clinical Supplies & Other Non-Pay	(3.88)	(7.86)	(3.99)
IS Capacity Slippage	4.31	2.38	(1.93)
Post EBITDA Slippage	0.87	1.39	0.52
Technical Reserve Release	2.68	4.14	1.45
CIP Non-Delivery (excl Technical)	0.01	0.05	0.05
Forecast Deficit	**(7.59)**	**(8.04)**	**(0.45)**

The Trust is currently £3.78m behind plan at the end of month 9 with a year to deficit of £2.49m and is £0.3m adrift of its improvement trajectory. This is despite receiving additional funding to cover the pay award funding gap and reducing the Lincs ICB misalignment, with Non-pay pressures in Clinical Supplies and IS offsetting the upside income position.

If no mitigating actions are taken, the forecast projects a potential £8.04m end of year deficit risk.

The Trust has non-recurrent flexibility of £5.2m remaining, leaving a potential residual un-mitigated deficit of £2.8m.

Performance against Improvement Trajectory

	AP01	AP02	AP03	AP04	AP05	AP06	AP07	AP08	AP09	AP10	AP11	AP12	TOTAL
Headline Surplus (Deficit) pre-mitigation	(109)	(549)	(599)	(1,175)	(154)	(1,420)	457	(728)	(1,068)	(1,268)	(1,018)	(895)	(8,527)
Total Mitigations	0	0	0	0	0	0	0	1,574	1,588	1,588	1,588	2,188	8,528
Forecast Surplus (Deficit) Improvement Trajectory	(109)	(549)	(599)	(1,175)	(154)	(1,420)	457	846	520	320	570	1,293	1
Actual Surplus (Deficit)	(109)	(549)	(599)	(1,175)	(154)	(1,420)	457	326	734				
Variance from Trajectory	0	0	0	0	0	0	0	(520)	214				
Cumulative Variance from Trajectory	0	0	0	0	0	0	0	(520)	(306)				

Actions

Medicine
Actions the Division have in place & needs to continue with are roster/rota reviews; medical staff deep dives; budgetary analysis of both over and underspent areas for CIP and run-rate improvement opportunities; CIP forum & focussed PMO support; workforce establishment & plan reviews; SLR/cost base reviews & Specialty Business meetings.

Surgery
Non-pay deep dives to continue – they have so far identified unbudgeted changes in clinical practice in Urology (use of disposable scopes) and general theatres (both use of heating devices and energy sealing devices to aid patient recovery).
With help from Procurement, review NHS supply chain and other non-pay for any further inflation impacts.
Restricted duties of medical staff – HR/Workforce assisting in addressing these restrictions.
Continued focus on recruitment to medical staffing and nursing vacancies.

Therapy and Community
£0.34m overspends across Community equipment / orthotics and wheelchairs are awaiting detailed prescription and activity data analysis since 19-20, to be provided by the division.
Reduce unallocated CIP through review of large underspends.

Family Services
Deep dive into medical staff for Obstetrics/Gynae/Paediatrics, over-establishment/split between Obstetrics/Gynae - job plan alignment, sickness and rota cover Obstetrics/Gynae/Paediatrics and use of additional sessions.

Estates and Facilities
Deep dive into non-pay – postage cost drivers and overspending areas including electricity, water, sewerage and building/engineering maintenance and materials.

General
Review enhanced Bank incentive rates, reverse enhanced agency rates intended to reduce Tier 3 supply, conclude Consultant deep dives and implement any identified recovery actions.

System Financial Position

Humber and North Yorkshire ICS System Performance at Month 8

The ICS reported a deficit of £11.68m for the first eight months of the year but is reporting a forecast end of year break-even position.

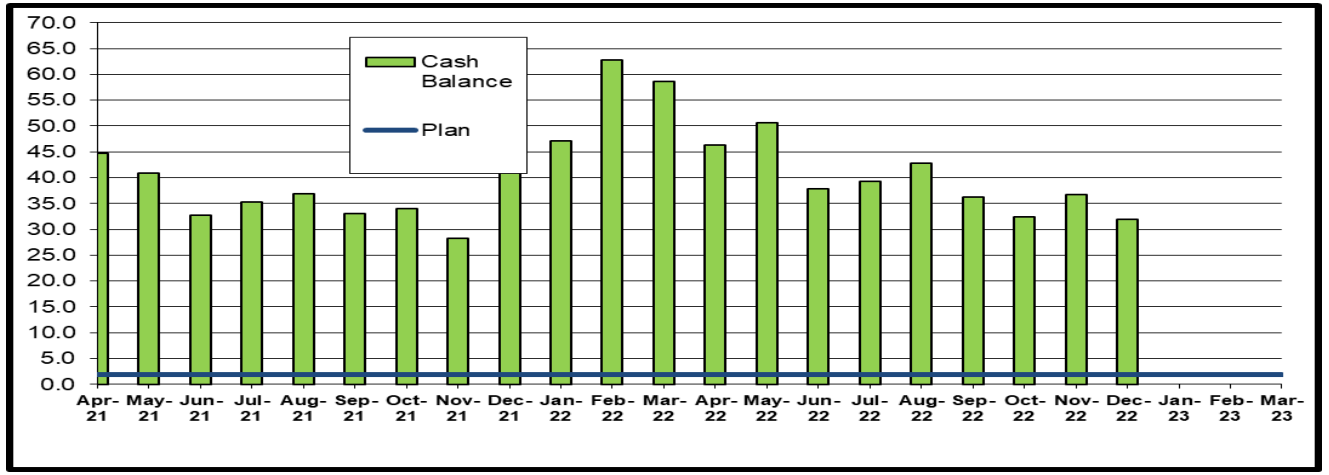
Humber and North Yorkshire ICS
Summary Surplus / (Deficit) Position - 2022/23 Month 08

Organisation	2022/23 Plan	Surplus / (Deficit) YTD Budget	Surplus / (Deficit) YTD Actual	Surplus / (Deficit) YTD Variance	Surplus / (Deficit) FOT	Surplus / (Deficit) FOT Variance
	£'000	£'000	£'000	£'000	£'000	£'000
East Riding Of Yorkshire Place	0	0	(814)	(814)	3,029	(3,029)
Hull Place	0	0	(73)	(74)	1,070	(1,070)
Hull University Teaching Hospitals NHS Trust	0	449	(71)	(520)	0	0
Humber Teaching NHS FT	0	(167)	(169)	(2)	0	0
Hull and East Riding	**0**	**283**	**(1,127)**	**(1,410)**	**4,099**	**(4,099)**
North East Lincolnshire Place	0	0	(12)	(12)	(88)	88
North Lincolnshire Place	0	(2,279)	(2,745)	(466)	896	(896)
Northern Lincolnshire and Goole NHS FT	0	765	(3,224)	(3,989)	0	0
North and North East Lincolnshire	**0**	**(1,514)**	**(5,981)**	**(4,466)**	**808**	**(808)**
North Yorkshire Place	0	(0)	(956)	(956)	5,597	(5,597)
York Place	0	0	(710)	(710)	3,952	(3,952)
York and Scarborough Teaching Hospitals NHS FT	0	(420)	(4,945)	(4,525)	0	0
Harrogate and District NHS FT	0	0	(3,159)	(3,159)	0	0
North Yorkshire and York	**0**	**(420)**	**(9,770)**	**(9,350)**	**9,550**	**(9,549)**
ICB-Wide Expenditure	0	2,279	5,198	2,920	(14,457)	14,457
TOTAL ICS SURPLUS/(DEFICIT)	**0**	**627**	**(11,679)**	**(12,307)**	**1**	**0**
ICB Total	0	(2,279)	(5,310)	(3,031)	14,457	(14,457)
ICB-Wide Expenditure	0	2,279	5,198	2,920	(14,457)	14,457
ICS Provider Total	0	627	(11,568)	(12,195)	1	0
TOTAL ICS SURPLUS/(DEFICIT)	**0**	**627**	**(11,679)**	**(12,307)**	**1**	**0**

Cash

The cash balance at 31st December was £31.90m, an in-month reduction of £4.8m.

	£m	£m
Cash Balance as at 31st December		**31.90**
Commitments:		
Income received in advance	3.00	
Capital creditors	5.43	
Capital plan underspend	10.40	
PDC due for Capital	-4.40	
Capital loan repayments	0.17	
Dec PAYE/NI/Pension	11.43	
Public Dividend Capital payment	1.12	
To support other creditors due	2.86	
		(30.01)
NHSi minimum balance		**1.90**



The Trust cashflow forecast to 31st March is detailed below.

	Apr-22 £000s	May-22 £000s	Jun-22 £000s	Jul-22 £000s	Aug-22 £000s	Sep-22 £000s	Oct-22 £000s	Nov-22 £000s	Dec-22 £000s	Jan-23 £000s	Feb-23 £000s	Mar-23 £000s
Closing Cash Balance	**46,376**	**50,581**	**37,865**	**39,347**	**42,746**	**36,219**	**32,467**	**36,709**	**31,904**	**24,740**	**24,764**	**20,919**

2022/23 CIP Delivery

Northern Lincolnshire and Goole NHS Foundation Trust

At the end of the third quarter, the Trust continued to fall short on its core programme delivering £7.91m of savings against its plan of £8.50m. The £0.59m shortfall has been covered by an over recovery of £0.7m on its COVID spend reduction targets but is primarily supported by the use of its non-recurrent technical reserves (£9.24m at the end of December compared to a plan of £5.10m). The forecast remains at £1.08m adrift on its core programme, again supported via COVID reductions and heavy reliance on technical savings supporting the Trust's overall financial position.

Workstream	Annual Plan £000s	Current Month - December 22				Year to Date at December 22				Forecast Year-end		
		Plan £000s	Actual £000s	Variance £000s	Risk RAG	Plan £000s	Actual £000s	Variance £000s	Risk RAG	Actual £000s	Variance £000s	Risk RAG
Clinical Workforce - Medical Staff	2,577	215	155	-60		1,933	732	-1,201		1,366	-1,211	
Clinical Workforce - Nursing and Midwifery	3,632	412	274	-138		2,207	1,568	-638		2,405	-1,227	
Clinical Workforce - AHP Staff	519	43	125	82		389	795	406		1,086	568	
QI & Efficiency	448	38	37	-1		336	340	4		445	-4	
Capital Programme	395	33	33	0		296	296	0		395	0	
Corporate and Non-Clinical Workforce	861	53	153	101		705	1,702	997		1,996	1,135	
Digital Transformation	91	8	6	-2		66	56	-10		80	-11	
Estates & Facilities	679	50	89	38		528	681	153		825	147	
Non-Pay and Procurement	2,219	205	171	-34		1,603	1,434	-169		1,910	-309	
Income	557	47	35	-12		417	303	-113		410	-147	
Grip & Control	10	1	1	-0		7	1	-7		1	-9	
Unidentified	14	1	0	-1		10	0	-10		0	-14	
Unallocated	0	0	0	0		0	0	0		0	0	
Risk Mitigation	0	0	0	0		0	0	0		0	0	
TOTAL CORE PROGRAMME	**12,000**	**1,105**	**1,079**	**-26**		**8,497**	**7,907**	**-590**		**10,919**	**-1,081**	
COVID Expenditure Reduction	3,600	300	426	126		2,700	3,404	704		4,735	1,135	
Technical Efficiency NON-RECURRENT	6,800	567	2,021	1,454		5,100	9,238	4,138		15,290	8,490	
TRUST TOTAL EFFICIENCY PLAN	**22,400**	**1,972**	**3,526**	**1,554**		**16,297**	**20,549**	**4,253**		**30,944**	**8,544**	

Workstream	Current Month - December 22				Year to Date at December 22				Forecast Year-end			
	Plan £000s	Recurrent £000s	Non-rec £000s	Variance £000s	Plan £000s	Recurrent £000s	Non-rec £000s	Variance £000s	Plan £000s	Recurrent £000s	Non-rec £000s	Variance £000s
Medicine	459	296	0	-163	2,913	1,406	6	-1,500	4,439	2,398	11	-2,031
Surgery & Critical Care	296	270	0	-26	2,116	1,761	45	-310	3,045	2,685	45	-314
Family Services	49	26	0	-23	465	377	0	-88	611	506	0	-105
Community & Therapy Services	60	34	42	16	541	321	249	29	720	434	375	89
COO'S Directorate	91	19	90	18	795	163	668	36	1,065	238	854	27
Total Operations	**954**	**645**	**132**	**-177**	**6,830**	**4,028**	**969**	**-1,833**	**9,880**	**6,260**	**1,285**	**-2,335**
Chief Executive's Office	18	72	-24	31	162	162	27	27	216	216	34	34
Chief Medical Officer's Directorate	9	8	28	27	86	72	274	260	113	96	328	310
Chief Nurse Directorate	4	3	16	15	78	28	215	165	89	37	229	178
Digital Services	7	2	17	12	238	19	273	54	258	25	286	54
Finance	10	10	24	24	92	92	288	288	122	122	326	326
People & OE	11	10	18	17	98	101	170	173	130	130	202	202
Strategic Development	2	1	9	8	14	6	87	80	18	8	98	88
Total Corporate Directorates	**60**	**106**	**88**	**134**	**767**	**479**	**1,334**	**1,046**	**946**	**634**	**1,503**	**1,191**
Estates & Facilities	55	23	71	38	573	241	485	153	739	310	576	147
Trust	36	-18	34	-21	326	68	302	44	435	-53	403	-85
Total Core Programme	**1,105**	**755**	**324**	**-26**	**8,497**	**4,816**	**3,090**	**-590**	**12,000**	**7,152**	**3,767**	**-1,081**
COVID Expenditure Reduction	300	426	0	126	2,700	3,404	0	704	3,600	4,735	0	1,135
Technical Efficiency NON-RECURRENT	567	0	2,021	1,454	5,100	0	9,238	4,138	6,800	0	15,290	8,490
Grand Total	**1,972**	**1,180**	**2,345**	**1,554**	**16,297**	**8,220**	**12,329**	**4,253**	**22,400**	**11,886**	**19,058**	**8,544**

Capital

	NHSI Plan £mil	YTD Plan £mil	YTD Actual £mil	YTD Variance £mil
Major Schemes				
DPoW Reconfiguration Programme	1.74	1.44	0.21	(1.23)
SGH & GDH Reconfiguration Programme	0.86	0.95	0.82	(0.13)
Emergency departments/AAU	17.99	17.32	13.43	(3.89)
SGH CT & Fit out	0.93	0.00	0.00	0.00
Elior Fit out	0.00	0.00	0.00	0.00
Feasibility Fees	0.10	0.08	0.00	(0.07)
Disabled access	0.05	0.05	0.00	(0.05)
Fire doors	0.35	0.35	0.00	(0.35)
Mortuary	0.54	0.30	0.01	(0.29)
SGH Max Fax	0.26	0.30	0.00	(0.30)
SGH fire Alarm	2.46	0.71	0.23	(0.48)
DPOW & SGH Theatres TIF	6.10	0.51	0.35	(0.16)
MRI software upgrade	0.06	0.00	0.00	0.00
Endoscopy simulator	0.07	0.00	0.00	0.00
Pathology LIMS	0.02	0.00	0.00	0.00
Transfer to HUTH	0.00	0.00	0.00	0.00
ICS contribution	0.00	0.00	0.00	0.00
Revenue to Capital transfers	0.36	0.00	0.00	0.00
Unallocated	0.00	0.00	0.00	0.00
Facilities Maintenance Programme	3.24	1.82	1.10	(0.72)
IM&T Programme	4.56	2.18	1.84	(0.33)
Equipment Renewal Programme	3.88	2.90	0.30	(2.60)
Right of Use Assets	0.58	0.39	0.58	0.19
Donated/Grant funded	0.28	0.15	0.23	0.08
Capital Programme Total	**44.44**	**29.43**	**19.10**	**(10.32)**

The Trust capital funding for 2022/23 is £44.4m. The Trust has received confirmation of additional funding for EPR £0.58m, diagnostics IREFER pilot, home reporting and imaging sharing £0.72m and cyber £0.05m.

The actual spend to 31st December was £19.1m, £18.9m relating to Trust funded schemes and £0.2m for donated and grant funded. Key variances are detailed below:

- The DPOW Gamma Camera is progressing and still expected to complete in March 2023.
- The ED/AAU schemes are still forecast to slip by £5.4m from 22/23 into 23/24. The Trust is now managing this by bring forward priorities from 23/24. The above plan reflects these changes.
- Facilities maintenance spend on water improvements and oxygen is progressing, orders have been placed for £0.2m. Orders for the chiller scheme are yet to be place £0.65m.
- Equipment orders are progressing, divisions have completed that all items will be delivered before 31st March.

Balance Sheet

BALANCE SHEET	Last Month	This Month
	£mil	£mil
Total Fixed Assets	266.51	268.92
Stocks & WIP	3.91	3.30
Debtors	10.06	12.36
Prepayments	7.14	7.60
Cash	36.71	31.90
Total Current Assets	57.82	55.17
Creditors : Revenue	34.70	31.65
Creditors : Capital	5.40	5.43
Accruals	20.39	20.10
Deferred Income	4.77	3.00
Finance Lease Obligations	0.98	0.77
Loans < 1 year	0.01	1.35
Provisions	1.29	1.74
Total Current Liabilities	67.53	64.02
Net Current Assets/(Liabilities)	(9.71)	(8.86)
Debtors Due > 1 Year	1.25	1.25
Creditors Due > 1 Year	0.00	0.00
Loans > 1 Year	8.21	6.88
Finance Lease Obligations > 1 Year	14.86	14.86
Provisions - Non Current	5.50	5.50
TOTAL ASSETS/(LIABILITIES)	229.49	234.08
TOTAL CAPITAL & RESERVES	229.49	234.08

- Stock balances have reduced in month in Pharmacy and Scunthorpe theatres, stocktakes have been completed.
- Debtors has increased in month, the Trust has received notification of additional funding for the 22/23 pay award paid to date.
- The Trust cash balance has reduced in month following and increase in payments to creditors, therefore reducing the Trust creditor balances. Capital spend has also increase in month. The Trust cash balance at 31st December was £31.9m a reduction of £4.8m.
- The deferred income reduction relates to the release of the December education income received in advance.
- Revenue creditors have reduced in month, the Trust completed 5 payment runs in month.
- The total BPPC figures for the Non-NHS invoices continues to be above 90%, total number of invoices paid within 30 days is 92% and total value is 92.8%. NHS continues to be 88.1% for value paid and 83.3% for number. We are continuing to monitor the BPPC and are communicating to staff the importance of authorising invoices.

Underlying Position

The Trust continues to assess the recurrent impacts on its underlying financial position bridging from its 2022/23 break-even plan. The following provides an update at this point for the known in year developments to the Trust's planning assumptions resulting in a revised estimated underlying deficit of £43.2m. The main driver for the increased run rate is due to the increased non pay forecast position and the reliance therefore on additional non recurrent technical savings.

It is expected that an element of ongoing COVID funding will be received albeit at a significantly reduced level, similarly with ERF which would improve the underlying position. Work is ongoing as part of 2023/24 planning process to stress test the assumptions underpinning the recurrent nature of these cost pressures and funding streams.

	£m
Planned Surplus / Deficit 2022/23	**0.00**
Non Recurrent Adjustments	
Elective Recovery Funding	(9.2)
Elective Recovery Capacity	7.3
NR System Funding Smoothing	3.2
Technical Savings	(15.3)
NR Savings Delivery	(3.8)
COVID Funding	(11.4)
FYE 2022/23 Investment Programme	(8.0)
Cost of Capital – Depreciation & PDC	(3.8)
22/23 Pay Award Funding Shortfall	(2.3)
Revised Underlying Deficit 2022/23	**(43.2)**

Conclusion

The Trust had a £0.53m surplus in month with a year-to-date deficit of £2.5m and is forecasting a challenging final quarter with a potential **£8.0m** deficit risk if the current run rate is not improved. The Trust has remaining non recurrent flexibility of £5.2m reducing this to a residual deficit risk of **£2.8m**.

The material issues for the Trust over the coming months are:

- Reducing its material cost pressures, reliance on premium agency in both Nursing and Medical Staffing, minimising additional escalation beds and ensuring greater control of non pay consumables.
- Maximising its planned care activity delivery, with a requirement to return to 19-20 productivity and activity levels within its core capacity and budget, reducing reliance on IS and WLI premium costs.
- Delivering a challenging stretch CIP programme, mitigating risks to delivery and conversion of non-recurrent savings into recurrent delivery schemes and identifying new schemes.

Brian Shipley

Operational Director of Finance

January 2023

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	7 February 2023
Director Lead	Lee Bond - Chief Financial Officer
Contact Officer/Author	Sally Stevenson – Assistant Director of Finance – Compliance and Counter Fraud
Title of the Report	**Annual Accounts 2022/23 – Delegation of Authority**
Purpose of the Report and Executive Summary (to include recommendations)	In order to ensure the timely sign off of the Trust's audited accounts by the Chief Executive and the External Auditor, prior to submission to NHSE on 30 June 2023, the Trust Board is requested to delegate formal authority to the Audit, Risk and Governance Committee at its meeting on 9 June 2023 to sign off the audited accounts and reports on its behalf. The Trust Board is asked to: • Note the key dates in the final accounts process. • Delegate formal authority to the Audit, Risk and Governance Committee to sign off the 2022/23 audited accounts on behalf of the Trust Board.
Background Information and/or Supporting Document(s) (if applicable)	NHSE 2022/23 Accounts Timetable
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: None
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.

Report to Trust Board – February 2023

ANNUAL ACCOUNTS 2022/23 - DELEGATION OF AUTHORITY

Introduction

The Audit, Risk and Governance Committee, under its delegated powers, reviews the draft accounts and reports before they are submitted to NHSE and the External Auditor on behalf of the Trust Board (SFI 3.1.3 b). This will take place at their meeting on 20 April 2023, ready for submission on 27 April 2023.

The Audit, Risk and Governance Committee also reviews the audited accounts and reports before they are submitted to the Trust Board for approval before final submission.

The key dates for the 2022/23 audited accounts, as confirmed by NHSE are as follows:-

Tuesday 6 June 2023	Trust Board meeting.
Friday 9 June 2023	Audit, Risk and Governance Committee meeting where the final audited accounts and reports will be reviewed in detail. The Chief Executive and Trust Chair are invited to attend this meeting.
Monday 12 June 2023	Chief Executive expected sign off date. Once signed will be passed to External Auditor for their formal sign off prior to return and submission to NHSE.
Friday 30 June 2023	Final audited accounts and reports to be formally submitted to NHSE by noon.

Given that the June 2023 Trust Board meeting falls early in the month, the audited accounts will not be ready for final review by that point. The Trust Board can therefore, as in previous years, delegate formal authority to the Audit, Risk and Governance Committee to approve the final accounts on its behalf before submission to the External Auditor and NHSE.

Recommendation

The Trust Board is asked to note the key dates in the final accounts process and is requested to delegate formal authority to the Audit, Risk and Governance Committee at its meeting on 9 June 2023 to sign off the 2022/23 audited accounts and reports on behalf of the Trust Board, prior to formal signing by the Chief Executive and the External Auditor and the submission to NHSE.

Lee Bond
Chief Financial Officer
February 2023

Northern Lincolnshire and Goole NHS Foundation Trust

NLG(23)020

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	7 February 2023	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance & Performance Committee Highlight Report**	
Purpose of the Report and Executive Summary (to include recommendations)	To highlight to the Board the main Finance areas where the Committee was assured and areas where there was a lack of assurance resulting in a risk to the delivery of the Trust's strategic objectives. • Recommendation for a Board discussion to be arranged on ways of reducing spend • Recommendation for a Board discussion to be arranged on the criteria for exiting the Recovery Support Programme for Finance. • The trust is still forecasting a year end balanced position	
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Executive Leads
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ✓ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ✓ Review ☐ Other: Click here to enter text.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	7 February 2023
Report From:	Finance & Performance Committee – 21-12-22 and 26-01-23

Highlight Report:

Review of NLaG monthly Financial position (Finance Report) (SO3.1/SO3.2b)
Finance Report Month 8

The Committee received the November financial report and discussions were had on:

- **Monthly Performance**

The Trust had an in-month surplus of £0.33m, £0.65m better than plan which resulted in a £3.22m year-to-date (YTD) deficit, £3.99m worse than plan. The Trust was formally forecasting a balanced financial position but was highlighting a deficit risk of £7.6m. This was predominantly driven through increased usage of temporary staffing, escalation beds and pay award pressures. The Committee queried the robustness of the plan to reach breakeven and was assured that if everything went as planned then it should be achieved this year by utilising the last remaining technical adjustments. However, there were growing risks from increased vacancies and additional spend to mitigate risks from extreme operational pressures plus the effects of industrial action in the health system.

Pay was £2.08m adverse in month, which equated to a £12.13m adverse year-to-date position. The Committee questioned what could be done differently as each month there appeared to be an overspend on temporary staffing. The Committee were informed that there were more medical vacancies now than at the start of the financial year and that there had been regular extra shifts in the Emergency Department (ED) and Same Day Emergency Care (SDEC) due to operational pressures. Those had not been planned until the new Departments were open. The Committee questioned the pipeline of incoming staff and whether this was working as well as it could and recommended further discussion at Board level on recruitment and retention and what the Trust could do differently to reduce the amount spent on temporary staffing, as all the improvements in the financial position month on month had so far come from technical adjustments and not changes in the rate of spending. The Committee all agreed that patient safety was the priority, but that there was a need for a sustainable financial position by reducing spend on temporary staffing, which would also enable the Trust to move closer to achieving the agency limits set by National Health Service England (NHSE).

Review of NLaG monthly Financial position (Finance Report) (SO3.1/SO3.2b)
Finance Report Month 9

The Committee received the December financial report and discussions were had on:

- **Monthly Performance**

The Trust had an in-month surplus of £0.73m, which was £0.21m better than plan although that was supported through the release of non-recurrent technical reserves. The Trust also received additional non recurrent funding support to cover the pay award in full of £2.055m for the year and £1.54m YTD. That funding should have improved the Trust's financial position, but it had been required to cover additional cost pressures in month in non-pay across Clinical Supplies, Drugs, Energy and referred Pathology testing. A detailed discussion took place around NSH supply chain invoices and the current medical stock levels within the Trust. The Finance team were continuing to investigate this as part of their due diligence, utilising a new non-pay dashboard developed by the team. Inflation was also a material issue and it was mentioned that several suppliers had increased delivery charges when fuel prices went up but had not reduced them now that fuel prices had started to reduce.
The Committee expressed concern as the releasing of all non-recurrent technical reserves would mean that none would be available in future years.

Capital

The Committee discussed the current capital position and requested assurance that the capital allocation would be spent by the end of the financial year. The Committee were assured that the

plans were heavily loaded in Quarter 4 and, if required, equipment could be brought forward from next year's plan. There was an expected spike in capital spend between now and the end of the financial year.
A discussion took place on activity levels and Elective Recovery Fund (ERF), as the quantity of elective care carried out was affected by the increase in unplanned care, due to extreme operational pressures on the Trust and wider system.

- **CIP**

The Trust continued to fall short on its Capital Improvement Program (CIP) target of £8.5m delivering £7.91m YTD. The Committee questioned the Medicine position, as their current forecast was only around half of their CIP target. It was confirmed that Medicine had a challenging target this year and, whilst the recruitment of nurses was happening as planned, lower than forecast retention of nurses had resulted in higher than forecast agency costs.

- **System Performance**

The System had a £11.7m deficit at the end of month 8, although all Trusts were still forecasting a balanced position.

Recovery Support Programme for finance (RSPf)
In December, the Committee discussed the latest review of the Trust's progress in exiting from the Recovery Support Programme for Finance. It was difficult for a recommendation to be made for the Trust to exit from that programme whilst the Trust was off trajectory for delivering the current year's financial plan. The Trust had been asked to propose the level of transitional support that would be required and a request had been submitted for additional funding for workforce-related activities. The Committee went on to discuss the difficulties that could be encountered with hitting breakeven next year and it was agreed that the Committee should recommend a discussion at Board level about the criteria to exit from the RSPf in the context of national extreme operational pressures.

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

Confirm or Challenge of the Board Assurance Framework:

The Committee focused on Strategic Objective SO3-3.1 in January, but were assured by the updates to the BAF and agreed that the risk score accurately reflected the level of risk to the Trust's achievement of the objective.

Action Required by the Trust Board:

The Trust Board is asked to note the key points made and consider the Committee's recommendations for a Board level discussion on ways of reducing spend on temporary staffing and on the criteria for exiting the Recovery Support Programme for Finance.
Gill Ponder
Non-Executive Director / Chair of Finance and Performance Committee

NLG(23)021

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 7 February 2023
Director Lead	Ivan McConnell, Director of Strategic Development / HAS
Contact Officer/Author	Kerry Carroll, Deputy Director of Strategic Development Claire Hansen, Programme Director, HAS
Title of the Report	**Strategic & Transformation Report – Key Issues**
Purpose of the Report and Executive Summary (to include recommendations)	The attached report provides the Board with an update and overview of our progress against the delivery of: **Strategic Objective 1 - 1.3: To give great care** **Strategic Objective 4: To work more collaboratively** The Board is asked to note: The progress that is being made on the delivery of the Humber Acute Services critical milestones of Programme 2 Core Service Change and the continued engagement in the enabling programmes of 'Out of Hospital', Digital, and Planned Care. The progress that is being made on the development of a Capital Strategic Outline Case to support major capital investment within NLAG and HUTH and the associated capital financing risks we face: • Potential announcement of the New Hospitals Programme (NHP) for the remaining 8 Hospital Trusts • Residual capital risks we face even if we gain a place on the NHP, in particular within SGH Our continued participation in and leadership of collaborative ventures through partnership working, notably: • Membership of Place Boards • Leadership of Collaborative of Acute Providers (CAP) Strategy • Leadership of CAP Planned Care Strategy and Operational Planning/Delivery • Leadership of South Bank Community Diagnostic Centres Programme The Board is asked to note that whilst significant progress has been made in the delivery of the agreed milestones for Humber Acute Services there are potentially significant risks and key issues that still remain to future implementation and delivery: • The timing of consultation has moved to summer 2023 but could be impacted by wider system change in that time period • The risk of not being selected as one of the remaining 8 Trusts to become part of the New Hospitals Programme limiting our potential access to National funding and leaving us with a significant capital infrastructure and funding risk
Background Information and/or Supporting 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.

Strategic Service Development and Improvement – February 2023

Strategic Objective 1 (1.3) - To give great care

Strategic Objective 4 – To work more collaboratively

- With partners in the Humber Acute Services Review, we will engage fully in leading and supporting the development of a Pre-Consultation Business Case (PCBC) for the delivery of new models of care for ***(programme 2) linked to submission of a Capital Expression Of Interest (EOI) and Pre- Strategic Outline Case (SOC) (Programme 3) for:***

    - Urgent & Emergency Care
    - Maternity, Neonates & Paediatrics
    - Concepts of Planned Care and diagnostics

- We will play a full part in the development of the Humber and North Yorkshire Health & Care Partnership, including the:

    - Humber & North Yorkshire Integrated Care Board (H&NY ICB)
    - Acute Collaborative
    - Community Collaborative
    - Primary/Secondary Care Interface Groups – North and South Bank
    - Place Boards - North and North East Lincolnshire, East Riding of Yorkshire and working groups
    - HNY Cancer Alliance and associated professional networks
    - HNY Clinical and Professional Leaders Group
    - Community Diagnostic Centres

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

Highlights	Lowlights	Risks

Overall
• Continued engagement with the H&NY ICB re the HAS Programme – potential options and consultation approach/timeline, Clinical evaluation planning, workforce and finance approaches.
• Continued engagement with the Overview Scrutiny Committees (OSC) and discussion re the timescale for setting up a Joint Health OSC to oversee the Consultation and Decision
• Review potential capital development options to include becoming one of the remaining 8 Trusts on the New Hospitals Programme (NHP) Place, or potential next steps should we not be a member of the NHP
• NHSE/I monthly assurance reviews continue with positive challenge and support
• Ongoing briefings of individual ICS Executive Team members, Place Directors and Primary/Secondary Care interface Groups
• Progression with joint PMO developments with Place Directors to support the design and implementation of the essential out of hospital programme changes
• Finance team engagement for revenue and capital costing planning
• Place Director x4 and wider system – ongoing briefings Doncaster/Lincoln
• The Consultation Institute Assurance report on the HAS pre-consultation engagement
• Planning and co-ordination of the wider ICS planned care strategy for future service option opportunities
	• Complicated acute review spanning all programmes and aligning to out of hospital and community diagnostic changes
	  • Out of Hospital (OOH) programme requires new governance and leadership – HAS team to support Place Directors for next 6 months and set up Programme Management Office to govern – challenging to implement within the wider ICS consultation
	• Challenges of continuous engagement and involvement / time commitments for busy operational staff (including key clinical leads during recovery phase)
	  • Associate Medical Director Strategy/Programme Director and Deputy Director Strategy undertaking and maintaining continuous Divisional engagement on ongoing basis – this will be an increased requirement given timescale changes
	• Potential media interest in emerging options as we continue to engage widely
	• Misunderstanding of wider staff groups in relation to HAS/Group structures and Interim Clinical Plan.
		• Potential further movement of consultation timelines – political
		• Pathways in P2 look beyond hospital boundaries and require out of hospital transformation – OOH programme governance is not sufficient to deliver
		• Potential options may be subject to OSC, Public challenge resulting in Independent Review, Judicial Review or Secretary of State review
		• Potential options may displace activity to neighbouring health economies
		• The delivery of changed pathways will require capital investment in digital as well as wider infrastructure – funding sources not yet known
		• Planned care pathways must align to wider ICS Elective recovery and Community Diagnostic Hub programme implementation
		• Potential further COVID wave and impacts on elective delivery and ability to continue with engagement and evaluation of key stakeholders
		• Potential impact on staff who have been engaged in process due to legislation delay – may lose interest and enthusiasm
		• Need for temporary service change as a result of quality/safety issues – perception/management/pre-determination

Programme 2 (P2):

- H&NY ICB briefings x 2
- Timeline reset against consultation change to summer 2023
- Finalisation of PCBC contents - finance and economic chapters in train
- Collaborative procurement of consultation and engagement external support with H&NY ICB – 2x contractors appointed, and planning for pre-consultation commenced.
- Staff engagement events arranged (inc. drop in sessions, speciality workshops) to continue based around Integrated Impact Assessment
- Specialty meeting's attended and focused meetings to go through the detailed modelling scheduled
- Further targeted engagement with hard to reach groups through the support of the VCSE and Maternity Voices Partnership within the system and on the boundaries.
- Positive assurance report received from the Consultation Institute on the pre-consultation engagement
- Alignment of PCBC activity, workforce, capital and finances
- Stakeholder Mapping event scheduled

Programme 3 (P3)

- Awaiting announcements on final 8 Trusts selected to become part of New Hospitals Programme – potentially mid/end October 2022 (*delayed still TBC)*
  - If selected multiple business cases will be required to support funding applications
  - If selected will still require significant capital cover for Back Log Maintenance/Critical Infrastructure Risks – particularly in SGH during any design/build phase
- Capital options in support of Expression of Interest (EOI) Strategic Outline Case (SOC) developed:
  - Investment Objectives
  - Options – Business as Usual (BAU)/Do minimum/Do Maximum
  - Phasing considered
  - Risk analysis undertaken
  - Funding options considered

- Capital funding sources not yet agreed – raised issue with Regional Finance Director – funding sources and capital gaps

- Delays to capital submission outcomes and potential extension of timelines for delivery of NHP – impact on funding short term Back Log Maintenance and Critical Infrastructure Risks costs

- Lack of affordability from internal capital for priority capital investment in the short term

- Potential for developments in ICB Strategy, Place Strategies and Collaborative Acute Providers Strategies to change prioritisation and focus of effort

Partnership and System working

- We will play a full part in the development of the Humber and North Yorkshire (HNY) Health & Care Partnership
- We will play a full part in other national and regional networks, including professional, service delivery and improvement (e.g. GIRFT), and operational.

Highlights	Lowlights	Risks
Humber and North Yorkshire (HNY) Health & Care Partnership: **NLaG is an active member of a number of Boards/Groups across the Humber and North Yorkshire ICS:** • Trust is member of HNY Partnership Board • The Trust is an active member of the Collaboration of Acute Providers Board and other members of the Trust leadership community participate in sub groups • The Trust is an active member of the Community Provider Collaborative • The Trust is actively involved various community collaborative (i.e. Outpatients Transformation, Planned Care Programme, Diagnostics, Urgent & Emergency Care Network, Community Paediatrics, and the wider ICS 180 days workforce planning - leading on Retention) • The Trust COO and Head of Cancer are members of the HNY Cancer Alliance Board • Senior leaders from across the Trust are active participants in HNY Clinical Networks • Linkages and alignment to the ICS Out of Hospital Programme Board as part of the HAS Programmes. • The Trust is an active participant in the emerging Place Based Partnerships • HAS leads are part of the primary/secondary care interface groups • The Trust is an active member of the HNY Clinical and Professional Leaders Group	• Multiple and competing priorities for resourcing	• Management of conflicting priorities: o ICS, Sub System, Collaboratives, Place, Organisation • System pressures create a change of focus from long to short term action • Resource implications of servicing multiple and often duplicate meetings • Ensuring that NLaG retains a voice in all discussions • Availability of system wide resource to support design and implementation of initiatives

Collaboration of Acute Providers (CAP) • The Trust is an active member of the Acute Collaborative and has a number of leadership roles within that group, including: • Director of Strategic Development, Chairs CAP Strategy Group • COO Chairs, COO Group • NLaG is providing leadership of the CAP Planned Care Strategy • NLaG is providing leadership of the CDC programme on the South Bank **Place Based Partnership Boards** • Trust Chair, CEO, Director of Strategic Development are members of both the North and North East Lincolnshire Place Boards • Members of Trust Executive and Leadership teams provide support to multiple Place based working groups **National and regional networks:** • Members of the Trust Board and Senior Leadership Community are active members of national and regional networks. The Trust is an active participant in Getting It Right First Time (GIRFT) reviews • As part of the HAS Programme the Trust is actively engaged with National and Regional Network and GIRFT leads on Urgent Emergency Care, Maternity and paediatrics and a number of planned care specialties		

Name of the Meeting	**Trust Board – public meeting**
Date of the Meeting	07 February 2023
Director Lead	Simon Parkes, Non-Executive Director and Chair of Audit Risk and Governance Committee
Contact Officer/Author	Helen Harris, Director of Corporate Governance and Sally Stevenson, Assistant Director of Finance – Compliance and Counter Fraud
Title of the Report	**Audit Risk and Governance Committee (ARGC) – Terms of Reference (TOR)**
Purpose of the Report and Executive Summary (to include recommendations)	The ARGC TOR has been updated following a recommendation from the Internal Audit Report on the Board Assurance Framework, as follows: Section 5.9.6: The Committee will receive the Board Assurance Framework (BAF) and the High Level Risk Register on a quarterly basis, to gain assurance that it is operating as part of the Trust's overarching governance / control systems. The ARGC committee approved the revised TOR at their meeting on 24 November 2022. The Trust Board is requested to consider and approve the amended TOR.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Audit, Risk and Governance Committee and Lee Bond, Chief Financial Officer
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)	N/a	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	☐ Information ✓ Review ☐ Other: Click here to enter text.

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Finance

AUDIT, RISK AND GOVERNANCE COMMITTEE

Membership and Terms of Reference

Reference:	DCT122
Version:	1.98
This version issued:	~~07/04~~/22
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	~~05/04/22 / 24/02/22~~
Approving body:	Trust Board / Audit, Risk & Governance Committee
Date for review:	April, 2023
Owner:	Lee Bond, Chief Financial Officer
Document type:	Terms of Reference
Number of pages:	20 (including front sheet)
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Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

1.0 Constitution

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

2.0 Purpose

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

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

3.0 Authority

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

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

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

4.0 Accountability and Reporting Arrangements

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

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

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

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

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

5.0 Responsibilities

5.1 General Duties

5.1.1 The Committee supports the Board by:

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

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

5.2 Integrated Governance, Risk Management and Internal Control

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

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

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

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

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

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

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

5.3 Internal Audit

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

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

5.4 External Audit

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

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

5.5 Financial Reporting

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

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

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

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

- Letters of representation
- Explanations for significant variances

5.6 Risk Management

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

- Reviewing the Trust's information governance and cyber security arrangements, in order to provide assurance to the Board that the organisation is properly managing its information and cyber risks and has appropriate risk mitigation strategies
- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks
- Overseeing actions plans relating to regulatory requirements in terms of the Single Oversight Framework and Use of Resources
- Providing the Board with assurance over developing partnership arrangements (e.g., accountable care organisations) and mitigation of risks which may arise at the borders between such organisations

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

5.7 Counter Fraud and Security

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

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

5.8 Management

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

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

5.9 Other Assurance Functions

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

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

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

- Finance and Performance Committee
- Quality and Safety Committee
- Remuneration & Terms of Service Committee
- Workforce Committee
- HealthTree Foundation Committee
- Ethics Committee
- Strategic Development Committee

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

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

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

6.0 Membership

6.1 Core Membership

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

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

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

6.2 Regular Attendees

6.2.1 The following shall normally attend meetings:

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

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

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

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

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

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

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

7.0 Procedural Issues

7.1 Frequency of Meetings

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

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

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

7.2 Chairperson

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

7.4 Attendance

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

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

7.4.3 Executive Directors who are unable to attend will arrange for the attendance of an appointed deputy, whose attendance will be recorded in the minutes, making clear on whose behalf they attend. Formal deputies can attend up to 25% of all meetings.

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

7.5 Quorum

7.5.1 A quorum shall be two of the three members.

7.5.2 A quorum must be maintained at all meetings.

7.6 Administration and Minutes of Meetings

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

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

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

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

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

7.7 Decision Making

7.7.1 Wherever possible members of the Committee will seek to make decisions and recommendations based on consensus.

7.7.2 Where this is not possible then the Chair of the meeting will ask for members to vote using a show of hands, all such votes will be compliant with the current Standing Financial Instructions and Scheme of Delegation of the Northern Lincolnshire & Goole NHS Foundation Trust.

7.7.3 In the event of a formal vote the Chair will clarify what members are being asked to vote on – the 'motion'. Subject to the meeting being quorate a simple majority of members present will prevail. In the event of a tied vote, the Chair of the meeting may have a second and deciding vote.

7.7.4 Only members of the Committee present at the meeting will be eligible to vote. Members not present and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

7.7.5 The Trust's Standing Orders and Standing Financial Instructions apply to the operation of this Committee.

7.7.6 Decisions which are outside of the Scheme of Delegation will be escalated to the Trust Board with the findings and recommendations of the Sub Committee for action at Board level.

8.0 Monitoring, Compliance and Effectiveness

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

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

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

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

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

9.0 Review

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

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

10.0 Access to the Committee Chair

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

11.0 Whistleblowing / Freedom to Speak Up Guardian

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

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

12.0 Equality Act (2010)

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

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

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

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

ANNEX

Additional Provisions under Terms of Reference Paragraph 6.3

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

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

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

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

"3.0 Attendance at Meetings":

Additional paragraph **3.9** added:

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

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

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

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

"5.0 Frequency of Meetings":

Additional paragraph **5.3** added:

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

"7.0 Responsibilities":

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

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

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

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

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

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

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

"7.3 Internal Audit":

The following text added to the end of this section:

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

"7.4 External Audit":

The following text added to the end of this section:

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

"7.6 Risk Management":

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

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

"7.7 Counter Fraud & Security":

The following text added to paragraph **7.7.2**

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

"7.9 Other Assurance Functions":

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

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

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

Appendix A

HFMA NHS Audit Committee Handbook, 2018 – Extract

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

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

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

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

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

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

NLG(23)025

Name of the Meeting	**Trust Board - Public**
Date of the Meeting	7 February 2023
Director Lead	Dr Kate Wood, Chief Medical Officer Ellie Monkhouse, Chief Nurse Jug Johal – Director of Estates and Facilities Shaun Stacey – Chief Operating Officer Lee Bond – Chief Financial Officer Shauna McMahon – Chief Information Officer Ivan McConnell – Director of Strategic Development Simon Nearney – Interim Director of People
Contact Officer/Author	Helen Harris, Director of Corporate Governance Alison Hurley, Assistant Trust Secretary
Title of the Report	**Board Assurance Framework (BAF) 2022-23, Quarter Three Report**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of the quarter three report is to present the BAF to the Trust Board, to review current scoring of the strategic risks, note the referenced high-level risks and gain assurance that it is operating as part of the Trust's overarching governance / control systems. 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 Boards 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 have thorough oversight of strategic risks. The Trust Board is asked to: a) review the BAF in Appendix 1, b) review the high-level risk register in Appendix 2 and note the high-level risks linked to each of the strategic risks, c) note the Finance and Performance Committee, Quality & Safety Committee and Workforce Committee have reviewed their associated strategic risks, d) seek assurance from Executive Owners and Trust Board Committees that there are sufficient controls and assurances against each of the strategic risks and there is confidence about the likely achievement of each of the strategic objectives.
Background Information and/or Supporting Document(s) (if applicable)	N/A

Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Finance and Performance Committee, Workforce Committee, 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)	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 – Quarter Three Review (1 October 2022 – 31 December 2022)

1. Purpose of the Report

1.1. To present the BAF (Appendix 1) to the Trust Board to review current scoring of the strategic risks, note the referenced high-level risks and gain assurance that it is operating as part of the Trust's overarching governance / control systems.

1.2. 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 Boards 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 risks. It is used to support the Board in receiving confidence about the likely achievement of each of its strategic objectives**.**

1.3. The strategic risks have been reviewed by the Executive Owners and the Trust Board Committees during quarter three.

The exception to this, is the Strategic Development Committee will review strategic risks SO1.3, SO3-3.2 and SO4 at its meeting on 2 March 2023.

The Audit Risk and Governance Committee will review strategic risk SO1-1.5 at its meeting on 23 February 2023.

2. General Update

2.1. An assurance assessment is now required for every planned action. The 'key' to the colour coding is detailed in the last tab on the spreadsheet. This is to enable the Board and all Committees to seek assurance on the progress against each of the planned actions.

2.2. Trust Board and all Board Committees receive the High-Level Risk Register (Appendix 2) relevant to the strategic risks, which is to provide oversight on those high-level risks that could threaten and have an impact on the delivery of the strategic risk.

3. Strategic Objective Risk Ratings: 2022-23 Quarter Three

3.1. The table below illustrates the current risk rating of each Strategic Objective against the target risk rating by the end of March 2023:

Strategic Objective	2022-23				Risk Appetite Score
	Risk Rating Quarter 1	Risk Rating Quarter 2	Risk Rating Quarter 3	Target Risk by 31/03/2023	
SO1-1.1	15	15	15	15	4-6
SO1-1.2	20	20	20	15	4-6
SO1-1.3	12	12	12	8	4-6
SO1-1.4	20	20	20	20	4-6
SO1-1.5	12	12	12	6	4-6
SO1-1.6	16	16	12	8	4-6
SO2	20	20	20	12	4-6
SO3-3.1	15	20	20	20	8-12
SO3-3.2	12	15	15	20	8-12
SO4	12	12	12	8	8-12
SO5	12	12	12	8	8-12

3.2. Principal Risks

The Trust Board should note the:

a) significant number of planned actions (red and amber assurance rating) to be delivered against SO1-1.2 (the risk that the Trust fails to deliver constitutional and other regulatory performance targets), being:

- Workforce and resources to Humber Cancer Board
- Public Health England guidance (cancer diagnosis) reviewed and implemented
- Review of clinical pathways linked to Humber Acute Services Programme One, Interim Clinical Plan
- Consultant led ward rounds, further development and implementation (Emergency Care Improvement Support Team)
- Validation of all Referral to Treatment Clock Stops back to 100%
- Consultant job plans to be signed off for 2022-23,

b) key areas of concern against SO1-1.4 (the risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate), being:

- Backlog Maintenance (BLM) figures for 2021-22 are due to be reported and are expected to have increased,

- Capital Programme funding for 2023-24 will be impacted by the Critical Infrastructure Risk and BLM;

c) degree in which the Trust may not deliver on the financial position up to 31 March 2023; against strategic risk SO3-3.1 (the risk that either the Trust or the Humber Coast and Vale Healthcare Partnership fail to achieve their financial objectives and responsibilities),

d) target risk score for SO1-1.6 has increased from eight to 12; due to the workforce capacity to meet demand, the bed capacity due to workforce challenges, lower than expected uptake of influenza vaccinations; the recruitment pipeline to address nurse and medical staffing shortfalls and the testing / implementation of business continuity plans,

e) number of planned actions which are marked as Amber which could pose a risk to the delivery of the strategic objective SO1-1.1, being:

- birthrate plus review,
- delivery of deteriorating patient improvement plan,
- implementation of End of Life Strategy (system-wide),
- review of the policy and embedding supportive observation,
- management of Influenza outbreaks,
- preparation for Trust requirements in Deprivation of Liberty and the new Liberty Protection Safeguards by 31 April 2023, and
- business case completion for the Transition post,

f) number of High-Level Risks that could have an impact on the delivery of strategic objective 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):

- No 2976, High registered nursing vacancy levels = 25
- No 2421, Nurse Staffing, Risk Rating = 25
- No 2530, Poor Registered Nursing Skill Mix on Wards = 20
- No 3015, Insufficient estate resources to manage the workload demand = 20
- No 2898, Medical Staff - Mandatory Training Compliance = 16
- No 2960, Risk of inability to safely staff maternity unit with Midwives = 16
- 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 1851, Shortfall in Capacity within the Ophthalmology Service = 15

4. Recommendations

The Trust Board is asked to:

a) review the full BAF in Appendix 1,

b) review the high-level risk register in Appendix 2 and note the high-level risks linked to each of the strategic risks,

c) note the Finance and Performance Committee, Quality & Safety Committee and Workforce Committee have reviewed their associated strategic risks,

d) seek assurance from Executive Owners and Trust Board Committees that there are sufficient controls and assurances against each of the strategic risks and there is confidence about the likely achievement of each of the strategic objectives.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Board Assurance Framework - 2022 / 23

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

Risk Appetite Statement - 2022 / 23

The Trust's risk appetite is:

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

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

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

Context

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

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

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

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

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

Risk 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

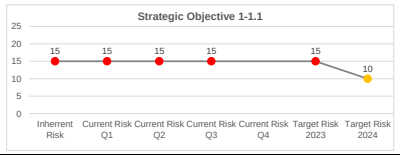
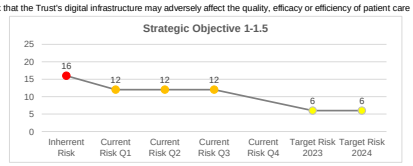
The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using the feedback as an opportunity 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.

Strategic Risk Ratings

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	Medical Director and Chief Nurse	Q&SC
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets 	Low	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	SDC
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
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	SDC
SO4	The risk that the Trust is not a good partner and collaborator 	Moderate	Director of Strategic Development	SDC
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives 	Moderate	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 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5		5	5	5
Likelihood	3	3	3	3		3	3	2
Risk Rating Score	15	15	15	15		15	15	10

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: January 2023, 10 October 2022, July 2022, 11 April 2022, 11 January 2022

Lead Committee: Quality and Safety Committee

Risk Owners: Medical Director and Chief Nurse

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy, Risk Management Strategy, Nursing, Midwifery & Allied Health Care Professionals Strategy, Clinical Strategy, Medical Engagement Strategy

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 and Serious Incident Review Group, 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

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
- Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board
- Health Scrutiny Committees (Local Authority)
- 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

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

Planned Actions

Action	Quarter / Year	Assurance
Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays)	Q2 2023/24	Green
Birthrate plus review	Q2 2022/23	Amber
Continue to develop metrics as data quality allows	Q4 2022/23	Green
Delivery of deteriorating patient improvement plan	Q4 2022/23	Amber
Implementation of End of Life Strategy (system-wide strategy)	Q4 2025/26	Amber
Annual establishment reviews across nursing, midwifery and	Q4 2022/23	Green
Update IPC BAF as national changes and requirements	Q4 2022/23	Green
Continued management of COVID19 outbreaks	Q4 2022/23	Green
Workforce Committee undertaking Workforce Planning linked to		
Review policy and embed supportive observation	Q4 2022/23	Amber
Audit of stop and check safety huddle compliance	Q3 2022/23	Green
Review of Ward Assurance Tool and Web V pilot	Q4 2022/23	Green
Pilot of 15 Steps Star Accreditation Programme	Q4 2022/23	Green
Management of Influenza outbreaks	Q4 2022/23	Amber
Preparation for trust requirements in DoLS and the new LPS by 31	Q4 2022/23	Amber
Business case completed for Transition post	Q3 2022/23	Amber

Future Risks

- COVID-19 and Influenza surges and other infections which impact on patient experience
- National policy changes to access and targets
- Reputation as a consequence of recovery
- Additional patients with longer waiting times and additional 52 week breaches, due to COVID-19
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility
- Impact of IPC plans on NLaG clinical and non clinical strategies
- Changes to Liberty Protection Safeguards
- Skill mix of staff
- Student and International placements and capacity to facilitate/supervise/train

Strategic Threats

Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints

Adverse impact of external events (ie. Britain's exit from the European Union; Pandemic) on business continuity and the delivery of core service

Workforce impact on HASR

Gaps in Controls

- Estate and compliance with IPC requirements - see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Attracting sufficiently qualified staff - see BAF SO2
- Funded full time Transition post across the Trust

Gaps in Assurance

- Mandatory training
- Delays with results acknowledgement (system live, process not yet embedded)
- Progress with the End of Life Strategy
- Ophthalmology Waiting List remains sizeable
- Safety and delays on cancer pathways

Links to High Level Risks Register

Divisional / Departmental Risks Scoring >15:
- No 2421 Nurse Staffing = 25
- No 2145 Quality of Care and Patient Safety - (due to nurse staffing position) = 20
- No 2245 Risk to overall performance, Surgery = 16 (previously 20)
- No 2562 Failure to meet constitutional targets in ECC, Medicine = 20
- No 2949 Joint Oncology Risk for HASR, Medicine = 20
- No 2244 Risk to overall cancer performance, Clinical Support Services = 16
- No 2898 Mandatory training compliance for medical staff, Medicine = 16
- No 3036 Risk of Harm in ED due to length of stay in department, Medicine = 16
- No 2992 Lack of Changing Places facility at SGH = 16
- No 2347 Deteriorating patient risk, Surgery = 15
- No 2388 Deteriorating patient risks, Medicine = 15
- No 3114 Delays in Children being seen at DPoWH by Paediatric Endocrine Service, Family Services = 15
- No 3031, Risk that the diabetes service in DPOW will not be able to operate fully due to long term sickness leading to parents having a lack of confidence of the service and not developing the service going forward eg transition to adults = 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 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5		5	5	5
Likelihood	4	4	4	4		4	3	2
Risk Rating Score	20	20	20	20		20	15	10

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: December 2022, 13 October 2022, July 2022, 11 April 2022, 24 January 2022

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy,Quality Improvement Strategy, Risk Management Strategy, Learning Strategy, Nursing and Midwifery Strategy, Clinical Strategy

Current Controls

- Operational Plan
- 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 4 Hour Wait (Breach to Non-Breach): Significant Assurance, Q2 2019.
- Benchmarked diagnostic recovery report outlining demand on services and position compared to peers presented at PRIM, October 2020. No significant differences identified, Trust compares to benchmarked peers.
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022
- Audit Yorkshire internal audit: Waiting List Management (including Clinical Harm): Significant Assurance, Q1 2022
- Completed job plans for relevant clinicians for 2021-22

External:
- NHSI Intensive Support Team
- Audit Yorkshire internal audit: A&E 4 Hour Wait (Breach to Non-Breach): Significant Assurance, Q2 2019.
- Humber Cancer Board
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022

Planned Actions

Action	Quarter / Year	Assurance
Workforce and resources to Humber Cancer Board	Q4 2021/22	Red
Public Health England guidance (cancer diagnosis) reviewed and implemented	Q4 2021/22	Amber
Further development of the ICP with HUTH	Q4 2021/22	Green
Review of clinical pathways linked to HASR programme 1 ICP, 7 specialties	Q4 2022/23	Amber
Consultant led ward rounds, further development and implementation (ECIST)	Q4 2021/22	Amber
Development of Phase 2 three year HASR Plan by 2022	Q1 2022/23	Yellow
Revision and Development of QSIS plans	Q1 2022/23	Yellow
Progress P1 of HASR Plan - Haematology, Oncology, Dermatology	Q2 2022/23	Yellow
Implementation phase 3 of AAU business case	Q2 2022/23	Yellow
Validation of all RTT Clock Stops back to 75%	Q2 2022/23	Yellow
Job plans complete for 22/23	Q2 2022/23	Yellow
Opening of new ED build at DPoW	Q3 2022/23	Blue
Implementation of the UCS Model (funding based on Business Case agreement) On hold - Review of South Bank Urgent Care Services taking place	Q3 2022/23	Yellow
Outcome of the Urgent Care Services Review for South Bank of ICS agreed	Q3 2022/23	Yellow
Winter Planning for 2022/23 - ongoing	Q2 2022/23	Green
Review and relaunch of the Daily Operations Meetings - ongoing	Q2 2022/23	Green
Develop divisional dashboards	Q2 2022/23	Yellow
Establishment of pathway for YAS to access the North Lincolnshire SPA in the same way as EMAS	Q2 2022/23	Yellow
Development of ward 25 at SGH to provide addition single rooms	Q3 2022/23	Blue
Validation of all RTT Clock Stops back to 100%	Q4 2022/23	Amber
Introduction of Pathway to enable referrals into SPA from technology enabled care providers to reduce ambulance calls and conveyancing	Q3 2022/23	Yellow
Further developemnt of the ICP with HUTH - Dermatology	Q3 2022/23	Green
Introduction of LLoS reviews in Medicine Division	Q3 2022/23	Green
Consultant job plans to be signed off for 2022-23	Q3 2022/23	Amber
Diagnostic and cancer pathways reviewed and implemented	Q4 2022/23	Yellow
Opening of new ED build at SGH	Q4 2022/23	Yellow
Consultant job plans to be signed off for 2023-24	Q4 2022/23	Green
Further developemnt of the ICP with HUTH - Cardiology, Respiratory, Gastroenterology,	Q4 2022/23	Yellow
Progress with implementation of General Internal Medicine Model	Q4 2022/23	Yellow

Future Risks

- Further COVID-19 surges and impact on patient experience and bed planning due to IPC guidance (including norovirus).
- National policy changes to emergency access and waiting time targets.
- Funding and fines changes.
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times over 18 weeks, 52 weeks, 62 days and 104 days breaches, due to COVID-19 and other ICP issues
- 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 from April 23
- Inability to staff UCS due to lack of support from Primary Care
- Impact of Mutual Aid work and increase in waiting times - 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.
- Mutual Aid

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.

Adverse impact of external events (ie. Continued Pandemic) on business continuity and the delivery of core service.

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 52 week waits and Diagnostics Constitutional Standards.
- Capacity to Reduce 52 week, 104 day and over 18 week waits to meet the trusts standard of 0 waits over 40 week in 2022.
- Limited single isolation facilities.
- Review of effective discharge planning.
- Diagnostic capacity and capital funding to be confirmed.
- Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations.
- Validation of RTT Clock Stops is being undertaken in high risk areas specialties only due to ongoing capacity pressure as a result of COVID
- Reduced bed capacity due to IPC compliance requirements and high levels of norovirus (DPOW) and Covid within the Trust
- High levels of staff sickness
- Ensuring the trust is utilising its current capacity

Gaps in Assurance

- QSIS Standards improvement plans.
- Demand and Capacity planning for Diagnostics.
- Meeting national standards
- Increase in Serious Incidents due to not meeting waiting times.
- Patient safety risks increased due to longer waiting times.

Links to High Level Risks Register

No 1851, Shortfall in capacity with Ophthalmology service = 15
No 2244, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2245, Risk to Overall Performance : Non compliance with RTT incomplete target = 16
No 2562, Failure to meet constitutional targets in ECC = 20
No 2347, Risk to Overall Performance : Overdue Follow-ups = 15
No 2576, Paediatric Medical Support Pathway for ECC - 'Fastrack' = 16
No 2592, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2949, Oncology Service = 20
No 3095, Data safety risk, delay to patient testing = 16
No 3131, Delay in paediatric assessment being carried out (multi-agency assessmenbt for under five years of age = 16

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- Collaboration with PCNs in NL / NEL to support full implementation of the UCS model

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.3: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

Risk to Strategic Objective 1 - 1.3: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	4		4	4	4
Likelihood	3	3	3	3		2	2	2
Risk Rating	12	12	12	12		8	8	8

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 14/10/22, 23/6/22, 13 April 2022, 12 January 2022

Lead Committee: Strategic Development Committee

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 2022/23
- Humber and North Yorkshire Health Care Partnership (HNY HCP).
- Integrated Care System (ICS) Leadership Group.
- Quality and Safety Committee.
- Acute and Community Care Collaboratives (ACC).
- Humber Cancer Board.
- Humber Acute Services - Executive Oversight Group (HAS.
- Health Overview and Scrutiny Committees (OSC).
- Trust Membership
- Council of Governors.
- Primary Care Networks (PCNs).
- Place Boards
- Clinical and Professional Leaders Board.
- Hospital Consultants Committee (HCC) / MAC
- Joint Development Board*(JDB)*
- Committees in Common (CIC)
- Strategic Development Committee (SDC)
- Patient Safety Champions

Assurance (internal & external)

Positive:
- NHSE/I Assurance and Gateway Reviews.
- OSC Engagement.
- Clinical Senate formal review

Internal:
- Minutes from Committees and Executive Oversight Group for HAS, JDB, CiC, SDC
- Humber and North Yorkshire Health Care Partnership.
- ICS Leadership Group.
- OSC Feedback.
- Outcome of public, patient and staff engagement exercises.
- Executive Director Report to Trust Board.
- Non-Executive Director Committee Chair Highlight Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE/I (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel (Humber).

Planned Actions

Action	Quarter / Year	Assurance
To formulate a vision narrative (PCBC) for Humber Acute Services review that is understood by partners, staff and patients by (draft complete)	Q3 2022/23	Green
To undertake continuous process of stocktake and assurance reviews NHSE/I and Clinical Senate review	Q1 2023/24	Green
Joint OSC - reviews	Q1 2023/24	Green
CIC / SDC / NED / Governor reviews	Q4 2022/23	Green
Citizens Panel reviews	Q4 2022/23	Green
To undertake continuous engagement process with public and staff	Q1 2023/24	Green
Evaluation of the models and options with stakeholders	Q4 2022/23	Green
Draft report from Clinical Senate review 2 (due end July 22)	Q1 2022/23	Green
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Green
NHSEI Gateway review	Q4 2023/24	Green
ICB Executive Assurance Board / ICBoard Approval	Q4 2023/24	Green
Public Consultation	Q2/Q3 2023/24	Green

Future Risks

- Change in national policy
- Delays in legilsation.
- Operational pressures and demand affecting opportunity to engage.
- Uncertainty / apathy from staff.
- Lack of staff engagement if not the option they are in favour of.
- Out of Hospital enablers and interdependencies
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- Government legislative and regulatory changes.
- Change in local leadership meaning priority changes.
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.
- Creation of Placed based partnerships
- Strategic Capital allocation

Gaps in Controls

- A shared vision for the HAS programme is not understood across all staff/patients and partners
- Link to SO3 - 3.2 re: Capital Investment

Gaps in Assurance

- Feedback from public, patients and staff to be wide spread and specific in cases, that is benchmarked against other programmes.
- Partners to demonstrate full involvement and commitment, communications to be consistent and at the same time.
- Alignment of strategic capital
- Alignment to a System wide Out Of Hospital Strategy and ICS Strategic workforce planning

Links to High Level Risks Register

Future Opportunities

- Clinical pathways to support patient care, driven by digital solutions.
- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.
- HAS Programme
- Joint workforce solutions inc. training and development Humber wide

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.4: To offer care in estate and with engineering equipment which meets the highest modern standards.

Risk to Strategic Objective 1 - 1.4: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5		5	5	5
Likelihood	4	4	4	4		4	4	4
Risk Rating	20	20	20	20		20	20	20

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Lead Committee: Finance and Performance Committee

Last Reviewed: January 2023, October 2022, July 2022, 12 April 2022, 11 January 2022

Risk Owner: Director of Estates and Facilities

Enabling Strategy / Plan: Estates and Facilities Strategy, Clinical Strategy, Digital Strategy

Current Controls

- Audit Risk & Governance Committee
- Finance and Performance Committee
- Capital Investment Board
- Six Facet Survey - 5 years
- Annual AE Audits
- Annual Insurance and External Verification Testing
- Estates and Facilities Governance Group
- Trust Management Board (TMB)
- Project Boards for Decarbonisation Funds
- BLM Capital Group Meeting
- PAM (Premises Assurance Model)
- Specialist Technical Groups

Assurance (internal & external)

Positive:
- External Audits on Estates Infrastructure, Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- PAM

Internal:
- Minutes of Finance and Performance Committee, Audit Risk & Governance Committee, Capital Investment Board, Estates and Facilities Governance Group, TMB, Project Board - Decarbonisation
- PAM
- Non Executive Director Committee Chair Highlight Report (bi-monthly) to Trust Board
- Executive Director Report (6 monthly) to Trust Board
- Specialist Technical Groups

External:
- External Audits on Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- ERIC (Estates Return Information Collection)

Planned Actions

Action	Quarter / Year	Assurance
Continue to explore funding bids to upgrade infrastructure and engineering equipment - Action date; ongoing	Ongoing Actions	Green
Secure sufficient Core Capital Funding to ensure the infrastructure, engineering and equipment needs identified in the 6 facet survey can be managed appropriately.	Ongoing Actions	Red
Continue Backlog Maintenance programme	Q4 2022/23	Green
Complete Core Capital Programme	Q4 2022/23	Green
Complete refurbishment of old DPOW ED	Q4 2022/23	Green
Clear Ward 25 defects	Q4 2022/23	Green
Start refurbishment of SGH ED	Q4 2022/23	Green

Future Risks

- COVID-19 future surge and impact on the infrastructure
- National policy changes (HTM / HBN / BS); Ventilation, Building Regulation & Fire Safety Order
- Regulatory action and adverse effect on reputation
- Long term sustainability of the Trust's sites
- Clinical Plan
- Adverse publicity; local/national
- Workforce - sufficient number & adequately trained staff
- Without significant investment future BLM will increase (BLM figures for 2019/20 = £97M circa, and BLM figures for 2020/21 increased to circa £107M)

Strategic Threats

- Integrated Care System (ICS) Future Funding
- Failure to develop aligned system wide clinical strategies and plans which support long term sustainability and improved patient outcomes. This could prevent changes from being made
- The above prevents changes being made which are aligned to organisational and system priorities
- Government legislative and regulatory changes
- Within the next three years a significant (60%) proportion of the trust wide estate will fall into 'major repair or replacement' 6 facet survey categorisation
- A further breakdown of strategic risk detailed in the 2019/20 6 Facet Survey Report:
22% of SGH total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'
- 19% DPoW total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'
- 29% GDH total BLM investment required to bring the estate up to satisfactory condition is classified as 'running at serious risk of breakdown'

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR
- Insufficient Capital funding

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities (development in progress)

Links to High Level Risks Register

No 1620, Medical Gas Pipeline System = 20
No 2038, Fire Compliance = 20
No 2623, Failure of windows - Trustwide = 20
No 2088, Building Management Systems (BMS) Controller failure/upgrade = 20
No 2719, Water Safety Compliance: Coronation block = 20
No 2951, Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide = 20
No 2655, SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers = 20
No 3015 Insufficient estate resources to manage the workload demand - Trustwide = 20
No 1774, Poor condition of Fuel Oil Storage Tanks - SGH = 16
No 2035, Equality Act 2010 compliance - Trustwide = 16
No 2272, EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide = 16
No 2905, Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW = 16
No 2952, Water Safety Compliance: Fire ring main - Trustwide = 16
No 2953, Water Safety Compliance: Sensor taps - Trustwide = 16
No 2959, Replacement/Repairs of flat roof - Trustwide = 16
No 2036, Ventilation and Air Conditioning - HVAC - Trustwide = 15
No 2954, Asbestos; Risk of exposure to asbestos - Trustwide = 15
No 2955, Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide = 15

Future Opportunities

- Closer ICS working.
- Humber Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.
- Expression of Interest submitted for New Hospital Programme (NHP)
- PSDS 3B 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				Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
		Q1	Q2	Q3	Q4			
Consequence	4	4	4	4		3	3	3
Likelihood	4	3	3	3		3	2	2
Risk Rating	16	12	12	12		9	6	6

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Lead Committee: Audit, Risk and Governance Committee

Enabling Strategy / Plan: Digital Strategy

Last Reviewed: October 2022, July 2022, 11 April 2022, 11 January 2022

Risk Owner: Chief Information Officer

Current Controls

- Strategy and Development Committee
- Finance and Performance Committee
- Upto date Digital / IT policies, procedures and guidelines
- Digital Strategy Board
- Digital Solutions Delivery Group
- Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.
- Audit Risk & Governance Committee (including external Audior reports)
- Annual Penetration Tests
- Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication
- Trust Management Board (TMB)

Assurance (internal & external)

Internal:

- A Digital Strategy Board reviews progress of the plans to achieve the strategy
- Highlight reports to Trust Board, Audit Risk and Governance Committee, Strategic Development Committee, Finance and Performance Committee and TMB
- Digital / IT Policies all current
- CIO/Executive Director Report (6 monthly) to Trust Board

External:

- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Limited Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Limited Assurance, Q3 2019

Positive Assurance:

The Integrated Performance Report (IPR) has been revised and updated. This was done with NHSE/I who have stated it is now among the leading models for reportin

Planned Actions

Action	Quarter / Year	Assurance
• Development of a comprehensive IT BC / DR Programme including monitoring of adherence to the programme. Results of BC / DR tests recorded and formally reported by 31 December 2021. External Project Manager appointed to undertake further work on the IT BC/ DR Programme to be completed by 30,Sept. 2022 (extended from 30 April 2022) DSPT Ref: IA-20724	Q3 2022/23	Green
•Digital Reporting schedule/Work plan for Board Committees completed as of the 4th Qtr 21/22 Report to ARG July 27 / 6 Month updates provided to Board	Q3 2021/22	Blue
• The Data Warehouse options appraisal was approved through governance structures by February 2022	Q4 2021/22	Blue
• Implementation of the Data Warehouse commenced in April 2022	Q4 2021/22	Blue
• Year 2 Digital Aspirant Funds available to support funding Digital Programs (20/21 & 21/22)	Q4 2021/22	Blue
• IPR - further review of current IPR for adding Digital, Finance and Estates KPI. S, Review in April 2023	Q1 2023/24	Green
• Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Plus Accreditation (2nd Qtr 22/23 -July 2022)	Q4 2022/23	Amber
• Secure resources to deliver Digital Strategy and annual priorities (PAS; EPR; Data Warehouse; RPA; Document management; Infrastructure upgrades). Digital Aspirant Funds £5 M secured with additional internal Capital to deliver projects 21/22 & 22/23. Depending on when NHSX releases funds for the Unified Tech Fund, we work with the ICS to bid for funds to continue our "levelling strategy" across the ICS	Other	Amber
• £250k NHS/X/D Cyber Security Capital Funding Bid Approved - Improving Cyber Security and Management over Medical Devices and other unmanaged IT devices on the Trust network	Other	Blue
The Data Warehouse with core data sets will be completed and running on the new platform by March 2023.	Q4 2022/23	Green

Future Risks

- COVID-19 surge and impact on adoption of digital transformation
- National policy changes in some cases in short notice, requiring revisions to work plan
- Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards
- IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG specific agenda
- Ongoing financial pressures across the organisation

Strategic Threats

- Capital funding to deliver IT solutions and establish a 3 yr plan
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve

Gaps in Controls

- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.
- Develop policy and procedure to address the gaps noted in the IT Business Continuity audit in April 2020.
- Achieve DSP Toolkit and mandatory training compliance - in progress

Gaps in Assurance

- Integrated Performance Report - the Digital and Estates
- Data Warehouse solution to support outcomes from BI review

Links to High Level Risks Register

- No 2300, Insufficient processes in place to ensure records management /quality against national = 16

Future Opportunities

- Humber Coast and Vale ICS, system wide collaborative working
- Clinical pathways to support patient care, driven by digital solutions
- Collaborative working with HASR and Acute Care Collaborative

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.6: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	4		4	4	4
Likelihood	2	4	4	3		4	3	1
Risk Rating	8	16	16	12		16	12	4

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Lead Committee: Finance and Performance Committee

Last Reviewed: 18 January 2023, December 2022, 13 October 2022, July 2022, 11 April 2022, 24 January 2022

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan: NLAG Winter Planning and Potential COVID-19 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
- COVID-19 Executive Incident Control (Gold Command).
- Patient Flow Improvement Group (PFIG)
- Discharge System Improvement Group
- Planned Care Improvement and Productivity (PCIP)
- Industrial action planning
- Emergency Preparedness, Resilience and Response Steering Group
- Bank Holiday Planing Group

Assurance (internal & external)

Internal:

- Regional EPRR scenarios and planning exercises in preparation for 'Brexit' have been undertaken alongside partners, including scenarios involving transportation, freight and traffic around local docks with resulting action plan.
- Business continuity management system and business continuity plans
- Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, Executive Incident Control Group, A&E Delivery Board, Clinical Reference Group, PFIG, Discharge System Improvement Group, PCIP

Positive:

- Half yearly tests of the Major incident response cascades
- Annual review of business continutiy plans.
- Internal audit of emergency planning 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 recommendations (2022/23)

Planned Actions

Action	Quarter / Year	Assurance
Lateral flow testing staff is ongoing	Ongoing	Green
Business Intelligence monitoring re: pandemic	Ongoing	Green
Rolling Schedule of annual business continuity plans	Ongoing	Green
Review of EPRR work programme and exercise programme	Q2 2022/23	Blue
Implementation of new national EPRR Strategic Health Commander training	Q2 2022/23	Blue
LRF Flood Exercise	O2 2022/23	Blue
Winter Planning for 2022/23	Ongoing	Green
CBRN training aligned to New DPOWH ED transition plan	Q4 2022/23	Green
Relaunch of loggist training and provision	Q4 2022/23	Green
Major incident table top training	Q4 2022/23	Yellow
National Exercise Artic Willow (Winter preparedness)	Q3 2022/23	Blue
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
National Exercise Mighty Oak (national power outage)	Q4 2022/23	Yellow
Review and update of Escalationand Surge Policy	Q4 2022/23	Yellow
Review of Evacuation Plan	Q4 2022/23	Green
Review of Major Incident Plan and Critical Incident Plan	Q1 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 due to COVID-19.
- Increase in seasional 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 2022/23
- 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

- Constitutional A&E targets (2562)
- Quality of Care (due to nurse staffing position) (2145)

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 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5		4	4	4
Likelihood	3	4	4	4		2	3	1
Risk Rating	15	20	20	20		8	12	4

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: January 2023, 14 November 2022, September 2022, July 2022, 6 April 2022, March 2022

Lead Committee: Workforce Committee

Risk Owner: Director of People

Enabling Strategy / Plan: People Strategy, NHS People Plan, Leadership Development Strategy

Current Controls

Locally
- Workforce Committee
- Audit Risk & Governance Committee
- Trust Management Board (TMB)
- PRIMS
- Nursing,midwifery & AHP recrutiment and retention group
- Nursing Apprenticeship task and finish group
- International recruitment programme Task & Finish group
- Remuneration and Terms of Service Committee (RATS)
- Culture Transformation Board (CTB) & Culture Transformation Working Group (CTWG)
- Workforce Systems Group (Finance, HR and Operations)
- NLAG People Strategy approved by the Board June 2020
- People Directorate - People Strategy Annual Delivery Implementation Plan 2022-23 (Workforce Committee approved July 2022 and TMB September 2022)
- Annual NHS staff survey and quarterly People Pulse

Regional and ICB
- Humber and North Yorkshire (HNY) – ICB Strategic Workforce Group
- Humber Workforce Group
- ICB People Strategy
- HNY ICB HRD Group
- Yorkshire and North East – HRD Group

National
- National HRD Forum
- NHS People Plan and People Promise
- NHS Employers Forum

Assurance (internal & external)

Internal:
- Minutes of Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, PRIMS, Recruitment and Retention Group, Nursing Apprenticeship Group, Internal Recruitment Programme Group, Culture Transformation Board, Workforce Systems Group, Remuneration and Terms of Service Committee.
- NHS People Plan, NLAG People Strategy and Implementation Plan reported to Workforce Committee.
- Recruitment Plans signed off divisionally
- Workforce Integrated Performance Report
- Annual staff survey and people pulse results
- Medical engagement survey 2019
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board

Positive:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance

External:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance
- Minutes of Regional and ICB workforce groups
- Minutes of National HRD Forum and NHS Employers Forum

Planned Actions

Action	Quarter / Year	Assurance
Developing Recruitment plans for 22/23 to recruit to non registered an	Q1 2022/23	Blue
Review of Recruitment Processess to ensure that they are streamlined, inclusive, responsive and timely	Q1 2022/23	Blue
Health and Wellbeing plan communicated to staff	Q1 2022/23	Blue
Just and Learning Culture Framework to be introduced/piloted as part of the roll out of the new disciplinary policy -- subject to approval of disciplinary policy	Q1 2022/23	Blue
Setting up a working group to oversee payment processes to ensure streamlined processes between People/Operations and Finance Directorate	Q1 2022/23	Blue
Set up Culture Transformation Board to develop plans to address issues identified through staff survey, FTSU and other data on staff morale and culture	Q2 2022/23	Blue
Review of Statutory and Mandatory training is underway to clarify what staff need to undertake in line with national benchmarks	Q2 2022/23	Blue
Development of Recrutiment Dashboard to support recrutiment delivery	Q2 2022/23	Blue
Culture Transformation Launch event - 4th August	Q2 2022/23	Blue
Development and Sign off of Performance Metrics to support roll out of Leadership Strategy and Culture Transformation	Q2 2022/23	Yellow
Implementation and roll out of Clever Together - Big conversation - Be the change to support staff engagement	Q2 2022/23	Blue
Continued delivery against NHS People Plan	Q3 2022/23	Blue
Continue collaboration between NLAG and HUTH and the HCV wider network	Q3 2022/23	Blue
Analysis of results from Big Conversation - Be the Change (clever together)	Q3 2022/23	Blue
Continued review of the Health and Wellbeing offer to staff	Q3 2022/23	Blue
Review of the Educational /Leadership Development offer and future roll out of programmes	Q3 2022/23	Blue
Staff Survey 22/23 roll out	Q3 2022/23	Blue
Continued implementation of People Strategy by 31 March 2024	Q4 2022/23	

Future Risks

- Staff morale and turnover
- COVID-19 & FLU winter surge and impact on staff health and wellbeing.
- National policy changes.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Provide safe services to the local population.
- Succession planning and future talent identification.
- Visa changes / EU Exit.
- Staff retention and ability to recruit and retain HR/OD staff to deliver people agenda

Strategic Threats

- ICS Future Workforce
- Integrating Care: Next Steps
- Future staffing needs / talent management

Gaps in Controls

- Slower international recruitment of clinical staff due to visa backlogs

Gaps in Assurance

- Increase in nurse staff vacancies and conversion of the 50 overseas nursing recruits

Other Significant Risks & Links to High Level Risks Register

No 1851, Shortfall in Capacity within the Ophthalmology Service - 15
No 2421, Nurse Staffing, Risk Rating = 25
No 2530, Poor Registered Nursing Skill Mix on Wards = 20
No 2898, Medical Staff - Mandatory Training Compliance = 16
No 2960, Risk of inability to safely staff maternity unit with Midwives = 16
No 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

Future Opportunities

- Closer ICS working
- Provider collaboration
- International recruitment

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.1: To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP.

Risk to Strategic Objective 3 - 3.1: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5		5	5	5
Likelihood	2	3	4	4		1	4	4
Risk Rating	10	15	20	20		5	20	20

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Lead Committee: Finance and Performance Committee

Enabing Strategy / Plan: Trust Strategy, Clinical Strategy, ICS

Last Reviewed: 9 January 2023, 19 July 2022, 18 May 2022, 31 January 2022

Risk Owner: Chief Financial Officer

Current Controls

- Capital Investment Board, Trust Management Board (TMB), PRIMs, Model Hospital.
- National benchmarking and productivity data constantly reviewed to identify CIP schemes.
- Engagement with Integrated Care System on system wide planning
- Monthly ICS Finance Meetings
- Operational and Finance Plan 2022/23
- Counter Fraud and Internal Audit Plans
- Trustwide Budgetary Control System

Assurance (internal & external)

Internal:
- Minutes of Audit Risk & Governance Committee, Trust Management Board, Finance and Performance Committee, Capital Investment Board, PRIMs, Monthly ICS Finance Meetings
- Non-Executive Director Highlight Report (bi-monthly) to Trust Board

Positive:
- Letter from NHSE related to financial special measures and achievement of action plan. On track to deliver the requirements set out by NHSE
- Internal Audit Reports - Internal Control - significant assurance

External:
- Financial Special Measures Meeting - Letter from NHSE related to financial special measures and achievement of action plan
- Approval received at ICS Level for 2022-23 capital plan
- Internal Audit Reports - Internal Control - significant assurance
- Agreed Financial Plan at ICS Level for 2022/23

Planned Actions

Action	Quarter / Year	Assurance
Undertake financial planning as part of HNY HCP exercise and agree a balanced financial plan for 2022/23 - this is still work in progress with a plan deficit of £6m currently. Included within this are two key actions: productivity improvement plans to return the Trust to 19/20 activity levels as a minimum, and a robust and recurrent cost improvement plan which is capable of being delivered in year	Q4 2022/23	Blue
Work with system partners, specifically community and local authorities to ensure that our local systems are working in unison to	2022/23	Green
Agree financial recovery plan to meet 2022/23 year-end target	Q4 2022/23	Green
Release of balance sheet flexibility to support 2022/23 forecast outturn	Q4 2022/23	Green

Future Risks

- COVID-19 further surges and impact on finance and CIP achievement
- National policy changes
- Impact of HAS plans on NLaG clinical and non clinical strategies
- Savings Programme not sufficient and deteriorating underlying run rate which is execerbated by the elective recovery programme
- Impact of external factors such as problems with residential and domicilary care, causing hospitals to operate at less than optimum efficiency and cause financial problems
- Grip and control of non-pay spend emerging from Month 8
- Vacancy levels in medical and nursing driving an unplanned level of spend

Strategic Threats

- ICS Future Funding
- Integrating Care: Next Steps
- System wide control total

Gaps in Controls

- Systems plans may not address individual organisational sustainability
- Challenges with HASR, CIP Delivery
- Uncertainty on application of long term financial framework.
- Clinical strategy required to inform Finance Strategy
- As we progress, the emerging uncertainty around the financial implications of decisions from the HAS process
- Month on month adverse variants against operational budgets

Gaps in Assurance

- Trustwide Budgetary Control System, 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

Links to High Level Risks Register

No 3074, Financial Risk - Medicine CIP 2022/23 = 16

Future Opportunities

- Closer ICS working
- Provider collaboration
- System wide collaboration to meet control total

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.2: To secure adequate capital investment for the needs of the Trust and its patients.

Risk to Strategic Objective 3 - 3.2: The risk that the Trust fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	4	5	5		5	5	5
Likelihood	3	3	3	3		3	3	3
Risk Rating	15	12	15	15		15	15	15

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 9 January 2023, 14/10/22, 23/6/22, 13 April 2022 (DoSD), 14 February 2022

Lead Committee: Strategic Development Committee

Risk Owners: Chief Financial Officer and Director of Strategic Development

Enabling Strategy / Plan: Trust Strategy, Clinical Strategy, Humber Acute Services Programme/ Capital Investment EOI and potential SOC for NHP

Current Controls

- Capital Investment Board (Internal Capital)
- Trust (Internally) Agreed Capital programme and allocated budget - annual/three yearly
- Trust Strategic Development Committee
- Trust Board
- Trust Committee(s) in Common
- ICS Strategic Capital Advisory Group
- NHSE/I - HAS Assurance Reviews
- NHSE/I Financial Speciall Measures Assurance Reviews

Assurance (internal & external)

Internal:
- Minutes of Internal Trust Meetings

External:
- Financial Special Measure Meeting with NHSE/I
- NHSE/I attendance at AAU / ED Programme Board
- NHSE/I Assurance Review Feedback
- CiC Minutes

Planned Actions

Action	Quarter / Year	Assurance
Agree forecast spend for current year as part of wider ICS capital planning exercise	Q4 2022/23	Green
Find a solution to address BEIS/Salix funding issues with regards to year end cut off	Q2 2022/23	Blue
Develop strategic capital plan as part of comprehensive service planning exercise - to be completed by end March 2023	Q4 2022/23	Green
Secure approval for Acute Assessment Unit, Full Business Case	Q4 2021/22	Blue
Develop Capital Investment Strategic Outline Case for development of SGH/DPoW	Q3 2022/23	Green
Develop TiF submission through acute collaboratives for additional theatre capacity	Q3 2022/23	Blue
Develop integrated bid across N and NE Lincs for implementation of CDH aligned to ICS Core Programme	Q4 2022/23	Green
Review and seek if there are ways of applying for future rounds of PSDS funding	Q4 2022/23	Green

Future Risks

- National policy changes - implications of three year capital planning
- Lack of investment in infrastructure through Targeted Investment Fund (TIF)
- Inability of Trust to fund capital through internal resource - potential lack of external funding sources
- Inability of Trust to gain Capital Departmental Resource Limit (CDEL) cover for strategic capital investment if not on New Hospital Programme (NHP)
- Not gaining a place on the NHP
- Challenges with existing estate continue and significant issues remain with Backlog Maintenance (BLM), Critical Infrastructure Risk (CIR)

Strategic Threats

- ICS Capital Funding Allocations
- Inability to gain national strategic capital through NHP
- Inability to offset CDEL if non NHS funding sources used for capital investment

Gaps in Controls

- Comprehensive programme of Control and Assurance - potential inherent risk on ability of Trust to afford internal capital for major spend
- Control environment whilst comprehensive may not have ability to influence availability of Strategic Capital - investment funding/affordability
- Control environment may not be able to eliminate or reduce risk of estates condition in the short term

Gaps in Assurance

- Assurance review process does not create a direct link to sources of strategic capital investment
- ICS CDEL may not be sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providers

Links to High Level Risks Register

Future Opportunities

- Provider collaboration and use of Place based funding
- Use of TiF, CDH and Towns Centre funds to support capital spend
- System wide collaboration to major capital development needs.
- Announcement of multi year, multi billion pound capital budgets for NHS
- Gaining a place on the NHP

Strategic Objective 4 - To work more collaboratively

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

Risk to Strategic Objective 4: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	4	4	4		4	4	4
Likelihood	3	3	3	3		2	2	2
Risk Rating	15	12	12	12		8	8	8

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: October 2022, 23/6/22, 13 April 2022, 12 January 2022

Lead Committee: Strategic Development Committee

Risk Owner: Director of Strategic Development

Enabing Strategy / Plan: NHS Long Term Plan, Trust Strategy, Clinical Strategy, Humber Acute Services Programme, Communications & Engagement Strategy

Current Controls

- Audit Risk & Governance Committee (ARGC).
- Trust Management Board (TMB).
- Finance and Performance Committee (F&PC).
- Strategic Development Committee (SDC).
- Capital Investment Board (CIB).
- HAS Executive Oversight Group.
- HNY HCP.
- ICS Leadership Group.
- Wave 4 ICS Capital Committee.
- Executive Director of HAS and HAS Programme Director appointed.
- NHS LTP.
- ICS LTP.
- NLaG Clinical Strategy.
- NLaG Membership of ICP Board NE Lincs.
- Committees in Common (Trust Board approved 1/6/2021)
- Acute and Comunity Collaborative Boards
- Clinical Leaders & Professional Group
- Council of Governors.
- Joint Overview & Scutiny Committees
- MP cabinet and LA senior team briefings
- Primary/Secondary Interface Group (Northbank&Southbank)

Assurance (internal & external)

Positive:
- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE/I Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Clinical Senate review approach and process

Internal:
- Minutes of HAS Executive Oversight Group, HNY HCP, ICS Leadership Group, Wave 4 ICS Capital Committee, ARGC, F&PC, TMB, SDC, CIB, CoG
- Non Executive Director Committee chair Highlight Report to Trust Board
- Executive Director Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE/I (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE/I Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Councillors / MPs / Local Authority CEOs and senior teams

Planned Actions

Action	Quarter / Year	Assurance
Recruit to Strategic Development - Associate Medical Director to support the ICS collaboration - Dec 21 (complete and in post)	Q3 2021/22	Green
HAS two year programme (current to March 2023) - 12 month rolling	Q4 2023/24	Green
Options appraisal for HAS Capital Investment to be approved	Q4 2022/23	Green
To undertake continuous process of stocktake and assurance reviews NHSE/I and Clinical Senate review	Q1 2023/24	Green
Joint OSC - reviews	Q1 2023/24	Green
CIC / SDC / NED / Governor reviews	Q4 2022/23	Green
Citizens Panel reviews	Q4 2022/23	Green
Clinical Senate reviews	Q4 2022/23	Green
To undertake continuous engagement process with public and staff	Q4 2022/23	Green
Evaluation of the models and options with stakeholders	Q4 2022/23	Green
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Green
NHSEI Gateway review	Q1 2023/24	Green
ICS Board approval	Q1 2023/24	Green
Public Consultation	Q2/Q3 2023/24	Green

Future Risks

- National policy changes
- Delays in legislation
- Long term sustainability of the Trust's sites.
- Change to Royal College Clinical Standards.
- Capital Funding.
- ICS / Integrated Care Partnership (ICP) Structural Change.
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- ICS Future Funding.
- Failure to develop aligned system wide strategies and plans which support long term sustainability and improved patient outcomes.
- Government legislative and regulatory changes.
- Integrated Care: Next Steps and Legislative Changes.
- Strategic capital.

Gaps in Controls

- Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.
- Local Authority, primary care and community service, NED and Governor engagement / feedback (during transition)
- ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Lack of integrated plan and governance structure.
- Alignment with Out of Hospital strategies and programmes

Links to High Level Risks Register

Future Opportunities

- HNY ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Strategic workforce planning system wide and collaborative training and development with Health Education England / Universities etc.
- Acute and community collaborative.

Strategic Objective 5 - To provide good leadership

Description of Strategic Objective 5: To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk to Strategic Objective 5: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

Risk Rating	Inherent Risk	Current Risk				Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
		Q1	Q2	Q3	Q4			
Consequence	4	4	4	4		4	4	4
Likelihood	4	3	3	3		2	2	2
Risk Rating	16	12	12	12		8	8	8

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: January 2023,14 November 2022, September 2022, July 2022, 6 April 2022, March 2022

Lead Committees: Workforce Committee and Trust Board

Risk Owner: Chief Executive

Enabing Strategy / Plan: Trust Strategy, NHS People Plan, People Strategy, Leadership and Development Strategy

Current Controls

- Trust Board, Trust Management Board, Workforce Committee, PRIMS
- CQC and NHSE Support Teams
- Board development support programme with NHSE support.
- Significant investment in strengthened structures, specifically (a) Organisational structure, (b) Board structure, (c) a number of new senior leadership appointments
- Development programmes for clinical leaders, ward leaders and more programmes in development
- Communication with the Trust's senior leaders via the monthly senior leadership community event
- NHSI Well Led Framework
- PADR compliance levels via PRIM as part of the Trust's focus on Performance improvement
- Joint posts of Trust Chair and Chief Financial Officer, with HUTH
- Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, Humber and North Yorkshire Health and Care Partnership.

Assurance (internal & external)

Internal:
- Leadership Strategy signed off by Trust Board - May 2022
- Minutes of Trust Board, Trust Management Board, Workforce Committee and PRIMS
- Trust Priorities report from Chief Executive (quarterly)
- Integrated Performance Report to Trust Board and Committees.
- Letter from NHSE related to financial special measures and achievement of action plan.
- Chief Executive Briefing (bi-monthly) to Trust Board
- Board and Commiteee meeting structures
- Workforce Implementation Plan report (includes development and leadership programmes) to Workforce Committee
- Senior Leadership Community presentation
- Trust Board - Well-Led assessments at Board Development

Positive:
- Letter from NHSE related to financial special measures and achievement of action plan.

External:
- CQC Report - 2020 (rated Trust as Requires Improvement).
- Financial and Quality Special Measures.
- NHS Staff Survey.
- Minutes of Collaborative Working Relationship groups

Planned Actions

Action	Quarter / Year	Assurance
Introduction of x3 Portfolio Governance Boards including one for leadership and career development with representation from all stakeholder staff groups, leadership development programmes we design in-house, commission, or subscribe to, align with our People Strategy aims of attracting, developing and retaining leaders as a preferred employer. From April 2022.	Q1/2 2022/23	Blue
Continued development of the Leadership Development Model for all leaders and managers towards building a culture of compassion-centred, collective leadership. This programme, modular in approach, will include Leading with Kindness, Courage and Respect, underpinned with processes and skill development in difficult conversations, embodying the Trust values, and improving what it feels like for staff to work at NLaG. From April 2022, subject to funding	Q1/2 2022/23	Blue
Refreshing of the coaching model with the move towards a Coaching and Mentoring Bureau, offering staff at all levels, opportunities for coaching and mentoring. All participants on leadership development programmes will have a coach for the duration of their development course. We aim to introduce mentoring, both peer to peer, role and career, and reverse, during 2023 with some small scale pilot programmes including a pilot EDI-centric reverse mentoring programme to further strengthen inclusion.	Q2 2022/23	Yellow
Refresh of our PADR process referred to in the Training & Development submission, will include process components and skills training to enable identification of talent, development of potential, and proactive planning for succession. Refer to the Leadership and Career development draft schematic in the Appendices for concept. December 2022	Q3 2022/23	Yellow
Introducing a managerial core skills programme for newly appointed managers 2022 and beyond - February 2023	Q3 2022/23	Yellow
Continued development and implementation of Value based leadership - subject to funding and resources	Q4 2022/23	Blue

Future Risks

- COVID-19 third surge and impact on finance and CIP achievement.
- National policy changes.
- Impact of HASR plans on NLaG clinical and non clinical strategies.

Strategic Threats

- Non-delivery of the Trust's strategic objectives
- Continued quality/financial special measures status
- CQC well-led domain of 'inadequate'
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives
- Failure to obtain support for key changes needed to ensure improvement or sustainability
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users

Gaps in Controls

- No investment specifically for staff training / courses to support leaders work within a different context and to be effective in their roles as leaders within wider systems

Gaps in Assurance

- Financial Special Measures
- Quality Special Measures

Links to High Level Risks Register

None

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration
- System wide collaboration to meet control total
- HASR

Key to Assurance	
Red	Action rated red means the action is off track, with no mitigation and pose a significant risk to the delivery of the strategic objective
Amber	Action rated amber mean it is in progress, but off track with, no mitigation and could pose a risk to the strategic objective being delivered
Yellow	Action rated 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

Number	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Assessor	Owner	Site	Directorate	Risk Rate Score	Next Review Date	Control Details	Gaps In Controls	Control Assurance
1620	08/01/2013	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Med Gas: Medical Gas Pipeline System outlet and plant - Trustwide	There is a risk of losing bed head medical gases due to medical gas wall point terminals (Oxygen, Vacuum Medical Air, Nitrous Oxide) being obsolete with limited spare parts. The loss of medical gas system could negatively impact the Trust's ability to treat inpatients and also prevents the capability to treat patients that have been transferred to the Trust.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	20	27/01/2023	Ongoing monitoring of alarms. National supplier support for business continuity. Replacement in line with ward upgrades. Flow rate meters VIE telemetry	Inability to determine flow rates around the systems, other than design flow rates.	Significant/robust contingencies in place which have been tested in the recent critical incident (W87371).
1774	05/06/2014	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Poor condition of Fuel Oil Storage Tanks - SGH	If the Trust lost gas supplies to the SGH site the boilers would have to be fuelled by oil. The material state of the oil storage tanks has resulted in the oil being contaminated and if called upon, could damage the boilers. The strategic risk are the boilers failing to provide heat and hot water due to main hospital site.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	16	27/01/2023	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	15	10/02/2023	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	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Equality Act 2010 compliance - Trustwide	The Trust has received numerous claims for slips, trips and falls from the state of the Trust's roads, pathways and corridors. These both damage the Trust's reputation and lead to financial loss. A number of facilities (lifts, toilets) are non-compliant with current regulations which may result in patients and staff being unable to move through the hospital sites safely and with dignity and respect.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	16	27/01/2023	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	22/08/2016	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Ventilation and Air Conditioning - HVAC - Trustwide	Failure of the heating and ventilation system. This would result in a negative impact on the effective delivery of patient care.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	15	27/01/2023	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	20	27/01/2023	Panels are being replaced. DPoW ward replacement programme includes updated detection loops.	Fire detection - Mixture of analogue and digital which increases the risk of failure. Closed protocol system at SGH. Drawings - Establishment and confirmation of existing fire compartments.	Automatic fire detection - current panels to be replaced. A review of existing drawings is near completion.
2088	04/11/2016	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Buildings, Land and Plant	Building Management Systems (BMS) Controller failure/upgrade	There is the risk of failure of elements of the Building Management Systems (BMS). The BMS controls the sites heating and hot water services, therefore, temperature control of both the hospital environment and water systems could become significantly compromised.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	20	27/01/2023	Continued monitoring of the system for operation (by Estates Staff).	Reactive to ongoing BMS failures. Current BMS runs on outdated windows support system.	There are limited assurances on controls highlighted by continued BMS failures.
2145	15/02/2017	31/12/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Staffing Levels & HR	Quality of Care and Patient Safety - (due to nurse staffing position)	The Registered Nursing vacancy position in Medicine, against current, agreed establishment creates significant issues with producing a robust nursing roster. The Nurse vacancy position within Medicine has a direct impact on quality of care and patient safety. There is also a cost associated with the use of Agency Nurses in order to fill the gaps in the rosters. SNCT establishment review undertaken with Chief Nurse and implemented from 4th November roster period. This increased the Nursing establishment on most wards and both Emergency Departments by increasing the number Nurses within Medicine, which has resulted in an increase in our Nurse vacancies despite mitigation. Medicine are also staffing Escalation areas which adds further risk. In addition, Nursing staff rosters are significantly impacted due to the COVID pandemic due to staff sickness and shielding. Patient harm, increased sickness, staff leaving are possible outcomes as a result.	Simon Buckley	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	20	30/11/2022	1.International recruitment of staff 2.Roster approval checks in line with Rostering Policy and Procedure. 3. Shifts identified to be sent to Bank and Agencies within specified timeframes. 4.Block booking in place. 5.Twice daily staffing meetings. Redeployment of staff between wards on a daily basis. Workforce meetings Safe staff meetings PRIMS KPI meeting Check challenge meeting with deputy nurse meeting Care Navigator Roles Clinical Sister Band 6 now in place	Inability to cover all shifts via Agency / Bank. Financial implication of using premium rate agencies.	6 monthly Establishment reviews capturing information related to SNCT and Safecare. Successful Overseas Nurse resruitment - Oct 2020 - date 46 staff recruited. Update - 21.07.21. 49 Pre-registration nurses appointed to Medicine NQN's due to start in September/Oct 21 On-going recruitment drives with the support of Recruitment Team and Talent Acquisition Long term workforce planning as part of P2 of HASR/AAU
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	16	06/10/2021	(1) Weekly Cancer RTT waiting time meeting to challenge and review all cancer PTLs (62 day 1st, screening, consultant upgrade, 31 day 1st, subsequent surgery, subsequent drugs) (2) Automated RAG rated PTL (updated twice daily to reflect current position and available to all Divisional Managers). (3) 62 day Cancer Improvement Plan has translated into the Cancer Transformation Programme (2 year programme commencing 2021) (4) Cancer performance/ backlog is reported weekly to Operational Management Group (5) Improved visibility on all aspects of cancer pathways through the Cancer Power BI Performance report (which is updated daily and available to all Divisional Managers/clinicians. (6) Cancer Trackers attend Divisional Huddles in some specialties (Colorectal/Gynae) as a point of escalation. (7) A trust-wide clinical harm review process is in progress	Failure to treat patients within Cancer Waiting / Performance Target 62 day may result in poor patient experience and potential harm	62 day backlog and 104+ days waits monitored weekly at Operational Management Group

2245	20/06/2017	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Overall Performance : Non compliance with RTT incomplete target	Given our current operating models, there is a risk that there is insufficient capacity to meet demand in a number of specialities which risks the RTT position and potential for adverse patient impact. Potential for 52 week breaches and potential to not meet current 40 week maximum RTT target This could result in clinical harm	Jennifer Orton	Mathew Thomas	Trustwide - All Sites (DPoW, S	Directorate of Operations	16	02/02/2023	(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	31/12/2022	To offer care in estate and with equipment which meets the highest modern standards	Environmental	EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide	There is a risk that the EHO could instruct that the ward based kitchen is unfit for food preparation and issue a prohibition notice which would prevent food/drink being prepared on ward areas. This would result in a delay to patients receiving food and drink.	Keith Fowler	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	16	02/02/2023	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	31/12/2022	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Information Governance	Insufficient processes in place to ensure records management /quality against national guidance	The Trust has insufficient processes in place to ensure records management / quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards.	Susan Meakin	Christopher Evans	Trustwide - All Sites (DPoW, S	Digital Services	16	04/01/2023	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	15	02/02/2023	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.
2388	09/07/2018	06/06/2022	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Clinical	There is a risk of deteriorating patients not being escalated appropriately.	There is a risk that patients observations and NEWS scores are not being consistently monitored and overseen which could lead to patient harm through deterioration.	Simon Buckley	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	15	30/11/2022	* Trust Policy and escalation process being updated and approved by Trust Management Board, * Roll-out of hand-held devices to ensure better monitoring of observations and escalation of any deteriorating patients in line with the newly updated Trust Policy, * Increased resource being applied for via business case for increased critical care outreach support and hospital at night teams, * Roll-out of ward based dashboards to support ward areas understand their performance against these quality metrics. * Continued roll-out of sepsis 6 bundle. RISK LINKED TO SEPSIS MANAGEMENT RISK NO 1513 Update - 21.01.20 - Snapshot Audit undertaken which will assist with monitoring compliance and inform actions for wards to take. Performance monitored through ward performance reviews which are later reported to PRM. Target for NEWS (on time) is 90%. * Divisional progress against targets is monitored via the Deteriorating Patient & Sepsis Group. * NEWS monitored as part of Quality updates provided to Medicine Board and Governance Meetings. * Monitored at divisional PRM Meeting. * News compliance discussed at Divisional Ward Review Meetings. * Compliance monitored at Deteriorating Patient & Sepsis Group.	Agency staff may be unaware of systems on commencement.	Maintaining NEWS compliance above 85% individual areas below this have plan and discussed at DP & Sepsis Group NEWS scoring reviewed as part of Ward Performance r/v with HoN/DHoN NEWS compliance reported through PRIM's During January 2020 an audit demonstrated - 83.68 % of NEWS scores completed within 30 minutes grace period. 74.75 % were completed without grace period. Update: NEWS trend (June '21 30 mins) 90.2% (May 89.3%) Maintaining NEWS compliance above 85% individual areas below this have plan and discussed at DP & Sepsis Group
2421	29/12/2016	31/12/2022	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce	Staffing Levels & HR	Nurse Staffing	The risk to the Trust is that we are unable to deliver safe and effective care to our patients and provide the required level of service due to staffing shortages and reliance on temporary staff.	Jennifer Hinchliffe	Eleanor Monkhouse	Trustwide - All Sites (DPoW, S	Chief Nurse	25	15/12/2022	Monthly nurse staffing assurance report that goes to the Quality & Safety Committee and reports to Board which includes nursing fill rates and CHPPD. This is triangulated with nursing sensitive indicators and discussed at a monthly nursing metrics meeting. Daily escalation process in place and Safe Care Live implemented April 2020 with supporting SOP. Head of Nursing challenge and oversight to daily staff deployment and facilitates escalation and authorisation of agency including sign off for all off framework requests. Nursing Workforce Group in place to oversee various strands of work (recruitment, retention, workforce plan and new roles). A number of task and finish groups are in place: Safe Staffing, Effective rostering, Recruitment and Retention and CNS Job Planning. Recruitment and retention strategy in place. New governance structure in place which includes effective rostering and a prospective and retrospective review of roster with Check, Challenge and Coach meetings. KPIs developed and being monitored including sickness, annual leave, training and nursing spend and bank and agency usage. April 2022 - agreed source of funding for registered nurse degree apprenticeship programmes to support career development opportunities and the future supply of RNs. Nursing staffing OPEL level developed and reported daily.	(1) High number of nurse vacancies leading to shortage of nursing staff available to cover required shifts and reliance on temporary staff. (2) 100% compliance with Safe Care Live census by all wards to inform deployment of staff both in and out of hours and to identify temporary staffing needs. (3) Visibility and use of data from Eroster to inform decision making and target areas for improvement, use of patient acuity data from Safe Care Live. (4) Demand for bank staff higher than supply resulting in inability to fill established shifts to support open escalation beds and reliance on agency staff.	(1) Level 1: Nurse staffing dashboard accessible and contains KPIs re. vacancy position, agency usage, nurse sensitive indicators etc. [Mixed assurance]. (1) Level 2: Monthly reporting to QSC and Trust Board [Mixed assurance]. (1) Level 1: Reduction in nursing turnover rates [Positive assurance] (2) Level 1: Anecdotal evidence from ward visits is that staff are transferred to different wards to support safe levels of staffing which leads to skill mix and morale challenges [Negative assurance] (2) Level 2: Daily staffing meetings with Matrons to review Safecare Live introduced Sept 2020 (risks and mitigating actions reviewed) [Mixed assurance]

2530	08/07/2019	31/10/2022	To provide care which is as safe, effective, accessible and timely as possible	Staffing Levels & HR	Poor Registered Nursing Skill Mix on Wards	Through the formal establishment reviews undertaken in March and April 2019 it has been identified that the registered nursing skill mix is low in some adult inpatient wards. The SNCT data collection over 20 days has shown some wards with their patient acuity have a need for additional registered nurses. Skill mix at times is less than 50%.	Jennifer Hinchliffe	Eleanor Monkhouse	Trustwide - All Sites (DPoW, S	Chief Nurse	20	15/12/2022	Formalised establishment reviews now in place to occur every 6 months with the Chief Nurse and all ward managers. SNCT licence in place to support the collection of data. Papers went to Trust Board in 2019 to recommend an increase in registered nurses, particularly out of hours as a twilight shift. Funding agreed in 2 phases to support recommendations and recruitment underway. Further CN safe staffing establishment review unertaken in 2021 and additional funding secured for priority recommendations for 2022/23. Staffing red flag incidents are being monitored by the Chief Nurse, Deputy Chief Nurses and Heads of Nursing. The Nursing Metrics Panel is meeting monthly to monitor fill rates, including substantive fill rates, incidents (including red flags) and key nursing quality indicators and outcomes. SafeCare Live implemented April 2020 to support deployment of staff. Participating in the HEE Global Learners Programme to support recruitment of overseas nurses. Direct recruitment of overseas nurses also being pursued by the Recruitment Team. Block booking of agency continues and continue to work to increase availability of bank staff. Recruitment and retention strategy in place and Task & Finish Group meeting monthly. Work includes review of flexible working. Supporting increasing numbers of student nurses to support future pipeline of RNs. Nursing apprenticeship business case funded in 2022/23 business planning.	National shortage of registered nurses. Not yet achieving 100% compliance with completion of Safe Care Live census although improving monthly and being sustained. Covid pandemic impacting on speed at which overseas nurses can commence in post.	Reduced RN turnover rate being sustained. Daily staffing meeting with Deputy Chief Nurse and Head of Nurse Staffing introduced Sept 2020 to review Safe Care Live data. 160 overseas nurses appointed between Oct 2020 and March 2022. A furhter 120 to be appointed by Dec 2022. Monthly reporting to Quality and Safety Committee/ Trust Board. Open days continue (virtually) to attract newly qualified nurses.
2562	01/09/2019	28/02/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Failure to meet constitutional targets in ECC	Due to a high level of demand at the front door and challenges with patient flow through the hospital, ED waits are a challenge which has an adverse effect on patient safety. Risk that the Trust's 4 hour A&E performance target may not be achieved and that 12 hour trolley breaches may occur. Due to a high level of demand at the front door and challenges in patient flow through the hospital, ED waits are an ongoing challenge, which has an adverse effect on patient safety.	Nicola Glen	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	20	12/01/2023	- 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 * Frailly 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, experience and performance against the 4 hour target
2576	10/03/2022	30/04/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Paediatric Medical Support Pathway for ECC - 'Fastrack'	There is a risk that children and young people are not triaged and assessed within the 15 minute standard as a result of acuity and activity within the Emergency Depratments which may lead to prolonged wait times for nursing and medical assessment within the Emergency Departments which may lead to a sick child not being recognised thus causing a level of harm	Deborah Bray	Preeti Gandhi	Trustwide - All Sites (DPoW, S	Directorate of Operations	16	21/01/2023	>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	31/10/2021	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	Failure to treat patients within the cancer waiting times may result in poor patient experience and potential clinical harm. Risk register also relates to Risk ID 2244.	Jennifer Orton	Jennifer Orton	Trustwide - All Sites (DPoW, S	Directorate of Operations	16	02/02/2023	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	23/10/2019	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Health & Safety	Failure of windows - Trustwide	There is the risk of failure of windows trust wide. Natural ventilation is used in most areas of the hospital, if windows are inoperable then restricted ventilation will occur, this is key to help with COVID guidelines. There is also the risk that a faulty window could fall down uncontrollably and hurt patients or staff	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	20	27/01/2023	Periodic planned maintenance	Due to the windows been in poor state it is difficult in determining when these could fail.	Labour management system Highlight reports Capital Backlog Maintenance Window cleaning contractor reports
2655	09/11/2021	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers	Risk is loss of heating and hot water on site. The steam raising boilers are 28 years old and could fail. Boiler failure would result in SGH closing down all clinical services until temporary boilers could be connected to site.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	20	02/02/2023	The management of the energy centre (steam boilers) is outsourced to Engie.	Engie contract has expired. Renewing annually.	Adhoc repairs are effective. No significant loss of service.

2719	01/11/2022	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety Compliance	There is the risk of Legionella from underutilised water services and insufficiently flushing regimes impacting on the wider water systems (lack of flow). This can spread to other areas of the hospital which could result in a patient/s contracting legionnaires disease whilst in hospital.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	20	27/01/2023	Risk assessments undertaken at two yearly intervals by external competent specialist contractors.	Lack of funding for infrastructure upgrading. Lack of funding to upgrade BMS system to enable thorough monitoring of water systems throughout the sites.	Hydrop defect portal giving real time data on progress of defects. Risk assessments. Good circulation temperature L8Guard electronic return management system. Authorised Engineer report. Water sampling results. Water Safety Group Minutes. Finance, &Performance Committee Highlight report to Board. Installation of TMVs to be risk assessed and approved at the relevant safety group. Maintenance to TMV are carried out through the SOPs and PPM regime.
2898	30/03/2021	17/11/2021	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Staffing Levels & HR	Medical Staff - Mandatory Training Compliance	Mandatory Training compliance for medical staff is currently below Trust requirements. February Report - Core: 57% (Target 90%) Role Specific: 49% (Target 85%). There is a risk to patient safety if medical staff do not complete their mandatory training before each element has expired. Due to the volume of doctors demonstrating low compliance across all grades, this has impacted upon the divisional CQC improvement plan.	Sarah Smyth	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	16	18/01/2023	* Feb Data - Core: 63% Role Specific: 52%. * Rota Coordinators providing more directed support to all level doctors across Medicine to allocate/support training time for them to complete MT * MT raised at SMT, Board Meetings, Workforce SMT and separately at AGM/Speciality/Clinical Lead/Line Manager Level * Workforce Development plans are being developed for each Speciality within Medicine which is being supported by the Medicine Quad, HRBP and AGM down to Clinical Leads. * Reviewed at Divisional Workforce Meeting Updated - 14.03.22 Identification of 2 least compliant staff members in each area each month and target set for compliance to be met HRBP meeting monthly with the rota co-ordinators to identify 10 least compliant doctors and allocate time on the roster to complete Divisional Clinical Leads to work with divisional SMT to develop recovery plans for their specialities Training incorporated at the Quality & Safety meetings Individuals with low compliance being contacted and targets for completion set on-going at ward review meetings Linking in with course leads to look at prioritisation and alternative ways of completing training e.g. targeted cohorts New rotational doctors commenced training prior to starting in post	Potential failure to meet CQC requirements Staff not adequately trained with potential to impact on patient care and staff H&WB	* Report collated by HR Business Partner. * Improvement plan led by AMD / ACOO. * Compliance monitored at Divisional Board / Divisional Governance Meetings. * Reviewed at Divisional Workforce Meeting * Reported via Performance Review Meetings.
2905	07/04/2021	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW	There is a risk that the following areas may not be able to receive essential supply of electricity in the event of a power failure due the age of generator (1979). This will affect clinical procedures and potential persons within the lifts becoming trapped, therefore directly affecting patient safety. - Ramp Plant Room (Med Gas Compressors +) - Theatre Plant Room (All Theatres) - Lifts - I.T and I.T Server - X-RAY - Theatres - Pathology If this risk materialises, the hospital would need to close	James Lewis	Simon Tighe	Diana, Princess Of Wales Hospi	Estates and Facilities	16	27/01/2023	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	Minor and major equipment services logged in compliance folders.

2949	26/07/2021	25/07/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Oncology Service	As part of the ongoing Oncology HASR work, a joint risk register has been created to capture all potential risks and their mitigating actions. The below are jointly reviewed at the weekly NLaG & HuTH Oncology meeting: 1)HUTH's consultant base is currently running at around 75-80% of the established workforce due to absences both related and unrelated to Covid19, and consultants leaving the organisation. There has also been a reduction in middle grades, as 2 Specialty Doctors have left. 2)Increased patient numbers, with a lesser staffed service may result in consultants and CNSs being under additional pressure, resulting in them leaving, or being off on long term sick with stress. There is also pressure due to increased workload on the administrative services. 3)The Trust are currently in the midst of the third spike of Covid19, and have over 200 inpatients, including some in the QCOH wards. We are now under national lockdown, enshrined in law, similar to that in March 2020. 4)NLaG Waiting times for Oncology patients are longer than expected due to absence of Consultant Oncologists at HUTH. Concerns escalated by Surgery Division at NLaG regarding Urology Cancer waiting times and delays to treatment of patients. 5)NLaG Matron has flagged as a serious risk, that inpatient chemotherapy can no longer be delivered on Amethyst due to a shortage of chemotherapy nurses at DPoW and difficulties in training new chemotherapy nurses. 6)A reduction in Band 5 chemotherapy nursing workforce on the nurse led chemo day unit at Scunthorpe General Hospital, and difficulty in recruitment of chemotherapy trained nurses. Unable to provide cross site cover from DPOW.	Rhiannon Wilson	Jill Mill	Trustwide - All Sites (DPoW, S	Directorate of Operations	20	02/12/2022	1)Currently looking for locum consultants to back fill some of the work, and a locum SpD has been secured, starting week commencing 30/11/2020. Interviewing for a further 5 SpDs. 2)Ongoing work around the management of clinics including clinic redesign, telephone clinic management, practitioner support, adequate time slots etc. Support offered to all staff from management. 3)Covid19 steering group in place, with CSS Health Group and SS Division input into command structure. 7no. Covid19 + beds still in place on C30 and position monitored closely to establish requirements into the future. 4)Liaison between HUTH and NLaG Senior Management Leads to ensure oversight of the waiting times and actions to mitigate avoidable delays. Plan is to develop a single joint activity / waiting times report wihc 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	04/08/2021	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide	There is the risk of failure of Electrical and/or mechanical LV components which could cause power interruptions to key areas. The impact of such failure is for clinical departments to experience reduced capacity or ability to treat and/or carry out diagnostic investigations on patients, leading to possible harm.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	20	27/01/2023	Monitoring switch gear regularly to ensure the situation is not deteriorating.	Lack of annual switching. Ensure operational areas understand the business continuity plan in the event this risk occurs. Lack of funding to replace LV infra.	Periodic inspections carried out annually. Thermal monitoring to identify hotspots carried out annually. Electrical safety group. LV audits undertaken by AE
2952	04/08/2021	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	16	27/01/2023	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.		Hydrop defect portal giving real time data on progress of defects. Risk assessments. Good circulation temperature L8Guard electronic return management system. Authorised Engineer report. Water sampling results. Water Safety Group Minutes. Finance, &Performance Committee Highlight report to Board. Maintenance to TMV are carried out
2953	04/08/2021	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety Compliance: Sensor taps - Trustwide	Due to the installation of sensor taps and the inability to flush for the required time period, there is the risk of legionella which could impact on the health of the building occupants (patients/staff).	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	16	27/01/2023	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.		
2954	04/08/2021	31/12/2022	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Asbestos; Risk of exposure to asbestos - Trustwide	Control of Asbestos Regulations 2012: Gap Analysis demonstrates large areas of SGH Site are current not surveyed. Therefore there is a significant risk to Patients and Staff that Asbestos containing material could be disturbed, thus Asbestos fibres could be released into a patient or work environment, resulting in an immediate closure of the affected space and a RIDDOR notification to be raised to the HSE.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	15	27/01/2023	-Currently, there are some Asbestos Management Surveys dated 2005 & 2008 respectively; there is also additional site information available within the Asbestos Management folder located on the H drive in the following location. H:\Estates and Facilities\Estates and Capital\Estates Operational Compliance\Asbestos (SH5)\SGH Log Book	-Gap Analysis carried out in June / July 2020 demonstrates SGH has having 95 areas requiring a suitable & sufficient Asbestos Management Survey to be in place and available. This is a requirement under Regulation 4 of Control of Asbestos Regulation 2012. -The gap analysis identifies SGH has 23 folders covering areas where Asbestos Management Plans have been conducted prior to the change of regulations in 2012. These type 2 surveys do not reference all areas asbestos containing material Information and therefore cannot be considered suitable or sufficient.	-Asbestos Training Records -Control of Asbestos Policy DCP 170 -Control of Contractors Policy DCP 220 -Permit to work Policy DCP 221
2955	04/08/2021	23/12/2022	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide	There is the risk of failure of the oxygen delivery system if the demand exceeds design capacity, which could result in loss of oxygen supply to patients causing the Trust to divert patients to neighbouring hospitals.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	15	02/02/2023	Daily monitoring of the oxygen consumption.		Medical Gas Policy DCP026 Medical Gas AP Staff Training Medical Gas Committee Health and Safety Committee Enhanced Med Gas AP provision CAS/DINs/NeDERs Med Gas AE support NHSEI support
2959	02/12/2022	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Replacement/Repairs of flat roof - Trustwide	There is the risk of failure of flat roofs across the sites. A number of roofs have failed across the site, one resulting in the immediate evacuation of the ITU department. Another resulted in a section of masonry coming away which had the potential to cause serious harm or even death to a member of staff, the public or a patient.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	16	27/01/2023	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.	
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.	Jane Warner	Preeti Gandhi	Trustwide - All Sites (DPoW, S	Directorate of Operations	16	05/02/2023	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	Nico Batinica	Trustwide - All Sites (DPoW, S	People and Organisatio nal Effe	25	02/02/2022	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	16	11/02/2023	There are disabled toilet facilities within the Trust	Complaints by members of the public and patients attending the outpatient department	
3015	01/02/2022	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Staffing Levels & HR	Insufficient estate resources to manage the workload demand	Due to an underestimation of the impact of current major capital projects on the estates team, there is a high risk that the Estates team will fail to deliver service level compliance, statutory requirements, and provide an environment that is fit for purpose. Compounding the risk is the limited (11 personnel) number of staff holding the duties of an Authorised Person (AP) for specialist engineering fields. This is intensified by the inability of the internal project team to recruit to technical roles to support the clinical schemes, Additionally, there has been an increase in claims being lodged in relation to areas where slips, trips and falls and statutory compliance is not being met. The impact to the Trust if not actioned;I Inability to meet statutory compliance, leading to potential prosecution for statutory non-compliance Lack of Engineer resource to complete mandatory work and project works Ineffective management of Pre-Planned Maintenance Ineffective management of water systems due to shortage of water APs (SGH) Inability to complete emergency testing across main estates disciplines (electrical system emergency testing, ventilation multi-disciplinary emergency testing) Ineffective management of the estates leading to reactive maintenance (firefighting) Inability to implement proactive management systems (MICAD helpdesk) Impact to patient safety Loss of workforce due to on-going work pressure and employee market shortage (supply/demand) Reduced staff morale Inability to support wider project delivery Further degradation and serious incidents within the estates Loss of financial resources due to settlement of claims (majority of claims are under the excess levels so Trust would pay full cost) Increase in overall BLM value (6 facet survey) due to limited resourcing levels in FY 2/22 & 22/23	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	20	27/01/2023	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 . Patient safety issues are delivered at cost pressure or delayed - dependant on the identified risk Until the volume of capital projects has abated, this risk will remain prevalent. This risk is expected to remain extant until completion of the ED/AAU schemes, at present this is mid 2023.	Internal policies and procedures in place
3031	26/07/2022	31/08/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Children's Diabetic Team DPoW	There is a risk that the diabetes service in DPOW will not be able to operate fully as a result of long term sickness and performance issues which may lead to parents having a lack of confidence of the service, not meeting best practice tariff, not addressing the educational needs of the ward staff (nursing and medical) and developing the service going forward eg transition to adults.	Vikki McAlpine	Debora h Bray	Diana, Princess Of Wales Hospi	Directorate of Operations	16	04/02/2023	Supporting staff to return to work with HR support	Staff member not currently at work, work related stress due to escalation of performance concerns. Working through LTS reviews, with HR and unions	
3036	17/03/2022	30/06/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS	There is a risk to patient safety, quality of care and patient experience due to delayed admission to ward beds due to challenges with patient flow throughout the Trust.	Simon Buckley	Anwer Qureshi	Trustwide - All Sites (DPoW, S	Directorate of Operations	16	03/02/2023	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	11/05/2022	30/08/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Medical Workforce Vacancies in Gastroenterology	Following departure of 2 consultants in Gastroenterology there is insufficient workforce to deliver the range of services. Resulting in: - Failure to meet constitutional targets (RTT &Cancer) - Delays in patients being seen both as inpatient & outpatients - Increased waiting times - Increase LOS - Failure to fulfil emergency GI Bleed Rota - Lack of training and supervision	Philip McGlone	Simone Woods	Trustwide - All Sites (DPoW, S	Directorate of Operations	16	11/01/2023	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.		
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	16	05/02/2023	Actively trying to recruit more clinicians through networks		
3063	29/06/2022	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Operational	Doctors Vacancies within Medicine Division	1.lack of substantive practitioners as a result of difficulties recruiting may lead to patient safety issues (lack of continuation of care due to the number of locums who may choose the leave at any time). 2. an increased financial burden for the Trust due to higher costs for locums (circa double the cost of Consultants on Trust contract). 3. There are fluctuating but significant number of vacancy posts required in Medicine	Sarah Smyth	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	16	18/01/2023	weekly workforce panel workforce SMT specialty business meetings review and oversight if data	development of specialty workforce plans	workforce panel workforce SMT Div Board workforce improvement plan

3074	29/06/2022	31/12/2022	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value	Financial	Financial Risk - Medicine CIP 2022/23	Non delivery of divisional financial objectives for financial year 2022/2023.	Darren Marshall	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	16	14/01/2023	General budgetary Financial Management - Includes reporting, variance analysis and actions / recommendations.		
3095	14/07/2022	15/07/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Information Technology	Data Safety Risk - Delay to Patient Testing (DartOCM)	There is a risk that DART OCM (sample requesting and reporting software) will fail due to the age of the hardware which is now over 15 years old. Additionally, the Windows Server 2008 operating system is no longer supported and poses a data safety risk as no security updates are available making the system more prone to hacking and cyber-attacks. The server is already showing signs of obsolescence with frequent crashes and system errors increasing reliance on manual processes. These processes are described in the business continuity plans however they have not been tested for prolonged outages as posed by the current set up and have inherent risk such as transcription errors increasing patient safety risks. Should the server fail the electronic requesting of pathology test for GP surgeries across all Lincolnshire and Northern Lincolnshire CCGs would be unavailable. Radiology and Pathology acute result communication back to all GP surgeries using Dart would also fail. Given the equipment service provider has reduced the level of support cover to best endeavours and can no longer guarantee support or repair, any failure poses a risk of significantly delay to patient diagnostics and treatment.	Benjamin Francis	Ian Storr	Trustwide - All Sites (DPoW, S	Directorate of Operations	16	06/10/2022	A meeting has been convened Chaired by the Path Links' Director to support interim measures and risk management to monitor effectiveness of actions.	Provider has recently been subject to buyout resulting in loss of skills to support the aging system. As such the system is becoming more reliant on in house solutions from NLG and Path Links IT teams, such as SQL database maintenance. Whilst the team follow the trusts change control policy the supplier change control processes may not be applied.	Path Links risks are reviewed monthly at PLMB / OMG and included on the QMS KPI monitoring report for oversight.
3145	28/12/2022	30/06/2023	To provide care which is as safe, effective, accessible and timely as possible	Equipment	Aging and Damaged ENT Theatre Kit Trustwide	There is a risk that patients on 31/62 and routine pathways are being cancelled due to lack of equipment suitable for the procedures. In addition, our theatre productivity is restricted due to inability to date multiple procedures Trustwide.	Kirsty Harris	Kirsty Harris	Trustwide - All Sites (DPoW, S	Directorate of Operations	16	29/01/2023	Monitoring theatre lists through theatre planning to prevent on the day cancellations	Should equipment fail, patients would need to be cancelled. Due to limitation of piece of equipment available, operations can only take place on one site at a time, again causing patients to be cancelled last minute if lists are not appropriately booked.	

NLG(22)026

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	7 February 2023	
Director Lead	Dr Peter Reading, Chief Executive	
Contact Officer/Author	Dr Peter Reading, Chief Executive	
Title of the Report	**Trust Management Board Terms of Reference**	
Purpose of the Report and Executive Summary (to include recommendations)	The Trust Board is asked to approve two minor revisions to the Trust Management Board's (TMB) Terms of Reference previously presented in August 2022. The first change is the amendment to the job title of the Medical Director to Chief Medical Officer in Section 5; and the second amendment is the addition of the Director of Pathology (Path Links) to the Attendees (Non-Voting) Section at point 7.1 after last year's Divisional restructure and reporting change, to ensure Path Links' continued representation at TMB.	
Background Information and/or Supporting Document(s) (if applicable)	Not applicable.	
Prior Approval Process	✓ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5 ✓ Not applicable
Financial implication(s) (if applicable)	None.	
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, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
1.2	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.
1.3	To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term. Risk to Strategic Objective: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.
1.4	To offer care in estate and with engineering equipment which meets the highest modern standards. Risk to Strategic Objective: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.
1.5	To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible. Risk to Strategic Objective: The risk that the Trust's digital infrastructure (or the inadequacy of it) may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources, and/or make the Trust vulnerable to data losses or data security breaches.
1.6	To provide treatment, care and support which is as safe, clinically effective, and timely as possible. Risk to Strategic Objective: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).
2.	**To be a good employer**
2.	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations. Risk to Strategic Objective: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.
3.	**To live within our means**
3.1	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP. Risk to Strategic Objective: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.
3.2	To secure adequate capital investment for the needs of the Trust and its patients. Risk to Strategic Objective: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate to make it fit for purpose for the coming decades.
4.	**To work more collaboratively**
4.	To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan. Risk to Strategic Objective: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.
5.	**To provide good leadership**
5.	To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible. Risk to Strategic Objective: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

Northern Lincolnshire and Goole NHS Foundation Trust

Chief Executive's Office

Trust Management Board (TMB)

Membership and Terms of Reference

Reference:	DCT182
Version:	3.0
This version issued:	25 January 2023
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	TMB 20 June 2022 / Trust Board 2 August 2022 / TMB 21 November 2022
Approving body:	Trust Management Board / Trust Board
Date for next review:	June 2023
Owner:	Peter Reading, Chief Executive
Document type:	Terms of Reference
Number of pages:	7 (including front sheet)
Authors / Contacts:	Helen Harris, Director of Corporate Governance and Heidi Forster, Personal Assistant to the Chief Executive

Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

1.0 Constitution

1.1 To be the senior operational decision making body of the Trust, determining or overseeing the determination of key operational policies, business cases, and decisions which need to be made at Trust level, but which are not matters reserved for decision by the Trust's Board of Directors.

1.2 To manage the clinical, operational and financial performance of the Trust on behalf of the Trust's Board of Directors, so that the Trust achieves the objectives set for it by the Board of Directors, by its regulators and by its commissioners, and meets (so far as is possible) the expectations of its other stakeholders.

1.3 To manage on behalf of the Trust's Board of Directors the development and delivery of the Trust's overall strategy and all its supporting and enabling strategies. This will include ensuring that there is appropriate integration, co-ordination and cooperation - between individual clinical services; between clinical and corporate functions; and with the Trust's key stakeholders and partners.

1.4 To support individual Executive and Divisional Medical Directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support, resolution of issues, and achievement of agreement between Trust Management Board (TMB) members.

1.5 To assure the Trust's Board of Directors that, where there are issues and risks that may jeopardise the Trust's ability to deliver its objectives, these are being managed in a controlled way with the interests of patients and tax-payers are the heart of decision-making.

1.6 To be the senior formal committee of the Trust through which all other committees (except committees and sub committees of the Trust's Board of Directors) report (directly or indirectly). The groups reporting into TMB are:

- Quality Governance Group
- Risk Management Group
- Digital Strategy Board
- Business Case Review Group
- Capital Investment Board
- Nursing and Midwifery Board
- Operational Management Group
- Emergency Planning and Business Continuity
- Divisional Board Meetings – Medicine, Surgery, Family Services and Community and Therapies
- Medical Education Committee
- Health, Safety and Fire Group
- JNCC
- JLNC
- Job Planning Committee (from June 2022)

1.6.1 The Chairs' of the above groups will be required to submit a highlight report to TMB. TMB reserves the right to request the Chair(s) of a group(s) to attend on an ad hoc basis.

2.0 Authority

2.1 TMB is authorised by the Trust's Board of Directors to manage the clinical, operational and financial activities and performance of the Trust within the overall Scheme of Delegation and subject to adequate reporting to the Board and its assurance committees.

2.2 TMB is authorised by the Trust's Board of Directors to develop and deliver the Trust's strategy and supporting enabling strategies, subject to those strategies being approved by the Board and subject to adequate reporting to the Board on their delivery.

3.0 Accountability and Reporting Arrangements

3.1 TMB is accountable through the Chief Executive to the Trust Board. Where required, reporting from the TMB will be to the Trust Board.

3.2 The Chair of TMB (the Chief Executive) has the overall responsibility for the performance of TMB and also has the final decision on actions required in order to comply with the Terms of Reference, or where a potential conflict may arise with the Trust's Board, or with their responsibilities as Accountable Officer.

3.3 Full members of the TMB may be invited to vote on matters on which consensus cannot be achieved or to give an indication of where differences of opinion lie, but any such vote is advisory to the Chief Executive and not binding. Votes will be recorded in the minutes, including the votes of individual TMB members.

3.4 The Chair of TMB shall prepare a summary report to the Trust Board detailing items discussed, actions agreed and issues to be referred to the Trust Board.

3.5 The minutes of the meetings shall be formally recorded and presented to the Trust Board.

3.6 TMB shall refer to the Trust Board any issues of concern it has regarding any lack of assurance in respect of any aspect of the running of the TMB.

3.7 Where the Chair of the TMB considers appropriate, they will escalate immediately any significant issue to the Trust Board.

4.0 Responsibilities

4.1 To develop and agree objectives for submission to the Trust Board, in the form of the Trust's Priorities and Annual Business Plan.

4.2 To deliver the agreed strategy and agree detailed capital and revenue business plans to deliver the objectives.

4.3 To ensure, where appropriate, the alignment of the Trust's strategy with the strategy of key stakeholders and other key partners.

4.4 To develop the Trust's clinical and non-clinical service strategies, ensuring co-ordination and alignment across the clinical divisions and corporate directorates.

4.5 To develop, agree and monitor implementation of plans to improve the efficiency, effectiveness and quality of the Trust's services.

4.6 To monitor and manage standards of care, quality and safety, ensuring appropriate actions are taken where necessary to maintain and improve these.

4.7 To identify and mitigate risk by monitoring the corporate risk register and board assurance framework, agree resourced action plans, and ensure their delivery, compliance and appropriate escalation in accordance with the Trust's risk management systems and processes.

4.8 To monitor the delivery of the Trust's service activity and financial objectives and agree actions, allocate responsibilities, and ensure delivery where necessary to deliver the Trust's objectives or other obligations.

4.9 To monitor and ensure the delivery of all specific actions agreed by the Trust Board, the TMB and by committees of both.

4.10 To devise the Trust's annual and longer term capital programme, submit to Trust Board for approval and monitor its delivery.

4.11 To oversee the agreement of all relevant policies (principally through sub groups) – other than those retained by the Trust Board - to ensure the delivery of external and internal governance, compliance and best practice requirements.

4.12 To commit resources, subject to approved business case(s), as detailed in the Trust's Scheme of Delegation.

4.13 To approve the Terms of Reference for all the sub committees and groups of the Committee, delegate work as appropriate and hold the respective Chairs to account.

5.0 Core Membership

TMB will include the following members:

- Chief Executive (Chair)
- All Executive Directors (voting and non-voting Trust Board members):
  - Chief Nurse
  - Chief Operating Officer
  - ~~Medical Director~~ Chief Medical Officer
  - Joint Chief Financial Officer
  - Joint Chief Information Officer
  - Director of Estates and Facilities
  - Director of People
  - Director of Strategic Development
- Divisional Medical Directors for Family Services, Surgery and Critical Care, Community and Therapies, and Medicine (joint)

6.0 Responsibility of Members

6.1 Members of the TMB have a responsibility to:

- Attend at least 80% of meetings, having read any papers in advance.
- Identify agenda items for consideration to the Chair/administrator at least five working days before the meeting. The Chair of TMB will have discretion whether to accept items submitted later than this.
- Prepare and submit papers for the meeting, using the Trust's agreed template, at least three working days before the meeting.

7.0 Attendees (Non-Voting)

7.1 Chairs of HCC and MAC, the Director of PGME, Chief Pharmacist, Director of Corporate Governance, the Associate Director of Communications and Engagement, and the Director of Pathology (Path Links).

7.2 In exceptional circumstances, deputies may be nominated to attend prior to the meeting, with the Chair's approval.

7.3 The Chair of the TMB may also extend invitations to other staff (or representatives of outside organisations) with relevant skills, experience or expertise as necessary to deal with the business on the agenda. Such staff will be in attendance and will have no voting rights and should only attend for the item for which they have been invited.

7.4 The Chair of the TMB may also invite other individuals to attend as observers from time to time (eg as part of their induction or development, or as part of external review or scrutiny).

8.0 Procedural Issues

8.1 Frequency of Meetings

8.1.1 Meetings will be held as a minimum on a monthly basis. Two meetings will normally take place per month (typically in the first and third weeks).

8.1.2 The business of each meeting will normally be transacted within a maximum of two hours.

8.2 Chairperson

8.2.1 The Chair of the TMB is the Chief Executive.

8.2.2 If the Chair is not present, then the Chair will nominate an Executive Director to chair the meeting in their place.

8.3 Secretary

The Personal Assistant (PA) to the Chief Executive (or if they are on leave, another Executive Director's PA) will act as secretary to the meeting and will be responsible for:

- Ensuring correct and formal minutes are taken, and distributing minutes.
- Keeping a record of matters arising and issues to be carried forward.
- Providing appropriate administrative support to the Chair and TMB members.
- Agreeing the agenda with the Chief Executive prior to sending the agenda and papers to members, no later than three working days before the meeting.

8.4 Quorum

8.4.1 A quorum will normally be seven members in attendance. Of these members:

- At least three must be Executive Directors, of whom at least two must be voting Trust Board members and one must be the Chief Operating Officer or the Medical Director or the Chief Nurse; and

- At least two must be Divisional Medical Directors from two separate Divisions.

8.4.2 When considering if the meeting is quorate, only those individuals who are members (or their deputies) can be counted, attendees cannot be considered as contributing to the quorum.

9.0 Decision Making

9.1 Wherever possible members of the TMB will seek to make decisions and recommendations based on consensus.

9.2 Full members of the TMB may be invited to vote on matters on which consensus cannot be achieved or to give an indication of where differences of opinion lie, but any such vote is advisory to the Chief Executive and not binding. Votes will be recorded in the minutes, including the votes of individual TMB members.

9.3 In the event of a formal vote, the Chair will clarify what members are being asked to vote on – the 'motion'. Subject to the meeting being quorate, a simple majority of members present will prevail. In the event of a tied vote, the Chair of the meeting may have a second and deciding vote.

9.4 Only the members of the TMB (or their deputies) present at the meeting will be eligible to vote. Members not present and attendees will not be permitted to vote, nor will proxy voting be permitted. The outcome of the vote, including the details of those members who voted in favour or against the motion and those who abstained, shall be recorded in the minutes of the meeting.

10.0 Review

The Terms of Reference will be reviewed annually, with recommendations on changes submitted to the Trust's Board of Directors for approval.

11.0 Equality Act (2010)

11.1 Northern Lincolnshire and Goole NHS Foundation Trust is committed to promoting a proactive and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

11.2 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.

11.3 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.

11.4 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).

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	7 February 2023
Director Lead	Lee Bond, Chief Financial Officer
Contact Officer/Author	Edd James, Director of Procurement
Title of the Report	**Establishment of a Shared Procurement Collaborative**
Purpose of the Report and Executive Summary (to include recommendations)	This business case is requesting investment to establish a collaborative shared procurement service, across Humber & North Yorkshire. Initially this will be for three acute provider organisations but the design is such to allow other partners to join later. The recommendation is that the existing three Trust procurement teams are centralised under a single management function which is hosted by HUTH. HUTH will become responsible for all Procurement pay and non-pay budgets, will act as the contracting authority for all future collaborative contracts and will manage the purchase to pay process, raising all purchase orders and paying all supplier invoices. Costs will be recharged back to the other Partner Trusts on a regular basis so there is no impact to HUTH's annual accounts. Individuals will not be TUPE'd to HUTH but all vacancies will be transferred and new recruitment activity will be undertaken by HUTH. The Trust Board are requested to support approval of the business case following prior approval at Trust Management Board on 23rd January 2023.
Background Information and/or Supporting Document(s) (if applicable)	Procurement is currently decentralised with each acute Trust having its own team who procure independently. Across the three trusts there is a non-pay spend of over £1bn, £538m of which is addressable by Procurement. In total we work with over 7,200 suppliers the majority of which we spend small amounts with. Procurement is administratively heavy and currently does not add the level of strategic value it could to any of the three trusts. In 2022 the three trusts appointed a joint Director of Procurement. This business case is the recommendation to now bring the Procurement teams together under a single management structure, increasing their strategic impact and delivering financial benefit for the three trusts.
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 live within our means:** ✓ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ✓ 4 **To provide good leadership:** ✓ 5

	To be a good employer: ✓ 2 ☐ Not applicable
Financial implication(s) (if applicable)	The additional investment is being split equally between the three Partner Trusts and as such each Trust is being asked to invest: • Pay Expenditure – £253,436 • Non-Pay Expenditure – £110,108 • Capital Investment – £44,300 The investment will deliver: • Procurement Business Partners linked to each care group; • Clinical Procurement Specialists linked to each Partner Trust; • Dedicated resource for Contract Management and Supplier Relationship Management; • Data Analysts; • An expanded Materials Management service releasing clinical time spent putting stock away and ordering stock; • A single Inventory Management system across all Partner Trusts which aligns to the Scan for Safety programme; • A single ordering system and catalogue across all Partner Trusts standardising the prices paid for goods and maximising our collective buying power; • Investment into the training and development of our staff. A £5.8m investment over 5 years, will yield a net benefit of £90.6m, representing a 15.9:1 return. This is a significant improvement on the existing ROI of 0.59:1. Inflation is the biggest risk to achieving cash releasing savings, however, costs will be even higher without procurement negotiating inflationary pressures. Without any change in practice we have already identified £1.1m in saving opportunities: • Through buying as one rather than separate organisations we can save £287k through NHS Supply Chain by having greater demand. • Through standardising our catalogue and buying at the lowest price paid across the three trusts we can save £254k on 1% of the catalogue alone. • By moving additional demand to NHS Supply Chain rather than buying directly from the supplier we can save £122k in 2 of the 3 trusts. • By implementing lodge cards with our top 10 invoicing suppliers we can save £79k and generate an income of £358k.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Positive improvements will be made through procurement and contracting.
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ 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

Humber & North Yorkshire
Health & Care Partnership
Procurement Collaborative

HUMBER & NORTH YORKSHIRE PROCUREMENT COLLABORATIVE

Business Case for the establishment of a shared procurement collaborative

Version 1.5
February 2023

Contents

Document History

Version No.	Implemented by	Organisation	Revision date	Approved by	Approval date	Description of change
0.1	Edward James	Humber & North Yorkshire Procurement Collaborative	17/03/2022	n/a	n/a	First draft
0.2	Edward James	Humber & North Yorkshire Procurement Collaborative	12/10/2022	n/a	n/a	Incorporating comments from L Bond and A Bertram
0.3	Edward James	Humber & North Yorkshire Procurement Collaborative	28/10/2022	n/a	n/a	Updated recommended structure following Procurement Board 26/10/22.
1.0	Edward James	Humber & North Yorkshire Procurement Collaborative	01/12/2022	Procurement Board	01/12/2022	Version updated to reflect approval at Procurement Board.
1.1	Edward James	Humber & North Yorkshire Procurement Collaborative	19/12/2022	HUTH Performance & Finance Committee	19/12/2022	Approval from HUTH Performance & Finance Committee
1.2	Edward James	Humber & North Yorkshire Procurement Collaborative	23/12/2022	n/a	n/a	Including comments from YSTH Business Case Panel
1.3	Edward James	Humber & North Yorkshire Procurement Collaborative	16/01/2023	Collaborative of Acute Providers	16/01/2023	Approval from Collaborative of Acute Providers
1.4	Edward James	Humber & North Yorkshire Procurement Collaborative	23/01/2023	NLAG Trust Management Board	23/01/2023	Approval from NLAG Trust Management Board
1.5	Edward James	Humber & North Yorkshire Procurement Collaborative	25/01/2023	HUTH Productivity & Efficiency Board	25/01/2023	Approval from HUTH Productivity & Efficiency Board

List of Figures

List of Abbreviations

Abbreviation	Full Text
AP	Accounts Payable
BAU	Business as usual
CCF	Central Commercial Function
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CIC	Community Interest Company
DHSC	Department of Health & Social Care
DoP	Director of Procurement
DPOW	Diana Princess of Wales
EBME	Electrical and Bio-Medical Engineering
EDI	Electronic Data Interchange
ENT	Ear Nose and Throat
ERP	Enterprise Resource Planning
FTE	Full Time Equivalent
HMRC	Her Majesty's Revenue & Customs
HNY	Humber & North Yorkshire
HNYICS	Humber & North Yorkshire Integrated Care System
HNYPC	Humber & North Yorkshire Procurement Collaborative
HoP	Head of Procurement
HR	Human Resources
HRI	Hull Royal Infirmary
HUTH	Hull University Teaching Hospital
ICB	Integrated Care Board
ICS	Integrated Care System
IM&T	Information Management & Technology
IT	Information Technology
JCT	Joint Contracts Tribunal
KPI	Key Performance Indicator
MCIPS	Member of the Chartered Institute of Procurement & Supply
MoU	Memorandum of Understanding
MPC	Manufacturers Product Code
NEC	New Engineering Contract
NHS	National Health Service
NHSEI	NHS England & Improvement
NHSSC	NHS Supply Chain
NICU	Neonatal Intensive Care Unit
NLAG	Northern Lincolnshire & Goole
NOECPC	North of England Commercial Procurement Collaborative
P2P	Purchase to Pay
PCR	Public Contract Regulations 2015
PEPPOL	Pan-European Public Procurement Online

Abbreviation	Full Text
PO	Purchase Order
PPE	Personal Protective Equipment
PPN	Procurement Policy Note
PTOM	Procurement Target Operating Model
ROI	Return on Investment
SCCL	Supply Chain Coordination Limited
SCS	Spend Comparison Service
SDCS	Strategic Data Collection Service
SFI	Standing Financial Instructions
SGH	Scunthorpe General Hospital
SME	Small & Medium Enterprise
SO	Standing Orders
SRM	Supplier Relationship Management
STA	Single Tender Action
STP	Sustainability & Transformation Partnership
VAT	Value Added Tax
WAU	Weighted Activity Unit
YSTH	York & Scarborough Teaching Hospitals

Foreword

I am delighted to see the progress made by Humber and North Yorkshire Procurement Collaborative (HNYPC) and commend Hull University Teaching Hospitals NHS Trust, Northern Lincolnshire & Goole NHS Foundation Trust and York & Scarborough Teaching Hospitals NHS Foundation Trust for their leadership and commitment to drive transformational change in commercial activity across their ICS.

I fully endorse the collaborative approach set out in the business case which aligns with our national objectives of the NHS Central Commercial Function to reduce unwarranted variation, leverage NHS buying power and deliver value for money for patients and the taxpayer.

It is clear the HNYPC leadership team have worked together with persistence and pace to engage with stakeholders and their approach has empowered all staff involved to embrace the challenges ahead. I look forward to seeing the sustainable benefits the shared service can bring to improve patient pathways and outcomes and deliver best in class commercial services for the Trusts.

We should be proud that the NHS already spends public money wisely and is one of the most efficient health services in the world, spending 2p in the pound on administration. However, we know we still need to go further and do more to ensure we are using our resources more effectively.

I hope ICSs across the country follow the excellent example of this programme as a blueprint for how to do that and to demonstrate how corporate and support services can be structured to enable greater collaboration.

Jacqui Rock
Chief Commercial Officer, NHS England

1. Executive Summary

1.1 The Opportunity

This business case is requesting investment to establish a collaborative shared procurement service, across Humber & North Yorkshire. Initially this will be for three acute provider organisations but the design is such to allow other partners to join later. The organisations currently engaged are Hull University Teaching Hospitals NHS Trust (HUTH), Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) and York & Scarborough Teaching Hospitals NHS Foundation Trust (YSTH). The case is for the consolidation of the three procurement functions into a single shared service. There will be in all cases a visible, local presence retained in all organisations.

The NHS spends around £15 billion on non-medical goods and services encompassing food, digital infrastructure, workforce, estates and transport from around 80,000 suppliers. Procurement is de-centralised and undertaken by individual NHS trusts. Although some collaboration between NHS trusts exists, this is unstructured and informal with each Trust deciding when and if it participates.

Various reviews of NHS Procurement have been undertaken which all identify greater collaboration as an opportunity to improve value for the tax-payer as well as better clinical outcomes through the standardisation of products used in clinical settings. In a time of reducing funding and increasing expectations from our patients, commissioners and tax payers, it is more important than ever that we are able to maximise benefit from procurement and commercial arrangements.

As part of the NHS blueprint and moving to Integrated Care Systems (ICSs) procurement is a specific workstream established to improve the way in which NHS procurement is undertaken. These national procurement initiatives play an increasingly important role in the drive for efficiencies and trusts need to have the governance in place to utilise ICS procurement to its full potential and maximise benefit.

In response to this HUTH, NLAG and YSTH have decided to appoint a single Procurement Director and to centralise the procurement function under a single management structure hosted by HUTH. The three trusts are the Partner Trusts of the new procurement collaborative, Humber & North Yorkshire Procurement Collaborative (HNYPC).

Obtaining a single version of the truth on Partner Trust expenditure which should be managed by a procurement function has proved incredibly difficult. For the purpose of evaluating expenditure to inform this business case accounts payable data for the calendar year 2021 has been used as this is broken down to line level detail allowing interrogation. This data identifies that the three Partner Trusts have a non-pay spend of £1bn, £538m of which is classified as addressable by Procurement, non-addressable spend includes: drug expenditure which is out of scope, NHS to NHS payments and rent and rates. 41% of the addressable expenditure is with the top 10 suppliers and 60% of addressable spend is covered by contract. 87% of the suppliers used have an expenditure of less than £100k and 60% less than £10k. There is significant opportunity for consolidating the supplier base, especially as HUTH and NLAG pay a fee for invoice transactions. In total 161,576 invoices were processed, 53% of which cost £2.30 to process, rather than the lower cost of £0.50.

National Model Hospital data has shown the lack of investment in procurement and the transactional and administrative nature of the function. Across the three Partner

Trusts procurement is the second lowest invested back-office function on both pay and non-pay budgets. Less than 1% of non-pay spend is invested into procurements pay spend and 0.05% in the non-pay spend budget. On average across Partner Trusts, back office functions have 1.86% of non-pay spend invested and 0.39% on their pay budget. This produces one of the biggest challenges with the current structure as over 65% of the Procurement function are band 4 or below. With investment in training and development well below the national average - £98 per person per year against a national average of £216 per person per year.

Across the three Partner Trusts there are 3,008 contracts managed by procurement, 37% of the contracts held have expired and almost 50% of all contracts held on the work plan are flagged for renewal in 2022/23. Of the 3,008 contracts, 35 contracts don't have end dates, 145 are with unknown suppliers and 332 have an unknown contract value.

There is also an opportunity to improve stock management. Model Hospital Data shows that the national peer average for stock holding is 36.1 days of static stock. HUTH performs well, reporting 30.8 whereas YSTH (67.2) and NLAG (69.1) sit significantly higher. A reduction in stockholding would reduce the risk of stock obsolescence and deliver a one-off cash benefit. The Scan for Safety programme at HUTH has been rolled out in a quarter of all clinical areas and has identified £143k of expired stock with a further £80k of stock expiring in the next 3 months. Better stock management would reduce wastage through expired stock and give better visibility of where short dated stock sits across the system.

Each department has differing strengths and weaknesses depending on where and how the current resource is deployed. There is a need for a more holistic commercial culture around procurement and supply chain activity in the NHS in general and the shared service model provides the scale for this to be achieved locally whilst retaining the connectivity to the individual organisations.

The proposed structure will create Procurement Business Partners, Clinical Procurement Specialists, Data Analysts and expand the Materials Management offering, staff who will engage with customers and suppliers to identify the right procurement strategies, deliver financial and non-financial benefits to the Partner Trusts and enable our staff to develop to their full capability.

Procurement is a critical function to ensure safe and efficient patient care as well as supporting financial sustainability. Over the past couple of years procurement has been expected to do a lot more by way of supporting other political objectives. Brexit has seen disruption to supply chains which have had to be managed locally with procurement staff reacting at short notice to identify clinically acceptable alternative products, ensuring clinical delivery can continue. Brexit will also see a new set of Procurement Regulations issued in 2023/24 which requires re-training all procurement staff. The pandemic also brought significant supply chain disruption and highlighted the importance of good procurement data, something the NHS lacks. Procurement is also expected to delivery other government horizontal policies such as the SME agenda and net zero. This is all at a time when the public sector is being asked to do more with less.

This business case provides the strategic direction to develop a combined service and the case for change. The case considers national guidance around procurement transformation and selects best practice to be embedded locally.

The proposed solution can be described as a single shared service, based on a common partnership approach and standardisation of processes, systems and strategy. A single Board with representation from each Partner Trust, will decide the direction of the function and agree work plans and strategy. A single senior management team will ensure consistency of service levels across all areas.

Technology and processes will be standardised, with “back-office” transactional activity consolidated and centralised. Supply chain and stock replenishment activities will have dedicated resources at each hospital site. Specialist procurement experts will be aligned to care group areas and will be responsible for the category spend across all Partner Trusts but will have a very local presence and develop close working relationships with expert stakeholders including clinicians.

In an economic environment where costs are increasing it becomes increasingly difficult for procurement to only be measured upon cash releasing savings. We need to work differently to release value, increase efficiency and to support clinical colleagues in delivering their aims and objectives. To do this, this business case suggests the adoption of value based procurement, an approach that delivers tangible, measurable financial benefit to the health system over and above a reduction in purchase price. Procurement will move closer to the customer to understand their needs and constraints and will develop procurement strategies which deliver value with our suppliers. We will make data based decisions, consider our impact on the environment, how we can use procurement to support social value and we will manage the contracts we award to ensure the value promised is delivered.

1.2 Background & Partner Trusts

In June 2022, Partner Trusts from HNYPC signed a Memorandum of Understanding which agreed to move to a fully shared procurement service.

It has been agreed that the following NHS organisations will join the collaborative as Partner Trusts:

- Hull University Teaching Hospitals NHS Trust;
- Northern Lincolnshire & Goole NHS Foundation Trust;
- York & Scarborough Teaching Hospitals NHS Foundation Trust.

Other NHS and CIC organisations within the Humber & North Yorkshire ICS region may join the Procurement Collaborative at a later date, on the agreement of the HNYPC Board. These other NHS and CIC organisations have been consulted and inputted into the development of this business case and associated policy documents.

1.3 Scope of the Procurement Service

HNYPC will be responsible for:

- Procurement – including developing category management, sourcing, contract management and supplier relationship management for revenue and capital expenditure;
- Materials Management – in accordance with current arrangements for the existing Partner Trusts being transferred into HNYPC.

The spend within scope of the procurement service, includes all non-pay expenditure other than Pharmacy medicines expenditure which is managed through the shared service agreement in place with Leeds Teaching Hospitals NHS Trust on behalf of

NHS England & Improvement's Commercial Medicines Unit. Any changes to addressable spend will be reviewed periodically and approved by HNYPC Board.

Procurement is often referred to as a procure-to-pay service however payments tend to be the responsibility of Finance. At HUTH and NLAG the payments process is outsourced to East Lancashire Financial Services and includes access to e-financials and e-procurement systems from Advanced Business Services. YSTH outsource their payments process to North East Patches and includes access to e-financials and e-procurement systems from Oracle.

1.4 Governance Structure

HNYPC will be governed through a procurement board which has executive representation from each Partner Trust. An operational delivery group within HNYPC will manage all procurement activity within the agreed procurement strategy endorsed by the Board and will report progress on a monthly basis. The HNYPC Board will report into each Partner Trust Board as and when required.

1.5 Options Considered

The following options were considered as part of the business case with option 5 being the preferred option.

Option #	Option	Description	Average 5 Year ROI	Decision
1	Business as Usual (BAU)	Maintain the procurement structures as-is under the current Partner Trusts with each procurement team providing dedicated procurement support to their own Trust.	0.59	This option is discounted on the basis it does not meet the objectives set for collaborative procurement.
2	Do Minimum (Soft Collaboration)	Maintain procurement as is in separate Partner Trusts but have a more formal arrangement around working together. This could be undertaken by adapting the MOU as to how to work together which has already been agreed by the three Partner Trusts. This could see the three Partner Trusts agree their joint work plans at the start of the year and how resource would be equally released to deliver joint procurement. It would however result in the awarding of separate contracts, therefore not delivering volume benefits.	1.64	This option is discounted on the basis it does not meet the objectives set for collaborative procurement.
3	Establish Outsourced Shared Service	Establish a separate strategic procurement function which each Trust pays into based on spend/use. The establishment of the function would be similar to the York Facilities Management LLP, whereby the shared service provides services to its members but can also attract commercial	n/a	This option is discounted on the basis that it would require special approval from NHSEI and HMRC as it would be considered a significant transaction which would require the tax treatment of such an agreement to be approved. It is not believed that this approval would be given.

		income from selling procurement services to other organisations.		
4	Single Procurement Organisation/ Separate Finances	Centralise the existing Trust procurement teams but leave the operational elements of Procurement (PO raising and invoice management) at a Partner Trust level.	2.82	This option is discounted as it does not deliver all of the efficiencies that a fully collaborative procurement function can bring.
5	Single Procurement Organisation and Finances	Centralise the existing Trust procurement teams as well as non-pay spend so only one system for PO/invoice is required for each contract awarded.	3.74	Preferred Option.
6	Join Another ICS Procurement Collaborative	Speak to other ICS Procurement collaborative organisations who may be further advanced to add HNY strategic procurement requirements to their existing structures and plans. Use the existing operational procurement workforce to manage local engagement as business managers.	n/a	This option is discounted as following discussion with NHSEI there are no other ICS procurement teams far enough advanced to be able to provide this service.
7	Outsource Procurement	Run a competition to outsource the procurement function to a standalone provider.	n/a	This option is discounted as it does not establish a commercial centre of excellence nor ensure that all staff are given the opportunity to develop.

Figure 1 – List of Options

1.6 Option 5 Investment & Benefits Summary

This business case seeks a total investment of £1,223,530 which is to be split equally between each of the three Partner Trusts:

Investment Type	Total Investment	Partner Trust Investment	Investment Delivers
Pay	£760,307	£253,436	• Procurement Business Partners linked to each care group; • Clinical Procurement Specialists linked to each Partner Trust; • Dedicated resource for Contract Management and Supplier Relationship Management; • Data Analysts; • An expanded Materials Management service releasing clinical time spent putting stock away and ordering stock.
Non-Pay	£330,322	£110,107	• A single Catalogue Management system across all Partner Trusts which standardises prices; • A single ordering system and catalogue across all Partner Trusts standardising the prices paid for goods and maximising our collective buying power; • Investment into the training and development of our staff.
Capital	£132,900	£44,300	• A single Inventory Management system across all Partner Trusts which aligns to the Scan for Safety programme; • Moves all Procurement staff onto a single IT hardware platform.

Figure 2 – Investment Ask

This investment will deliver the following benefits:

Opportunity	2023/24	2024/25	2025/26	2026/27	2027/28
Cash Releasing					
Exiting Trust Savings Plan	£2,185,806	£2,185,806	£2,185,806	£2,185,806	£2,185,806
NOECPC Rebate	£90,000.00	£90,000.00	£90,000.00	£90,000.00	£90,000.00
NHS Supply Chain Collaboration	£151,545.00	£215,772.00	£215,772.00	£215,772.00	£215,772.00
Price Standardisation	£358,005.00	£463,628.00	£633,478.00	£633,478.00	£803,328.00
Volume Savings	£3,197,060.63	£5,888,493.94	£8,579,927.26	£11,271,360.57	£13,962,793.88
Value Based Procurement	£0.00	£50,000.00	£100,000.00	£150,000.00	£200,000.00
Capital Buyer Recharge	£116,191.76	£116,191.76	£116,191.76	£116,191.76	£116,191.76
Tail Spend Management	£43,000.00	£86,000.00	£86,000.00	£86,000.00	£129,000.00
Sustainability	£52,770.00	£52,770.00	£112,000.00	£112,000.00	£112,000.00
Stock Management Improvements	£54,000.00	£100,000.00	£250,000.00	£250,000.00	£250,000.00
Cash Releasing Sub-Total	**£6,248,378.39**	**£9,248,661.70**	**£12,369,175.02**	**£15,110,608.33**	**£18,064,891.64**
Cost Avoidance					
Inflationary	£100,000.00	£150,000.00	£100,000.00	£50,000.00	£10,000.00
Contract Management	£500,000.00	£2,000,000.00	£5,000,000.00	£10,687,002.49	£10,687,002.49
Supplier Rationalisation	£100,000.00	£100,000.00	£50,000.00	£20,000.00	£10,000.00
Cost Avoidance Sub-Total	**£700,000.00**	**£2,250,000.00**	**£5,150,000.00**	**£10,757,002.49**	**£10,707,002.49**
Total Benefit	**£6,948,378.39**	**£11,498,661.70**	**£17,519,175.02**	**£25,867,610.82**	**£28,771,894.14**
Cumulative Benefit	**£6,948,378.39**	**£18,447,040.09**	**£35,966,215.11**	**£61,833,825.93**	**£90,605,720.07**
Total Cost	£4,959,296.75	£4,816,396.75	£4,816,396.75	£4,816,396.75	£4,816,396.75
Return on Investment	1.40	2.39	3.64	5.37	5.97

Figure 3 – Return on Investment

The new structure and strategy will deliver a step change in the performance of procurement, delivering financial and non-financial benefits to HNYPC Partner Trusts, whilst minimising disruption to existing services and providing continuation of local representation.

Non-financial benefits will include improved customer experience and quality of services, transparency of spend and KPI reporting, enhanced supplier performance and innovation, reduced supply chain risk, reduced transaction volume processing of purchase orders and invoices through supplier consolidation, greater focus on social value and sustainability in-turn supporting the Green Plan, improved procurement compliance and efficiencies across several other business areas that interact regularly with procurement.

Financial benefits are driven by enhanced procurement practices, including the embedding of value based procurement and more effective collaboration across HNYPC leading to a greater spend being managed at an ICS level – which will result in greater procurement savings year-on year.

The financial benefits are outlined within section 8, and a high-level financial summary is provided below:

- From £1bn of annual non-pay spend, £538m has been identified as addressable spend;
- An assessment of addressable spend across clinical and non-clinical categories identified numerous opportunities to deliver between £10.9m (option 1) and £90.6m (option 5) in aggregate savings over 5 years.

The savings forecasts were developed through analysis of the spend data, contracts, and data analysis undertaken by North of England Commercial Procurement Collaborative (NOECPC), NHS Supply Chain (NHSSC) and the current collaborative work-plan for HNYPC.

Due to the number of contracts which need to be re-procured, a 5-year timeframe is used for the financial benefits and the return on investment calculations to enable all addressable spend to be tackled, and for benefits from the transformation and saving delivery programme to fully accrue.

1.7 Decisions Required

This business case is seeking approval of the following decisions:

Decision #	Decision	Recommendation
1	The extent to which all options set out in the long list are explored in full detail.	Option 3 (outsourced shared service), option 6 (join another ICS procurement collaborative) and Option 7 (outsource procurement) should be discounted at the long list stage.
2	Host Partner Trust.	HUTH are the host Trust for Humber & North Yorkshire Procurement Collaborative.
3	HNYPC pay and non-pay costs.	All pay and non-pay costs are fully centralised to a single Partner Trust - HUTH. Additional costs are proportioned across Partner Trusts equally with budget transferred to HUTH.
4	HNYPC HR and employment.	All staff will remain employed by their existing Partner Trust and would only transfer if they applied for a new role within HNYPC. All new roles and vacant roles would be recruited by HUTH with budget adjustments made as appropriate. Each Partner Trust also retains their own HR risk around any future structure.
5	Contracting Authority and risk management.	HUTH acts as Contracting Authority however existing contracts are not novated to HUTH, it is only for future contracts. These legacy contracts would still be managed by HNYPC on behalf of each Partner Trust.
6	Non-pay spend management.	Non-pay spend is centralised to HUTH and recharged to each Partner Trust as part of a cash account ensuring no detrimental impact to HUTHs accounts. Costs to be charged at a cost centre and budget holder level so they can take ownership of all expenditure.
7	Addition of new Partner Trusts.	New Partner Trusts who choose to join HNYPC will centralise as per decisions 3-6 above with proportion recalculations happening at the start of the next financial year. Any new Partner Trust joining part way through a financial year will be charged based on the point at which they join.
8	Governance structure.	The proposed governance structure meets the needs of the Trust Board.
9	Procurement strategy.	The three-year procurement strategy is approved as meeting the needs of the Partner Trusts and is fully supported by the Trust Board.
10	Standing Financial Instructions.	The proposed changes to the Trust Standing Financial Instructions are approved by the Trust Board as providing adequate governance. Partner Trusts support a move to a no-PO, no-Pay policy, a standard set of thresholds and support that all contracts (other than those for the purchase of medicines managed by Pharmacy) have to be signed by someone within HNYPC.
11	Resource grading.	HNYPC will not align to NHSEI suggested bandings for procurement staff due to affordability and accept the risk this could lead to talent leaving HNYPC to undertake a similar role at a higher grade at another ICS. This is currently tracked on the risk register as high risk and will

		be monitored on an ongoing basis. Directors of Finance have escalated to the Director of Finance at NHS England.
12	Agile working.	To ensure HNYPC attract the best talent there will not be a requirement for HNYPC strategic procurement team to be office based. Individuals will be expected to work flexibly to deliver their aims and objectives and will be expected to be on site(s) for key meetings with stakeholders.
13	Proposed structure.	HNYPC should be structured to align with care groups and should establish Procurement Business Partners.
14	HNYPC future structure.	The preferred structure should be adopted to generate the benefits set out within business case, this includes the appointment of specific Procurement Business Partners, Clinical Procurement Specialists, Contract Managers and Data Analysts to improve the customer experience around Procurement.
15	Contract and supplier relationship management.	Contract and supplier relationship management is deployed across HNYPC to ensure the value promised during the tender process is delivered by the supplier throughout the contract period.
16	Materials management service offering.	The materials management service offering should be standardised across sites to ensure that stock management is the responsibility of HNYPC.
17	Procurement data and technology.	HNYPC should move towards standard technology and therefore be able to report data centrally in a consistent manner. National systems should be utilised even where local systems have been contracted for where the local system does not offer full functionality.
18	Benefits realisation.	HNYPC should be measured upon and report on the range of benefits delivered including, cash releasing savings, cost avoidance savings, service improvement and sustainability improvements.
19	Apportionment of savings.	All savings to be calculated back to a cost centre level, will be approved by the cost centre budget holder and link to the respective Trust resource management teams.

Figure 4 – Decision Log

1.8 Next Steps

Following endorsement of this business case by HNYPC Partner Trusts, work will commence:

- On procurement transformation supported by existing procurement teams to deliver the benefits outlined and fully embed the new strategy and organisational structure by September 2023;
- Deep dives on key supplier contracts, and specific spend areas. The work will be planned in a way that minimises, as far as possible, any disruption to existing procurement service delivery for HNYPC Partner Trusts.

1.9 Business Case Structure

The remaining parts of the business case are split into the following structure:

- Section 2 sets out the strategic case and the case for change;
- Section 3 identifies the key metrics and baseline data used to inform the options appraisal;
- Section 4 discusses the options considered as part of the business case and scores them to identify a preferred option;
- Section 5 sets out the governance structure for the preferred option;
- Section 6 proposes the resources required to deliver the preferred option and the structure they will be established in;
- Section 7 identifies the data and technology requirements to deliver the preferred option;

- Section 8 shows the benefits that can be delivered from the preferred option and the return on investment that can be expected;
- Section 9 discusses the process for change.

2. Strategic Case - The Case for Change

2.1 National Context - Procurement Target Operating Model (PTOM)

The NHS spends around £15 billion on non-medical goods and services encompassing food, digital infrastructure, workforce, estates and transport from around 80,000 suppliers. NHS England and Improvement (NHSEI) have launched the PTOM which is primarily focused on the £10bn spent on non-clinical goods and services. It aims to move NHS procurement from a local Trust level to an ICS level. This is to deliver better value for money to tax-payers, create a category approach to procurement which will see some categories managed locally, some regionally and others nationally and to upskill procurement professionals. It directly supports the delivery of the ambitions set out in the Carter Review and the Long Term Plan. It aims to:

- Improve patient outcomes;
- Influence supplier markets to deliver better products and services;
- Maximise commercial value.

As ICS's begin to operate as legal entities and patient care reviewed as part of a care pathway, it will be essential for procurement to ensure it is aligned to this way of working to deliver contracts and operations fit for the future. Procurement will be a key enabler to ensure that the support services which exist to allow clinical services to function, continue to do so as clinical services are restructured.

The outcome, vision and mission of the PTOM programme is set out in the following graphic:

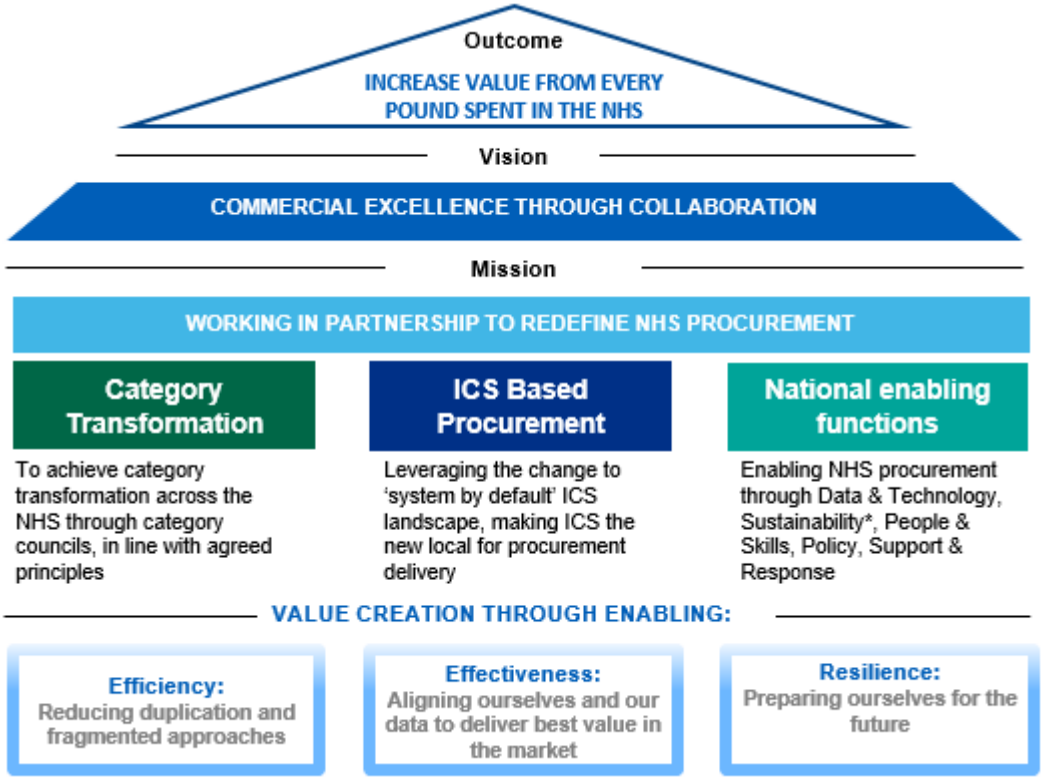


Figure 5 – PTOM Vision & Mission

PTOM uses a category-led approach which means procurement expertise is used in a particular category to benefit both NHS buyers and suppliers by ensuring consistent

commercial terms and standards when embarking on complex procurements. For example knowledge of interoperability and cyber security when procuring digital systems or building regulations for estates procurement.

NHSEI state that Procurement is not currently achieving its full value potential and that there is:

- Opportunity to make better use of our collective resource as a whole system;
- Limited ability to unlock scale and continue to deliver the differentiated value our profession is built on;
- Sufficiently addressing the macro-risks that now face our broader supply chain activities is easier through collaboration, not competition;
- Lacking a coordinated and consistent approach to demand management and aligning needs at scale, leading to variability and subsequently, lesser value gained from each health pound spent.

The benefits of moving to an ICS model are identified by NHSEI as:

- Improved Resilience - Covid-19 taught us that working together is essential to mitigate risk. Working together across the ICS and at greater scale (where appropriate) provides greater protection from supply failures, price increases and quality defects;
- Reduced total Cost - The ICS represents a publicised and policy driven way of driving 'at scale' procurement delivery; enabling greater efficiency and effectiveness through the potential to standardise and reduce repetition;
- Greater Value - The ICS enables us to demonstrate social and financial value across organisational boundaries to drive better outcomes for our patients;
- Better Supplier Management - Working closer together helps leverage scale and value attained through our supplier base through a single voice for categories;
- Optimised Workforce - The ICS enables us to make best use of our collective resource through reduction in duplicated activities and access to more diverse roles across the system;
- Improved Capability - Working together frees up capacity to give us time to develop and leverage specific skills and expertise;
- Great Careers - ICS provides a great platform for career growth with a more diverse set of challenges and opportunities across the commercial life cycle;
- Empowered Culture - The ICS provides an opportunity to fundamentally change and shape the way we work across the system and into the future.

The aims set out by NHSEI for the move to ICS based procurement are:

- To have procurement capabilities deployed across the ICS, with common spend policies underpinning procurement processes, shared access to key data sets, and staff with roles dedicated to delivery across the ICS;
- To have category-based procurement management in place across the vast majority of total ICS third party spend. ICS categories managed by nominated and accountable category leaders, who coordinate stakeholder inputs from each Partner Trust;
- To build out from the new ICS procurement delivery model, putting in place firm channels of communication with neighbouring ICSs across the region. Extending those channels to the National team – to ensure ICS needs are met via existing, and new, nationally let contracts/ agreements where that scale will drive value on behalf of procurements customers.

There are seven dimension set out by NHSEI for NHS organisations to follow as part of the change programme:

- Strategy & Organisation - The strategy that outlines the vision, defines the priorities, and sets out how leadership intends to deploy its collective procurement resources at an ICS level. Inclusive of the skills of its people and its financial, data and technology assets;
- Policies & Procedures - The shared policies and processes that show intent and help determine all key decisions for ICS procurement activity on a day-today basis. Ultimately enabling decisions to be made rapidly, whilst reducing risk and improving value;
- People & Skills - The capacity and capability put in place at the ICS level that ensures effective, efficient and resilient delivery of targeted priorities. Shared access to skilled support. Critical roles in place with accountability and responsibility to the system itself;
- Data, Technology & Performance - The data that is codified, cleansed and shared, and the systems that are integrated or collectively invested in across the ICS which drive insight on future value opportunities, risk mitigations and performance outcomes;
- Strategic Procurement - The delivery of best in class sourcing and procurement activity on behalf of the ICS. Aligning activity to targeted spend categories, and using regional and national networks to drive aggregation, commitment and value for ICS service users;
- Supply Chain Management - The management of our suppliers, their extended supply chains, our assets and inventory at an ICS level to reduce supply risk, cut waste, release space and ensure right product is at the right place at the right time to ensure patient safety;
- Sustainability - The improvement of environmental (Net Zero), social value (anchors and levelling up agenda) and Modern Slavery impacts on the whole ICS supply chain lifecycle; from product design, to material selection, packaging, transportation, warehousing, distribution, consumption and disposal.

Under these seven headings there are 34 actions to deliver:

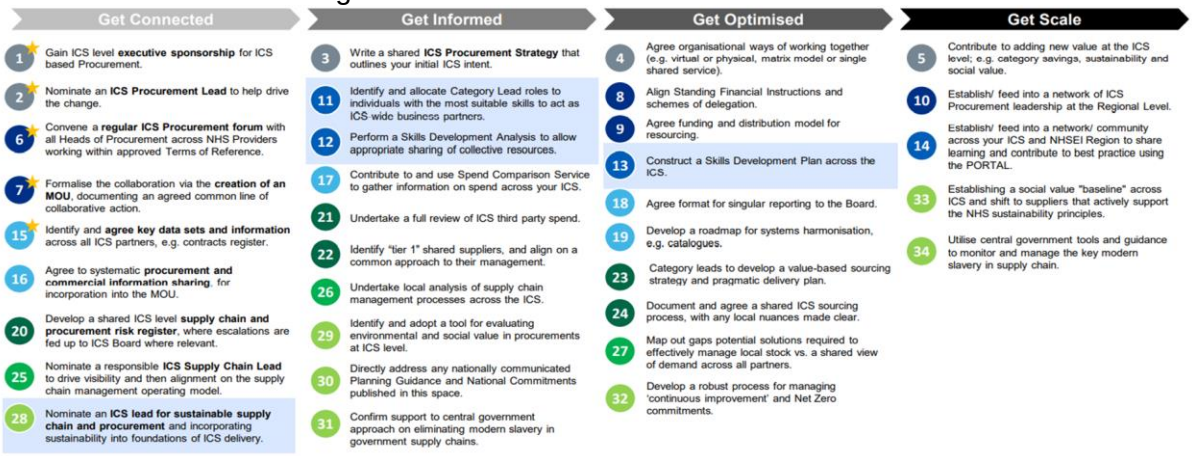


Figure 6 – PTOM 34 Actions

NHSEI identify four core capabilities that ICS procurement teams should be founded upon and built into the way of working to enable ICS procurement delivery:

- Transformation & Enablers:
    - Strategic leadership to focus and drive the change towards ICS ways of working for procurement by setting and delivering the vision for ICS journey–defining and sharing best practices in the form of enablers. Focus on setting aligned targets, measuring progression and supporting delivery effectiveness;

    - Enabling infrastructure will ensure coordination, consistency, and effectiveness across the joint ICS Procurement function. While many of the key frameworks and tools are in place already, consistent ways of working, robust governance, planning and measuring performance will bind the new ICS Procurement operating model;
    - Whilst maintaining the relationships, expectations and services that exist within their Trust landscape, ensuring continuation of the delivery throughout the transformation.
- Category Leadership:
    - Category Management approach is to drive strategic, high value, complex opportunities using specialist market knowledge and insight;
    - Procurement categories (including NHSEI PTOM as well SCCL category towers) are selected to best leverage the ICS purchasing power; aligned with the spend, timing and characteristics of ICS landscapes;
    - Demonstrating the high value a Procurement function provides to the business and acts as a true business partner through engagement to ensure requirements and are effectively captured and communicated;
    - Develop and document, consistent processes with clear indication of owners and hand-offs between Procurement teams and the business.
- Data & Technology:
    - Effective use of available tools and systems will be a key enabler in supporting ICS collaboration, efficiency improvements, identification of savings opportunities and management of risk;
    - Development and implementation of a data and technology transformation roadmap, including development of data standards, delivery of key datasets, analytics-based insights and best in class digital technology deployment (Atamis, Spend Comparison service etc.);
    - Supporting the ICS procurement teams to focus on value-add activity by providing streamlined processing and access to insight. Reducing duplication and adding consistency in information sharing and reporting.
- Sustainability:
    - The improvement of environmental (Net Zero), social value (anchors and levelling up agenda) and Modern Slavery impacts on the whole ICS supply chain lifecycle; from product design, to material selection, packaging, transportation, warehousing, distribution, consumption and disposal;
    - 65% of NHS emissions stem from our extended supply chain. We are collaborating across the system to: 1) develop procurement policy and practices that support the whole system to procure with purpose; 2) leading supplier engagement efforts centrally to align our delivery partners to our sustainability ambitions, and; 3) providing guidance on key operational interventions that will allow front line teams make more sustainable day-to-day delivery decisions.

2.1.1 NHS Central Commercial Function

In June 2022 NHSEI announced that the PTOM programme was being replaced with a new NHS Central Commercial Function (CCF). The change is being communicated as building on the PTOM programme so this business case should still align with the aims and objectives of the CCF as these are built over the coming months. The CCF

is built around seven areas, although these may change following feedback from Trust leads.

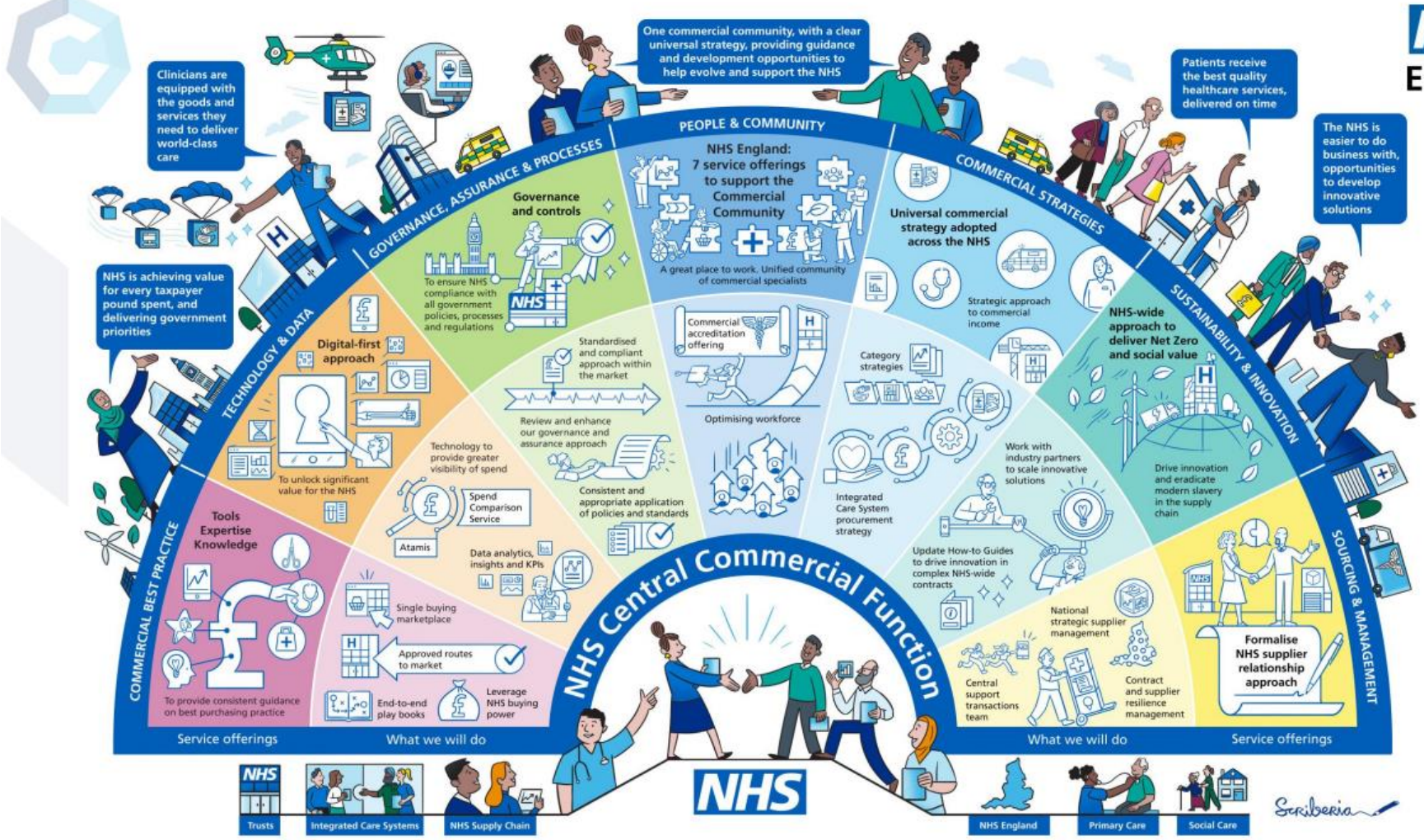


Figure 7 – CCF 7 Areas of Focus

2.2 Local Strategic Healthcare Developments – Humber & North Yorkshire ICS (HNYICS)

ICSs are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. They exist to achieve four aims:

- Improve outcomes in population health and healthcare;
- Tackle inequalities in outcomes, experience and access;
- Enhance productivity and value for money;
- Help the NHS support broader social and economic development.

Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care.

The HNYICS footprint was established in 2016. It covers the areas of Hull, the East Riding of Yorkshire, North Lincolnshire, North East Lincolnshire, the Vale of York, Scarborough and Ryedale and North Yorkshire:

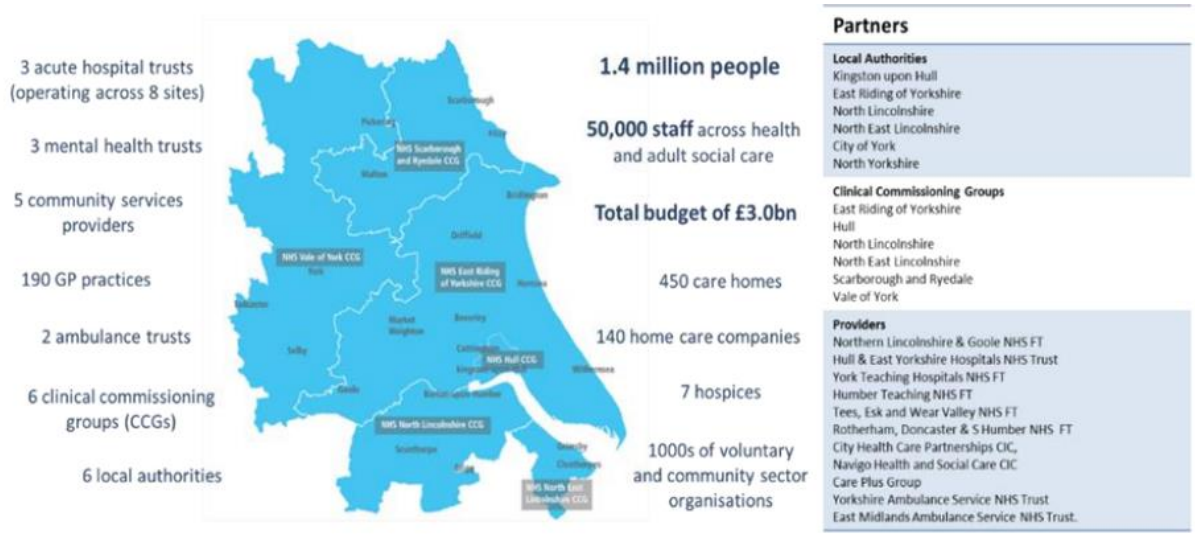


Figure 8 – HNYICS Footprint

In April 2020, Humber & North Yorkshire Health and Care Partnership become an ICS. The application for ICS status was ratified by NHSEI a year earlier than required by the NHS Long Term Plan. The HNY Partnership was one of only four sustainability and transformation partnerships (STPs) to achieve ICS status in April 2020, joining the 14 ICS already operating across England. HNY ICS organisations demonstrated that they share a common goal to improve health and wellbeing in their communities, supported by robust operational and financial plans, and proposals for collective leadership and accountability.

Although the Procurement Collaborative does not sit within the remit of HNY ICS, it operates with agreement of the NHS Acute Finance Directors in the ICS region.

The priorities of HNY ICS are:

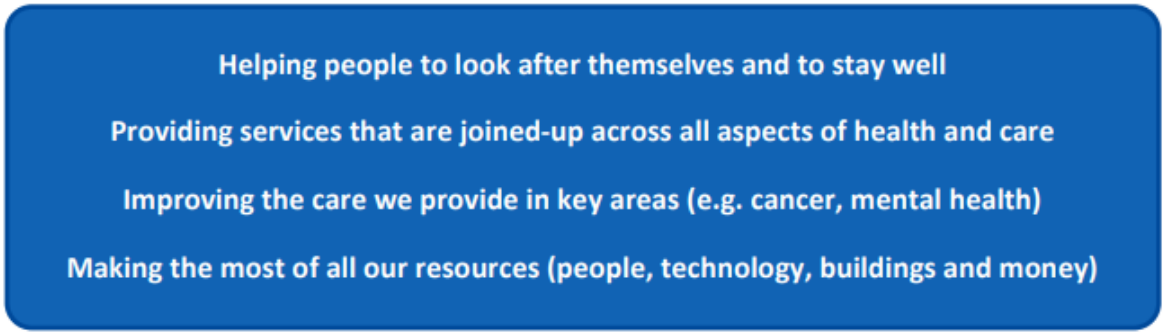


Figure 9 – HNYICS Priorities

The development of the HNYPC will support the delivery of the ICS vision by:

- Ensuring that the region has a single, aligned procurement function that reduces duplication therefore making the most of our people;
- Uses its collaborative power to influence the market, bringing innovative technologies to help improve clinical delivery and achieve best value for money;
- Supports clinical teams to deliver integrated and patient centred care, sharing best practice from across the region;
- Is seen as a great employer providing opportunities for people to learn and grow thereby attracting talent from across the region;
- Provides an efficient, effective and simple to use procurement service to all Partner Trusts.

2.3 Local Trust Strategic Aims and Values

The vision and mission for the new HNYPC will also be based on the vision and mission of the three acute Partner Trusts. The corporate priorities of each Partner Trust are listed below and it is reassuring to note that there is considerable convergence in terms of values and objectives. From a collaborative perspective, this means that the HNYPC has clear direction and a consistent message as to how it should align its activity to best support the corporate priorities.

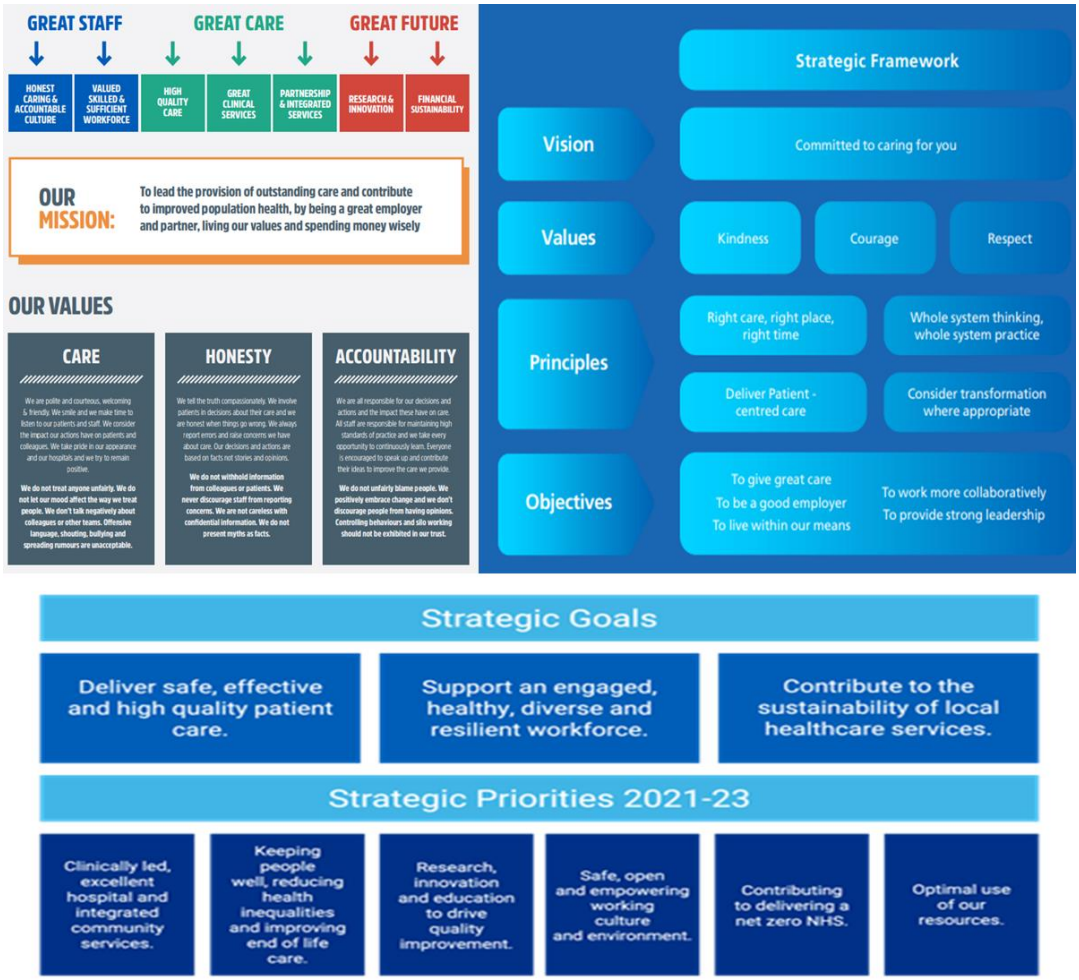


Figure 10 – Partner Trust Priorities

Procurement isn't explicitly mentioned in any Partner Trust strategy despite reference to other professional strategies (e.g. Estates/ Finance) or explicit mention to financial sustainability and getting more from every pound spent. There is also no clear link from the Partner Trusts visions and mission to the work procurement undertake which allows staff to link their work to the overall Trust strategy. This needs to be addressed as part of the HNYPC so that procurement is seen as a key enabler to each Partner Trust meeting their objectives and the golden thread can be followed from the Partner Trust aims and values through to the aims and objectives of those working in Procurement.

Going forward the values and behaviours listed above will be embedded into the values and behaviours of the HNYPC as well as incorporated into the procurement and supply chain strategy. In this way staff and customer groups will develop procurement and contracting strategies which work with suppliers to promote these ambitions.

The three Trust strategies overlap and can be combined into a single set of aims and values which will become the basis for HNYPC:

	Combined
Vision/ Strategic	• **Care** – ensure procurement promotes patient centred, high quality, great, safe, right place, right time care for all Partner Trusts;

Goals/ Principles	• **Staff** – encourage our staff to be the best they can who are collaborative leaders, engaged, healthy, and resilient; • **Future** – procurement to promote whole system thinking and practice encouraging Partner Trusts to consider transformation to deliver financial stability.
Mission	To deliver a procurement service which allows our Partner Trusts to offer great care, which supports people to start, live and age well. Being a great employer spending money wisely.
Values	• Respect/ Honest; • Caring; • Helpful/ Kind; • Listening, Courage to challenge, accountable.
Objectives/ Strategic Themes	• Ensuring Procurement supports our Partner Trusts to deliver high quality care through great clinically sustainable services with a home first approach; • To be a good employer who values and has a skilled & sufficient workforce who focus on improving our service; • Make best use of every pound to support Partner Trusts live within their means and deliver financial sustainability; • Work collaboratively in partnerships and integrated services/ alliances; • Embed an honest, caring and accountable culture with strong leadership; • Promote research & innovation.

Figure 11 – HNYPC Values and Mission

2.4 Procurement As-Is Assessment

The current procurement service model across the HNYPC is decentralised with three procurement teams supporting three acute trusts. Whilst there has been some cooperation during Covid-19 there is no joint working or formal collaboration undertaken demonstrating substantial opportunities for greater collaboration, efficiency, effectiveness in procurement operations and delivery of a multitude of incremental quantitative and qualitative benefits.

The key areas within the current procurement services identified as requiring improvement include:

- People – there are few high-calibre procurement managers able to drive major cross-ICS projects, a significant absence of supplier relationship management roles, data analytical roles and clinical engagement roles. The large element of procurement roles are transactional;
- Structure and Governance – does not enable the level of collaboration across HNYPC Partner Trusts required to unlock incremental value;
- Systems, Processes and Policies – fragmented systems across the ICS that hinder joined-up working; insufficient focus on Supplier Relationship Management and Contract Management; coupled with poor data visibility and management reporting. Improving these areas will enable the delivery of substantially greater savings through collectively leveraging the combined buying power of the HNYPC Partner Trust's annual addressable spend of £538m.

A summary of some of the key issues discovered as part of the as-is assessment are outlined below:

Data Transparency:

- Category and spend data analysis not effectively supporting strategic procurement / activity;
- Issues with quality of financial and procurement data;
- Lack of ICS view on supplier spend, performance, contracts, risks, and procurement operations in terms of transactions, performance, return on investment.

Lost Savings Opportunities:

- The system lacks the ability to identify and scope projects at an ICS level, due to capacity pressures, capability, conflicting Partner Trust priorities, and a lack of ICS mandated policy/ governance;
- ICS wide savings plan viewed as aspirational, limited collaboration and therefore lack of leverage across system wide suppliers, spend and delivery of savings;
- Lack of transparency and localised annual planning approach.

Inefficient Technology & Governance Landscape:

- Technology landscape inconsistent and deficient;
- Multitude of governance processes, policies and procedures;
- Inconsistent procurement approaches leads to a duplication of effort, lack of effective activity planning.

Inappropriate Team Structures:

- Team structures heavily weighted towards transactional procurement activities;
- Absence of procurement business managers and category plans to support procurement activities;
- Significant differences in access to qualified procurement staff, training, and development, coupled with culture of silo working approach;
- Limited automation and application of digital approaches.

Lack of Strategic Procurement Activity:

- Under resourced business partner capabilities, impacts effective procurement activity and wider stakeholder engagement;
- Absence of engagement with Trust stakeholders throughout the procurement process with stakeholders requesting more time with Procurement;
- Significant absence of supplier relationship management and engagement with strategic suppliers;
- Lack of long term planning.

Procurement & Supplier Risks:

- Immaturity of procurement operations increases risks to procurement delivery and supplier management;
- Little evidence of effective contract management, poor quality of contract register information;
- Reactive rather than proactive procurement approaches and basic procurement resource activity planning;
- Limited due diligence and supplier monitoring.

There are significant gaps in the skills required for a fully functional Procurement team with a high number of resources focussed toward transactional activities such as the processing of requisitions, replenishment of stock or tendering and sourcing activity. There are minimal resources focussed on strategic business partnering, stakeholder and market engagement. There is also an element of duplication in each Trust with similar roles being carried out, particularly at a management and transactional level that could be rationalised by centralising these resources. The size of each organisation means that some specialist resources are deemed as nice to have rather than essential.

Bringing staff up to a common standard of operating is key to ensuring that the organisation can deliver its goals. The concentration on annual savings targets has led to a narrow focus on achieving in-year savings rather than a strategic approach to the value opportunities which procurement can deliver.

All three trusts employ various methodologies regarding clinical engagement and product standardisation. Formal procurement/clinical meetings within the trusts can be sporadic or poorly attended. This is common with many trusts where standardisation groups suffer in terms of maintaining appropriate attendance levels and engagement.

There appears to be limited dialogue in terms of understanding the strategic plans of service groups and how procurement can work with customers to deliver their strategy. Despite clinical, medical and operational staff being the key customers there are no measures in place to understand customer satisfaction or allow clinical teams to contribute to governance or performance management. As part of the engagement with various members of staff across the three acute trusts the same asks were raised for any future service offering:

1. Support the trusts with their financial position;
2. Simplify the procurement process and eliminate confusion;
3. Standardise the use of products where possible;
4. Provide more face-to-face time with procurement staff, in particular staff who are authorised to make decisions;
5. The importance of attracting and retaining talent.

As part of the development of this business case supplier feedback was requested from the major suppliers to HNYPC. The key themes of this feedback were:

- Single Entity – it is a lot easier for the supplier to transact with a single entity rather than a front to three separate organisations. A single entity can achieve more in reductions of transaction cost but can also consider things such as bulk purchase that could deliver an additional 5%. Quite often collaborations between organisations don't go far enough and work as more of a bolt-on;
- Patient Pathways – Procurement should think and operate around patient pathways rather than product categories as this could deliver additional benefit rather than improving parts of a pathway. Operating on this basis could also see procurement influencing decisions around where care is provided by understanding what technology is available through suppliers;
- Value Based Procurement/ Strategic Relationships – Procurement should be undertaken to understand the added value suppliers can bring rather than just cost down of a product. These value add services need to be built into contracts and to hold suppliers to account. Suppliers have value add offerings such as pathway optimisation or technology offerings which can be offered as part of a joint contract. Other trusts have delivered theatre efficiencies of 10-15%. Quarterly business reviews should be held with key suppliers to measure performance and explore ideas for process efficiencies;
- Value of Data – clinical data is worth more to suppliers than the sale. How can procurement influence thoughts around the commercialisation of clinical data;
- Contract Terms – standard contract terms should be agreed across the ICS but there should be greater understanding within procurement as to how to manage risk within markets and to set this out in contracts which drive the right behaviours, for example how base wage rises and inflation is dealt with;
- Tender Documents – the quality of the tender documents and the process which is followed needs to be improved. Quite often specifications are not clear

around what is being procured and the evaluation documentation isn't followed. This makes it easy for the supplier to challenge the process. The view from the supplier is that this is down to capability issues within procurement;

- Pipeline Visibility – it would be beneficial to have regular catch-ups with procurement individuals to better understand the pipeline of opportunities but to also allow for supplier feedback on market trends and challenges so this can be included within any procurement exercise or as part of the contract management regime. The pipeline needs to consider ways of working and not rely on cash coming into the system at the end of the year. HUTH have recently bought Endoscopy scopes but haven't changed their ways of working to align with the additional technology and functionality. Start procurement exercises earlier, understand what is available from the market through innovation days and allow procurement documents to have the flexibility for innovation;
- Contract Management – Procurement need to be leading contract management to ensure that the supplier is delivering what was promised but also to provide the link between suppliers and customers. Recently suppliers have seen capital purchases completed where clinical staff do not know how to use the product and this has created issues. Both parties should be responsible for delivery of cost improvement;
- Supply Chain Resilience – improve supply chain resilience and minimise supply chain risk and disruption by identifying supplier networks rather than relying upon monopolies;
- Simplification of Process – the sign off process across the three organisations appears to be very different. As an example the process at NLAG appears smooth a quick whereas the sign off process for HUTH takes weeks and large orders are often delayed. Communication with HUTH can also go unanswered which is frustrating;
- Stakeholder Engagement – Procurement need to provide the link between the supplier, the clinical community and the ICB to ensure the best outcome for patients. There is a current visible lack of procurement engagement with the clinical community.

The respective establishment WTE headcount by function is shown below:

Function	HUTH	NLAG	YSTH	Total
Procurement	15.74	10.12	25.15	**51.01**
Systems & e-Commerce	0	0	1.9	**1.9**
Clinical Procurement Specialist	0	1	0	**1**
Receipt & Distribution	7	5.5	12.99	**25.49**
Materials Management	12.64	11	15.5	**39.14**
Total	**35.38**	**27.62**	**55.54**	**118.54**
Addressable Spend	£243m	£129m	£166m	£538m
£m per WTE	£6.8	£4.6	£3	£4.5

Figure 12 – WTE Headcount by Function

The above table shows a significant difference between the value of addressable spend per WTE with HUTH operating at £6.8m per WTE and York at £3m. Looking at other benchmarks, Manchester University NHS Foundation Trust have 132.92 WTE

with an addressable spend of £540m meaning an average of £4m per WTE. Working on £4m per WTE HNYPC would operate with a WTE headcount of 134.57.

In total 44 people work less than full time hours, this represents 33% of the total headcount working part time. There are also a number of grade gaps within the existing procurement structures which prevents individuals seeking careers internally.

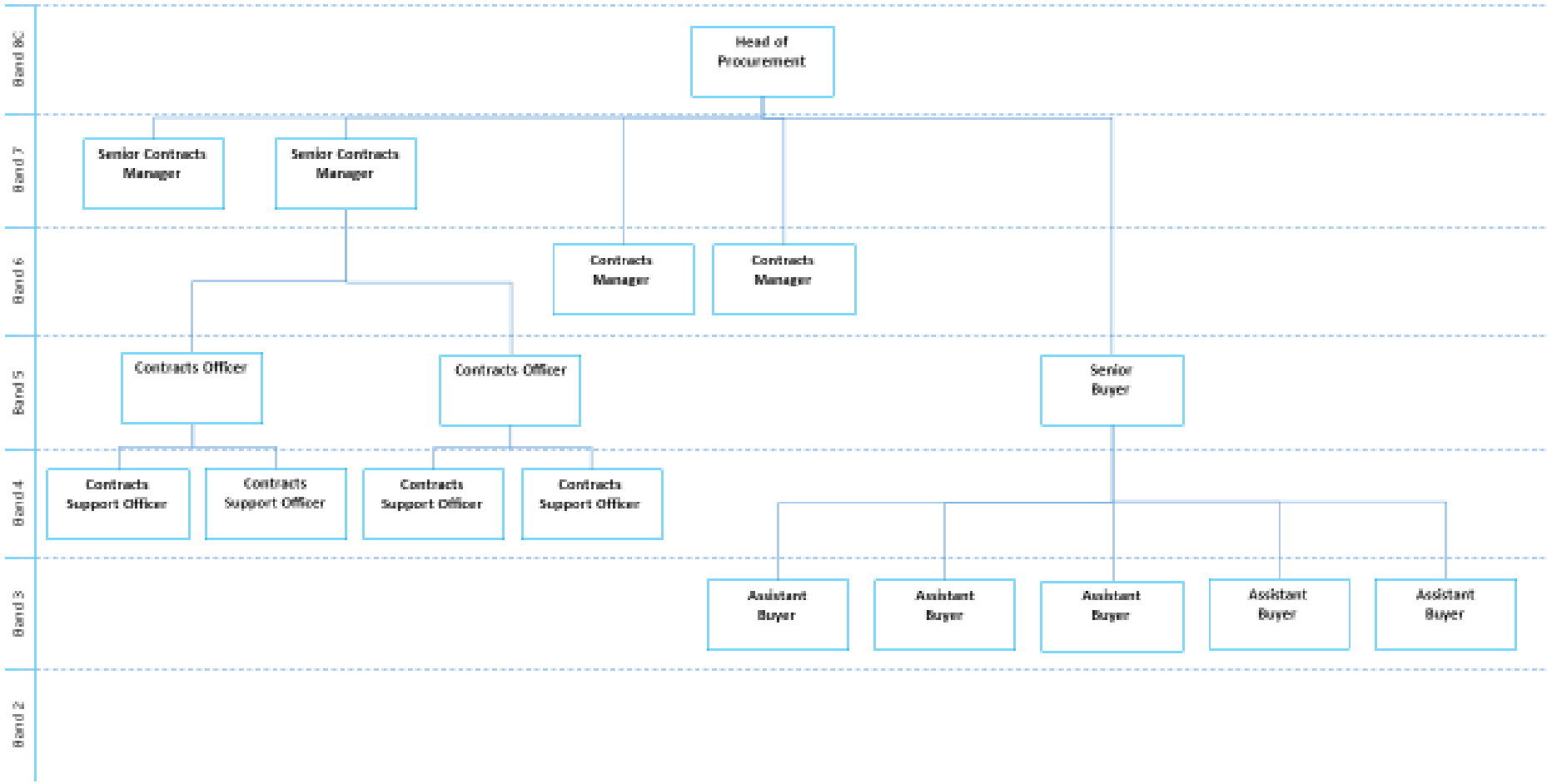


Figure 13 – HUTH Procurement Team

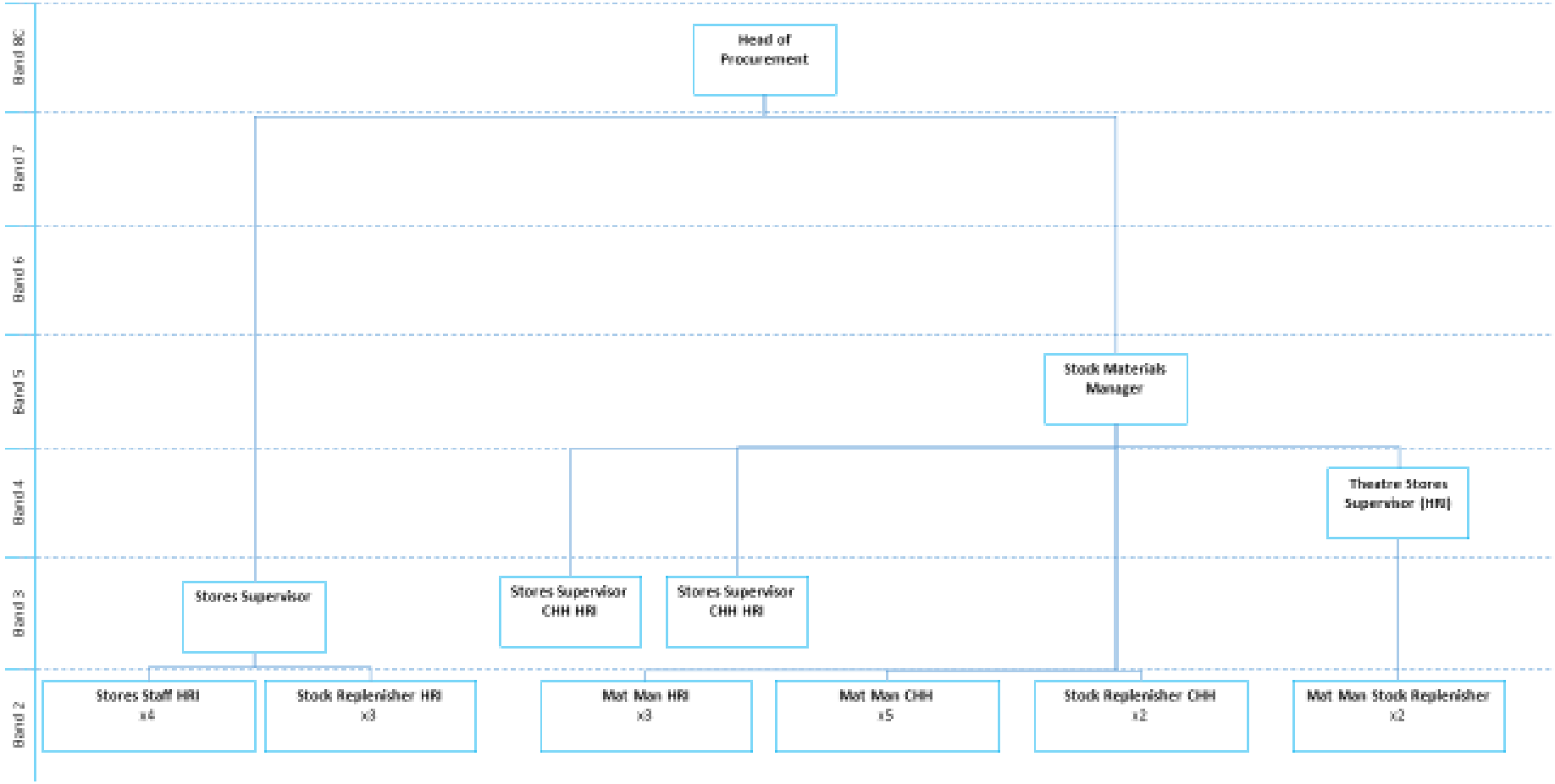


Figure 14 – HUTH Stores and Mat Man

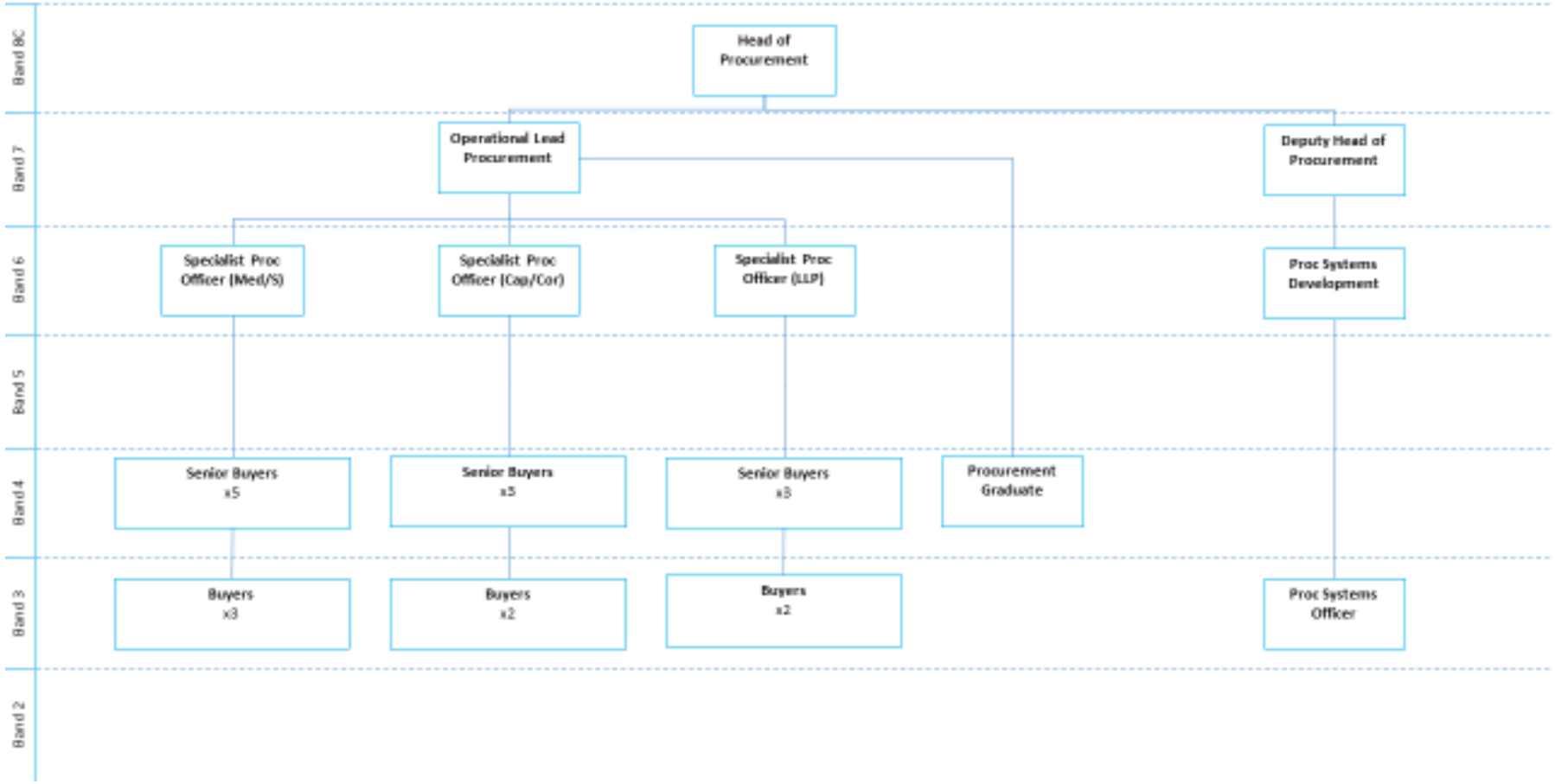


Figure 15 – YSTH Procurement Team

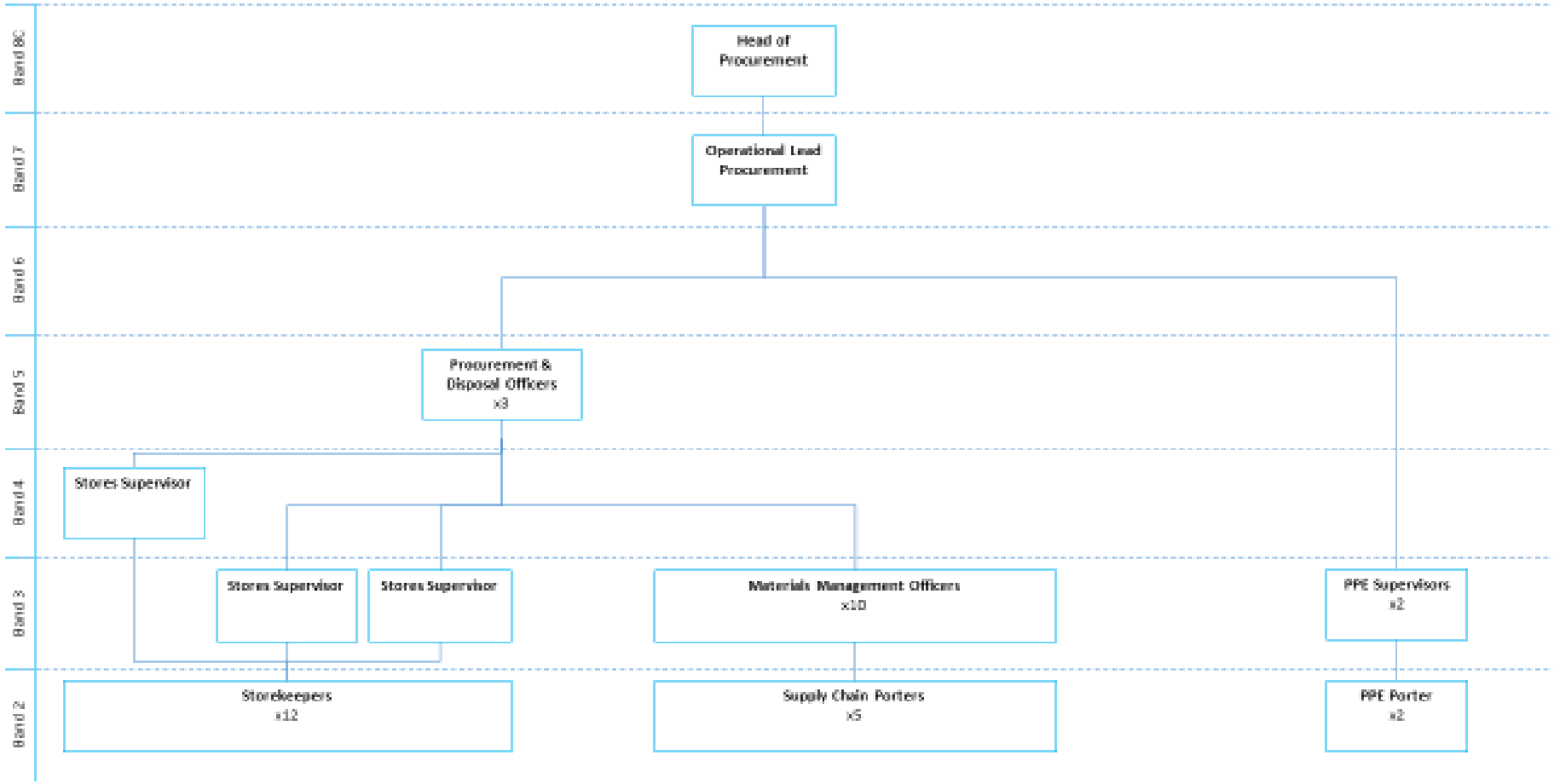


Figure 16 – YSTH Stores & Mat Man

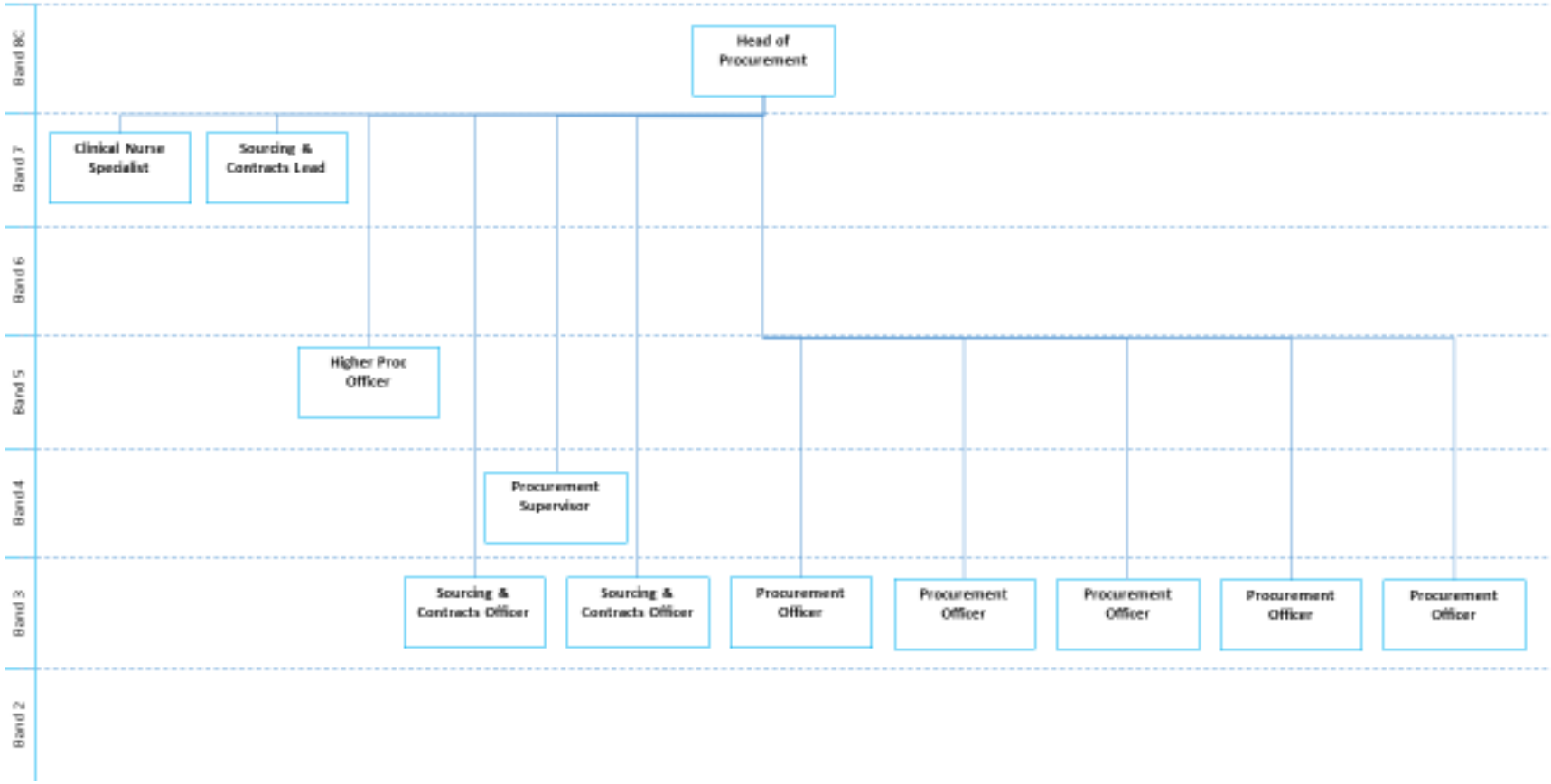


Figure 17 – NLAG Procurement Team

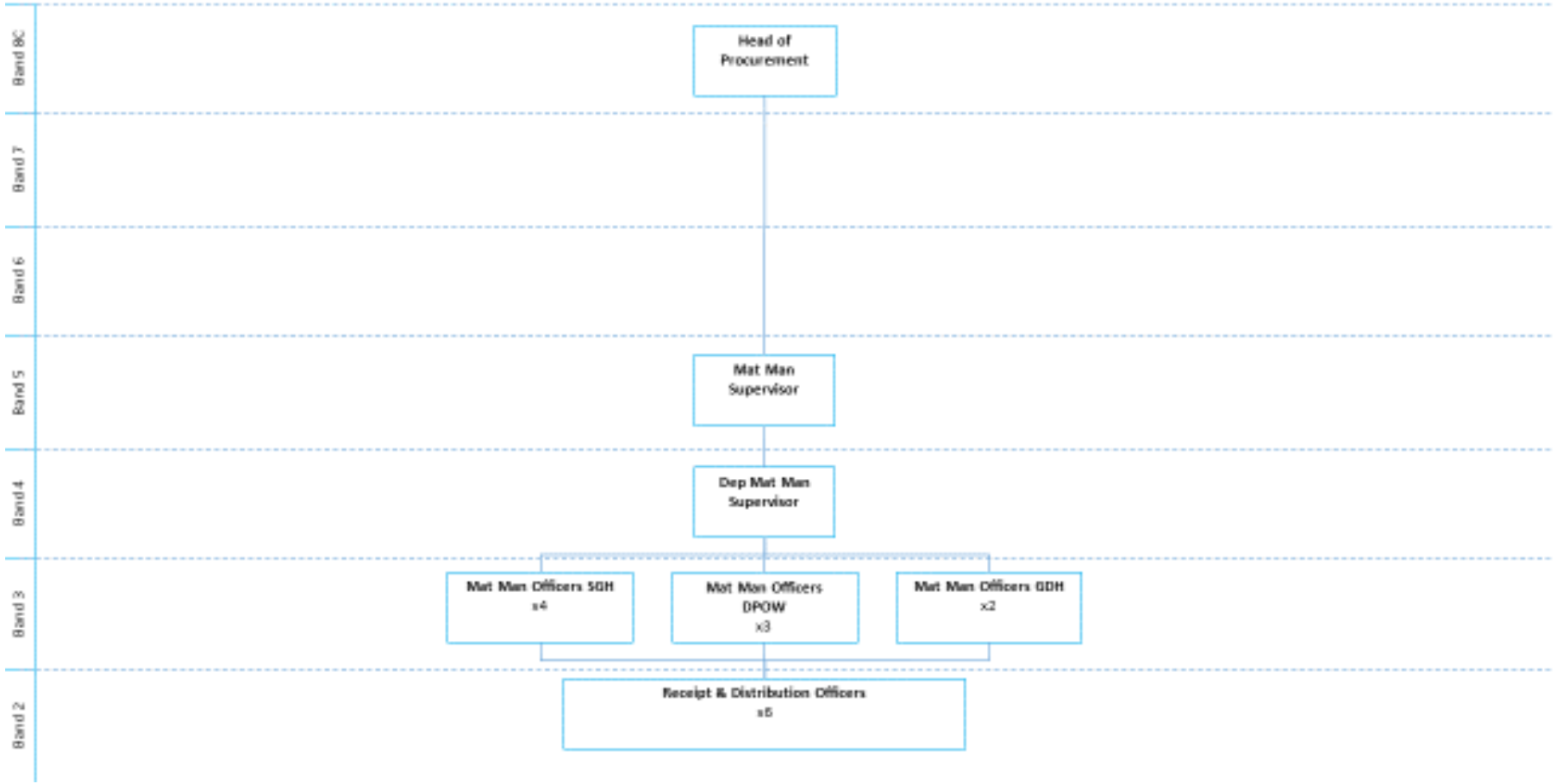


Figure 18 – NLAG Stores & Mat Man

2.5 Scope of Procurement Responsibility

Procurement currently has responsibility for non-pay spend in most areas however there are local exceptions such as:

- Pharmacy - the purchase of drugs;
- Estates & Facilities – not only capital expenditure;
- Purchased Healthcare/ Commissioning.

This leakage needs to be better understood as it will impact the data which sits in purchase order and invoice systems. Under the future procurement offering the HNYPC Board will be required to approve any change in scope of addressable non-pay spend.

3. Key Metrics & Baseline Data

3.1 Addressable Spend & Insights

Obtaining a single version of the truth on Partner Trust expenditure which should be managed by a procurement function has proved incredibly difficult. Addressable spend for Procurement has been calculated following a line by line review of all non-pay spend.

	HUTH	NLAG	YSTH	Total
Total Non-Pay Spend	£427.4m	£221.1m	£395.1m	£1,043.7m
Un-addressable Spend	£174.3m	£92.3m	£226.7m	£493.3m
Excluded Devices	£9.9m	£0	£2.2m	£12.1m
Addressable Spend	£243.2m	£128.8m	£166.2m	£538.2m

Figure 19 – Spend Profile

There is a lot of work that Partner Trusts need to undertake around who they spend their money with and how much they spend. HNYPC aims to put in place IT solutions that deliver one version of the truth on non-pay spend. For the purpose of evaluating expenditure to inform this business case accounts payable data has been used as this is broken down to line level detail allowing interrogation.

Following the receipt of spend, contracts and work-plan data, several reports were created to provide a high-level view of spend to illustrate procurement activity and identify consolidation opportunities. Total spend across the three HNYPC partners, during the baseline period (Jan 21 – Dec 21) was £1,043.7m. Any business fees and payments to government were removed as well as pass through costs from the total spend as these are not addressable by procurement, leaving £538.2m spend.

	HUTH	NLAG	YSTH	Total	Consolidated
Addressable with top 10 suppliers	£106.5m	£52.7m	£62.4m	£221.6	£185.6m
% with top 10 suppliers	43.8%	41%	37.5%	41.2%	34.4%
Number of Addressable Suppliers	2,857	1,706	2,708	7,271	3,812
£ per Supplier	£88.5k	£75.6k	£61.3k	£75.4k	£143.8k
Invoices per annum	102,006	59,570	104,406	265,982	
Invoices without PO	21.47%	56.92%	53.92%	42.15%	
Tier 1 Invoices (£1m+)	21 (£123m)	34 (£85.1m)	40 (£200.6m)	95 (£408.7m)	
Tier 2 Invoices (£100k-£1m)	448 (£127.6m)	178 (£55.5m)	186 (£52.2m)	812 (£235.3m)	
Tier 3 Invoices (£10k-£100k)	3,686 (£100.9m)	1,546 (£39.8m)	2,704 (£71.4m)	7,936 (£212.1m)	
Tier 4 Invoices (<£10k)	97,851 (£75.9m)	57,812 (£40.7m)	101,476 (£70.7m)	257,139 (£187.3)	
Number of Purchase Orders	28,769	28,305	28,042	85,116	

Value of Purchase Orders	£2,119m	£76.5m	£198.1m	£2,394m	

Figure 20 – Spend Breakdown

Where it is possible to provide a consolidated view of the data, for example the three Partner Trusts share a number of suppliers, this has been stated separately above.

Key insights from the analysis of the addressable spend include opportunities for:

- Supplier management consolidation – 3,459 suppliers are currently being managed by two or more Partner Trusts;
- Tail management – 60% / 2,279 of suppliers have a spend of less than £10k;
- Strategic contract management – 60% of the addressable spend is identified as being under contract;
- Reductions in transactional processing – some suppliers are submitting thousands of invoices per year. Consolidating these invoices would save transaction costs as well as contract costs with the outsourced payments provider. As an example, Stryker submitted 2,194 invoices to Hull of which 80% were less than £1,000.

The £538m addressable spend was categorised by e-Class and mapped to each organisations' care groups to understand the resource required for effective business partnering. The figures in the table below do not exactly match the addressable spend set out in the table above as it has not been possible to take out excluded devices at a line level and due to some spend being costed against care groups marked "n/a":

Care Group	Non-Pay Spend	% of Spend
Family Health	£8,217,905.85	2.78%
Surgery & Critical Care	£15,558,059.42	5.26%
Clinical Support Services	£143,345,510.96	48.47%
Specialist Medicine	£29,904,436.01	10.11%
Community & Therapies	£2,613,052.70	0.88%
Emergency & Elderly Medicine	£6,965,947.51	2.36%
Corporate	£89,164,186.14	30.15%
Sub-Total	**£295,769,098.59**	
Capital and Charitable	£243,193,849.50	
Total	**£538,962,948.09**	

Figure 21 – Care Group Non-Pay Spend

The top 20 suppliers to the three trusts are:

Normalised Supplier	Non-Pay Spend	% Share
NHS Supply Chain	£55,905,267.99	10.39%
Kier Construction Ltd	£21,671,539.62	4.03%
Bayer Plc	£18,509,466.99	3.44%
Lloyds Pharmacy Ltd	£17,265,141.00	3.21%
BOOTS UK LTD	£16,173,527.67	3.00%
Roche Diagnostics Ltd	£14,649,347.60	2.72%

HEALTHCARE AT HOME LTD	£13,522,766.61	2.51%
Ocs Group Uk Ltd	£10,091,430.08	1.87%
Lloyds Pharmacy Clinical Homecare Ltd	£9,145,787.05	1.70%
Baxter Healthcare Ltd	£8,724,389.68	1.62%
Fresenius Kabi Ltd	£8,516,282.64	1.58%
Healthcare Solutions (Hull) Ltd	£7,749,394.76	1.44%
SYNERGY LMS	£7,339,843.11	1.36%
Nimbuscare Ltd	£7,296,773.00	1.36%
Alliance Healthcare Distribution Ltd	£7,152,046.54	1.33%
Helix-Cms Ltd	£7,055,580.39	1.31%
Healthnet Homecare Uk Ltd	£6,572,734.75	1.22%
Alloga Uk Ltd	£6,474,135.67	1.20%
Qualasept Ltd	£6,415,888.18	1.19%
Ashcourt Contracts Ltd	£6,228,317.32	1.16%

Figure 22 – Top 20 Suppliers

3.2 Model Hospital Data

The Model Health System is a data-driven improvement tool that supports health and care systems to improve patient outcomes and population health. It provides benchmarked insights across the quality of care, productivity and organisational culture to identify opportunities for improvement. The Model Health System incorporates the Model Hospital, which provides hospital provider-level benchmarking.

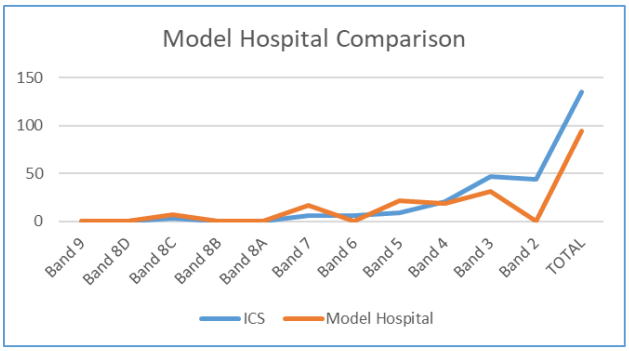
Model Hospital data allows the comparison of back office functions across the NHS based on their as-is operations, it does not provide a 'should-be' status as the NHS moves to working in ICS structures.

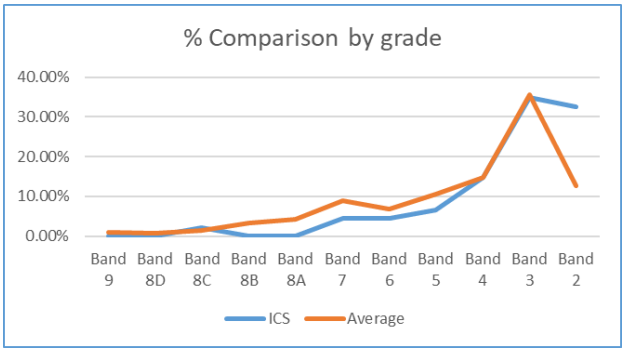
It is still important to compare the performance of the three acute trusts to understand how they perform compared to other NHS providers. Key findings from Model Hospital show:

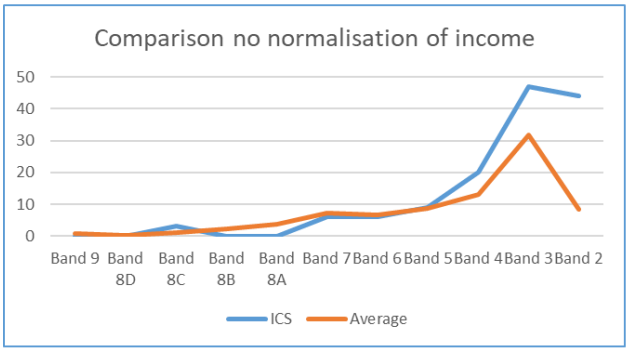
- The national average pay cost of the function is £3.7m against an actual cost of £3.69m;
- The national average FTE in Model Hospital is 95 against an actual FTE return from the Partner Trusts of 118.44;
- Average national cost per post is £39k against an actual cost per post of £34k;
- The majority of the additional posts sits in Materials Management (6 posts) and Receipt & Distribution (13 posts);
- Strategy & Leadership and Procurement Systems are both below the national average;
- Investment in training and development is below the national average of £216 per person per annum with a Partner Trust average of £98;
- Non-pay spend on contract is at 60% against a national average of 85%;
- Transactions on catalogue is in line with the national average;
- Stock holding is almost double of the national average;
- Materials management coverage in clinical areas is 73%, below the national average of 83%;
- Items covered by Materials Management is significantly higher than the national average.

Using the department descriptions and average wage costs provided within the Model Hospital data it is possible to create a 'should-be' structure based on the national

average. This structure includes more posts at the higher grades in Strategy & Leadership and less resource in the lower grades of Materials Management and Receipt & Distribution:







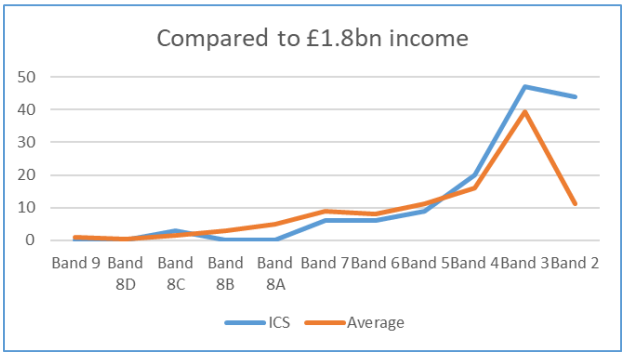


Figure 23 – Model Hospital Grade Data

To check the findings within the Model Hospital data comparisons have been undertaken against 6 other NHS trusts where it was possible to get their structures by grade. Cutting the data in various ways all tells the same story, the three Partner Trusts have significantly more resource at band 2 and less resource at band 5-8b.

Model Hospital uses Trust income as the key comparator. Between the three Partner Trusts the annual income is £1.8bn. Normalising the comparator trusts to the same income doesn't change the key findings around numbers of staff by grade.

Taking Model Hospital data to compare Procurement against other back-office functions across the three Partner Trusts shows it is the second to last area for investment in both pay and non-pay:

Pay	Investment as a % of Income	Investment as a % of non-pay
IM&T	1.13%	3.82%
HR	0.72%	2.43%
Gov & Risk	0.54%	1.83%
Finance	0.43%	1.46%
Procurement	0.20%	0.69%
Payroll	0.10%	0.34%

Non-Pay	Investment as a % of Income	Investment as a % of non-pay
IM&T	1.16%	3.91%
HR	0.25%	0.84%
Finance	0.11%	0.38%
Gov & Risk	0.04%	0.13%
Procurement	0.01%	0.03%
Payroll	0.00%	0.01%

Figure 24 – Corporate Services Investment

IM&T figures are significantly higher than all other back-office areas, the assumption is that this has been impacted by Covid-19. Removing IM&T from the average investment by income and non-pay spend gives an average for pay of 0.4% against income and 1.35% against non-pay. For non-pay function spend the average is 0.08% against income and 0.28% of non-pay spend.

If the average is applied to procurement then the pay budget would increase to £7.2m and non-pay to £1.5m which is an increase of £3.5m in pay and £1.3m non-pay.

Comparison of the Procurement grade split shows procurement to be under resourced between band 4 and 8b compared to other corporate service areas:

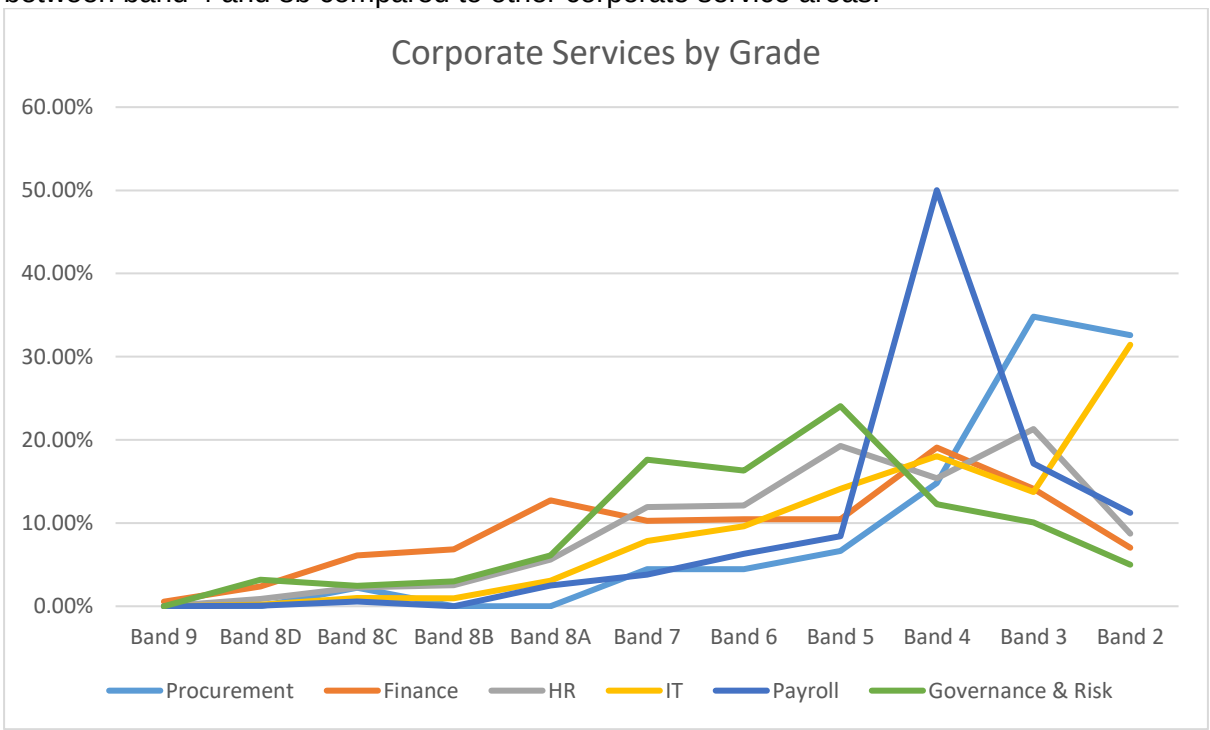


Figure 25 – Corporate Services by Grade

3.3 NHS Spend Comparison Service

The NHS Spend Comparison Service (SCS) was commissioned by NHS Improvement and is provided by NHS Digital on behalf of providers. It provides users with price benchmarking and spend analysis of procurement data for all NHS trusts within NHS England.

All NHS trusts are required to upload their purchase order and accounts payable data to NHS Digital's Strategic Data Collections Service (SDCS). Purchase Order data is collected on a weekly basis and Accounts Payable data is collected monthly. The raw Trust data is then aggregated and cleansed by NHS Digital, and this aggregate database then forms the foundation of the different visualisations and analysis found within the SCS analytics dashboards.

The service enables users to view the underlying data within several different formats, allowing for different methods of analysis, including benchmarking prices paid for goods and services, identifying alternative suppliers and products that may offer better value, as well as identifying inflation, possible sources of alternative stock, and insight into and trends within supply markets.

All three Partner Trusts are now putting their data into the SCS. By its nature, the PO analysis and AP analysis provide slightly different outputs but there are key themes which exist.

	HUTH	NLAG	YSTH	YSTH FM
Spend	£56.3m	£18.9m	£59.8m	£1.1m
% NHS Supply Chain	67.6%	64.7%	32.4%	100%
Suppliers	1,907	1,233	2,100	163
Product Codes	27,062	15,836	24,931	1,360
Variance to Median (£) (Opportunity)	£1.7m	£467k	£880k	£5k
Variance to Median (%) (Opportunity)	3%	2.5%	1.5%	0.4%
Variance to Min (£) (Opportunity)	£5.7m	£1.8m	£3.3m	£23.5k
Variance to Min (%) (Opportunity)	10.2%	9.7%	£5.6%	2%

Figure 26 – Spend Comparison Service Data

The data within the SCS suggests savings between £3m (variance to median) and £10m (variance to minimum). Each of the presented saving opportunities would need to be validated to ensure that the opportunity is achievable.

3.4 Contract Data & Work Plan 2022/23

The three Heads of Procurement were asked to share their contract databases and work plan for 2022/23. The work plans derive from contracts that need to be re-procured as well as new requirements raised through engagement with the business. The information provided shows that:

- There are 3,008 contracts in place across the three Partner Trusts;
- £445.6m is currently registered against these contracts however it should be noted a number of contracts (20%) have no value against them;
- 1,118 (37%) of the contracts have expired but these only represent 8% of the total contract value (£39m);
- The work plan for 2022/23 has 1,425 projects with a procurement value of £247m;

- There are significant opportunities for collaboration with either 2 or all 3 Partner Trusts having the same contracts on the work plan;
- Around 805 of the contracts on the work plan could be procured through a NHSSC framework;
- Around 236 of the contracts on the work plan could be procured through a NOECPC framework;
- 477 contracts are not covered by NHSSC or NOECPC frameworks.

The recommendation set out within this paper would not be able to immediately address the backlog of contracts which need to be renewed but these would need to be prioritised with the total number of projects also being reduced through collaboration.

3.5 Key Performance Indicators

The three procurement teams' performance is currently managed and monitored through the following key performance indicators:

3.5.1 Model Hospital Key Performance Indicators

KPI	HUTH	NLAG	YSTH	Peer
Clinical areas serviced by the Procurement function	75%	80%	64.9%	81%
Items covered by Materials Management	9,228	18,000	21,512	2,834
Purchase orders raised via top-up through Materials Management	12,729	5,000	24,279	11,056
Procurement function professional development spend per 'Procurement' function FTE	£43	£149	£101	£215
Apprenticeship levy drawdown for Procurement as percentage of 'Procurement' function pay cost	0%	0%	0%	1%
Number of 'Procurement' function staff accessing the apprenticeship levy drawdown for training as percentage of 'Procurement' function FTEs	4%	4%	0%	9%
Number of apprentices recruited in year for Procurement as percentage of 'Procurement' function FTEs	0%	4%	0%	7%
Non-pay spend on contract (%)	63.8%	31.5%	83.3%	85.7%
Transactions on eCatalogue (%)	95.4%	72.5%	96.5%	93.9%
Invoices matched to an e-PO (% by value)	87%	68.1%	85.1%	88.4%
Invoices matched to an e-PO (% by count)	91.6%	92%	91.9%	91.1%
PO lines transmitted through EDI (% by count)	88.4%	72.5%	74.1%	86.5%
Invoice lines transmitted through EDI (% by count)	88.%	72.5%	96.8%	73.6%
Supplies and services cost per WAU	£225	£282	£288	£236
Influenceable non-pay spend on PO (%)	73.2%	59.7%	61.8%	67.4%
Total non-pay spend on PO (%)	11.8%	11.6%	13.8%	10.7%
Supply chain expenditure as a proportion of non-pay expenditure (%)	7%	7.7%	7.7%	4%
Supply chain expenditure as a proportion of influenceable expenditure (%)	13.3%	13.10%	18.3%	9.5%
Supply chain expenditure as a proportion of clinical and general supply expenditure (%)	17.6%	26.2%	22.6%	16.4%
Dynamic days of stock cover			60.4	100.5
Static days of stock cover*	67.2	69.1	30.8	36.1

Variance from minimum price (%)	23.1%	23%	21.7%	20.6%
Variance from median price (%)	5.6%	4.7%	4.9%	4.5%
Variance for top 100 products (%)	13.5%	14.1%	15%	12.5%
Variance for top 500 products (%)	14.2%	14.5%	14.6%	12.5%
Products achieving best price in Top 500 products (%)	26.4%	28.4%	28%	29.2%
Blank MPCs (%)	1.3%	3.7%	5.6%	2.1%
Blank unit of measures (%)	0%	0%	0%	0%
Single organisation MPC (%)	0%	0%	0%	0%
Blank E-Class code (%)	9.7%	11.1%	19.9%	11.4%
Blank contract references (%)	6.9%	6.5%	21.7%	5.9%

Figure 27 – KPI Data

* Static days of stock cover are calculated by taking the inventory value of clinical and general supplies at year end (the year end stock take) and divided by to spend during year on clinical and general supplies and then multiplied by 365.

3.5.2 Trust Specific KPIs

Procurement within the three Partner Trusts is not measured on performance using KPIs which are Trust specific. Reporting of performance is linked to the model hospital key dataset above. To ensure that procurement, and those working in procurement, can evidence how they support their organisations to meet their aims and objectives, clear KPIs should be set out for procurement and reflected within individual's performance management documents.

NHS Procurement KPIs tend to measure the transactional performance of the team rather than the strategic achievements. Examples from other trusts include:

- Percentage Authorisation Transfers – reducing the number of requisition or purchase order approvals which are delegated from the nominated individual;
- Number of Contracts – reducing the number of contracts which have expired;
- Price Variance – reducing the number of invoices on hold as the price does not match the price of the purchase order;
- Processed Invoices – reducing the number of invoices processed without a purchase order;
- Purchase Order Buyer Intervention – reducing the need for buyers to intervene in purchase order raising through automation and better catalogue management;
- Purchase Order Three-Way Auto Matched – increasing the number of invoices that can be auto matched as the quantity and cost is correct;
- Percentage of Purchase Order Lines on Catalogue – increasing the number of purchase orders covered by catalogue;
- Savings Achievement – tracking savings achieved against target;
- Single Tender Waivers – reducing the number of single tender waivers received;
- Absence Rates – tracking staff absence rates;
- Appraisals Achieved – tracking the status of staff appraisals;
- Staff Professional Membership – increasing the number of staff who are members of a profession;
- Staff Turnover Rate – reducing the turnover rate;
- Vacant Positions – reduction in the number of vacant positions within the organisation;
- Continual Professional Development – tracking mandatory training rates;

- Speed of Procurement Transaction – increasing the speed for requisitions to be processed and orders to be receipted;
- Expenditure through Procurement – spend covered by contract or PO raised by procurement compared to total non-pay spend;
- Average Shelf Life – reducing the amount of stock held;
- Inventory Waste – reducing the amount of stock which is wasted through damaged, lost or beyond date.

4. Options Appraisal

4.1 Organisational Form

In developing this business case consideration has been given to the range of delivery vehicles potentially open to the Partner Trusts. The options considered are listed below with the recommendations produced as a result of engagement with Trust Executive Leads.

Each of the options is scored against the following criteria which was set out by the Trust Executive Leads:

- Supports the aims and vision of the ICS and collaborative members;
- Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Establishes the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts;
- Ensures innovative and robust Supplier Relationship Management (SRM);
- Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements;
- Enables effective partnering with senior stakeholders, internal customers and suppliers;
- Ensures all staff are given the opportunity to develop their potential.

4.2 Option 1 – Business as Usual (BAU)

4.2.1 Description

Maintain the procurement structures as-is under the current Partner Trusts with each procurement team providing dedicated procurement support to their own Trust.

4.2.2 Net Costs

The existing cost to running the procurement teams would remain:

	HUTH	NLAG	YSTH	Total
Annual Pay Budget	£1,152,509	£941,600	£1,636,461	**£3,730,570**
Annual Non-Pay Budget	£58,800	£31,700	£69,470	**£159,970**
Other Non-Pay Adjustments	£0.00	£0.00	(£154,773)	**(£154,773)**
Total Cost	**£1,211,309**	**£973,300**	**£1,551,158**	**£3,735,767**

Figure 28 – Option 1 Cost

The other non-pay adjustments refer to an income target at YSTH from selling equipment which is no longer required within the Trust.

4.2.3 Return on Investment

The return on investment for option 1 maintains the existing savings delivery and assumes no further improvement is made on the existing savings targets:

	Year 1	Year 2	Year 3	Year 4	Year 5
Cash Releasing Savings	£2,185,806	£2,185,806	£2,185,806	£2,185,806	£2,185,806
Cost Avoidance Savings	£0.00	£0.00	£0.00	£0.00	£0.00
Total Benefit	£2,185,806	£2,185,806	£2,185,806	£2,185,806	£2,185,806
Cumulative Benefit	£2,185,806	£4,371,612	£6,557,418	£8,743,224	£10,929,030
Total Cost	£3,735,767	£3,735,767	£3,735,767	£3,735,767	£3,735,767
Return on Investment	0.59	0.59	0.59	0.59	0.59

Figure 29 – Option 1 ROI

At present Partner Trusts do not calculate or record cost avoidance savings which is why these are zeroed.

4.2.4 Advantages

The advantages of the BAU option are:

- If the operations of the existing teams are reviewed this option could meet the aims and visions of each Trust individually;
- If the way in which each of the Partner Trust procurement teams is reviewed it could lead to standardised robust product selection and range management practices being in place in each individual Trust;
- It would only ensure that policies, practices and procedures are standardised and provide for the effective provision of procurement to each individual Partner Trust if each of these are reviewed in isolation;
- If each of the existing Partner Trust e-commerce processes are reviewed independently it could develop P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements on a per Trust basis;
- It could enable effective partnering with senior stakeholders, internal customers and suppliers on a per Trust basis if each Partner Trust procurement team increased their stakeholder engagement independently.

4.2.5 Disadvantages

This option does not address the following concerns with the current service:

- It would not meet the aims and vision of the ICS;
- It does not create a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- It will not establish the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- It does not support supplier rationalisation and cost savings;
- It does not ensure innovative and robust Supplier Relationship Management;
- It doesn't ensure all staff are given the opportunity to develop their potential as the full range of roles and opportunities are open to all.

4.2.6 Conclusion

This option is discounted on the basis it does not meet the objectives set for collaborative procurement as set out in 4.9 below.

4.3 Option 2 – Do Minimum (Soft Collaboration)

4.3.1 Description

Maintain procurement as is in separate Partner Trusts but have a more formal arrangement around working together. This could be undertaken by adapting the MOU as to how to work together which has already been agreed by the three Partner Trusts. This could see the three Partner Trusts agree their joint work plans at the start of the year and how resource would be equally released to deliver joint procurement. It would however result in the awarding of separate contracts, therefore not delivering volume benefits.

4.3.2 Net Costs

It is assumed that the existing running costs remain as there will be no additional cost to soft collaboration, there could however be an increase in non-pay savings:

	HUTH	NLAG	YSTH	Total
Annual Pay Budget	£1,152,509	£941,600	£1,636,461	**£3,730,570**
Annual Non-Pay Budget	£58,800	£31,700	£69,470	**£159,970**
Other Non-Pay Adjustments	£0.00	£0.00	(£154,773)	**(£154,773)**
Total Cost	**£1,211,309**	**£973,300**	**£1,551,158**	**£3,735,767**

Figure 30 – Option 2 Cost

4.3.3 Return on Investment

The return on investment for option 2 increases year-on-year with Procurement becoming self-sufficient in year 2. Some additional marginal benefits are delivered through soft collaboration:

	Year 1	Year 2	Year 3	Year 4	Year 5
Cash Releasing Savings	£2,453,543	£5,714,830	£5,714,830	£8,406,264	£8,406,264
Cost Avoidance Savings	£0.00	£0.00	£0.00	£0.00	£0.00
Total Benefit	£2,453,543	£5,714,830	£5,714,830	£8,406,264	£8,406,264
Cumulative Benefit	£2,453,543	£8,168,373	£13,883,204	£22,289,467	£30,695,731
Total Cost	£3,735,767	£3,735,767	£3,735,767	£3,735,767	£3,735,767
Return on Investment	0.66	1.53	1.53	2.25	2.25

Figure 31 – Option 2 ROI

4.3.4 Advantages

The advantages of the soft collaboration option are:

- If the operations of the existing teams are reviewed this option could meet the aims and visions of each Partner Trust individually;
- Soft collaboration between the Partner Trusts could lead to standardised robust product selection and range management practices being in place across the Partner Trusts on a case-by-case basis;
- It would only ensure that policies, practices and procedures are standardised and provide for the effective provision of procurement to each individual Partner Trust if each of these are reviewed in isolation;
- It could support supplier rationalisation and cost savings on a case-by-case basis;

- If each of the existing Partner Trust e-commerce processes are reviewed independently it could develop P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements on a per Trust basis;
- It could enable effective partnering with senior stakeholders, internal customers and suppliers on a per Trust basis if each Partner Trust procurement team increased their stakeholder engagement independently.

4.3.5 Disadvantages

This option does not address the following concerns with the current service:

- It would not meet the aims and vision of the ICS;
- It does not create a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- It will not establish the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- It does not ensure innovative and robust Supplier Relationship Management;
- It doesn't ensure all staff are given the opportunity to develop their potential as the full range of roles and opportunities are open to all.

4.3.6 Conclusion

This option is discounted on the basis it does not meet the objectives set for collaborative procurement as set out in 4.9 below.

4.4 Option 3 – Establish Outsourced Shared Service

4.4.1 Description

Establish a separate strategic procurement function which each Trust pays into based on spend/use. The establishment of the function would be similar to the YSTH Facilities Management LLP, whereby the shared service provides services to its members but can also attract commercial income from selling procurement services to other organisations.

4.4.2 Net Costs

As this option is unlikely to be approved a cost model has not been complete for this option.

4.4.3 Advantages

The advantages of establishing an outsourced shared service option are:

- Supports the aims and vision of the ICS and collaborative members for strategic procurement;
- Creates a single strategic procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Establishes the collaborative as a centre of strategic procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- Ensures that policies, practices and procedures are standardised and provide for the effective provision of strategic procurement to the collaborative trusts;

- Ensures innovative and robust Supplier Relationship Management centrally;
- Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all strategic purchasing requirements;
- Enables effective partnering with senior stakeholders, internal customers and suppliers;
- Ensures strategic staff are given the opportunity to develop their potential.

4.4.4 Disadvantages

This option does not address the following concerns with the current service:

- This option does not support the aims and vision of the ICS and collaborative members for operational procurement;
- There is a risk with this option that operational procurement is not seen as a centre of procurement excellence and this has an adverse impact on the strategic procurement function;
- There is a risk that policies, practices and procedures are not standardised for operational procurement which impact on the strategic procurement function;
- There is a risk that operational procurement e-commerce processes and systems are not developed which undermine the work of the strategic procurement team;
- Operational procurement staff would not have the same opportunity to develop their potential;
- This option would be considered a significant transaction and would require NHSEI and HMRC approval.

4.4.5 Conclusion

This option is discounted on the basis that it would require special approval from NHSEI and HMRC as it would be considered a significant transaction which would require the tax treatment of such an agreement to be approved. It is not believed that this approval would be given.

4.5 Option 4 – Single Procurement Organisation/ Separate Finances

4.5.1 Description

Centralise the existing Trust procurement teams but leave the operational elements of Procurement (PO raising and invoice management) at a Partner Trust level.

4.5.2 Net Costs

There would be development costs for establishing the shared service and triple running costs for maintaining three separate finance/e-procurement systems:

	HUTH	NLAG	YSTH	Total
Baseline Pay Budget	£1,152,509	£941,600	£1,636,461	**£3,730,570**
Increase/Investment	£425,916	£425,916	£425,916	**£1,277,747**
Option 4 Annual Pay Budget	£1,578,425	£1,367,516	£2,062,377	**£5,008,317**
Baseline Non-Pay Budget	£58,800	£31,700	£69,470	**£159,970**
Increase/Investment	£86,543	£86,543	£86,543	**£259,628**
Option 4 Non-Pay Budget	£145,343	£118,243	£156,013	**£419,598**
Capital Spend	£44,300	£44,300	£44,300	**£132,900**

Other Non-Pay Adjustments	£0	£0	(£154,773)	**(£154,773)**
Baseline Total Cost	**£1,211,309**	**£973,300**	**£1,551,158**	**£3,735,767**
Total Cost	**£1,768,068**	**£1,530,059**	**£2,107,915**	**£5,406,042**

Figure 32 – Option 4 Cost

4.5.3 Return on Investment

The return on investment for option 4 increases year-on-year with Procurement becoming self-sufficient in year 2. Some additional marginal benefits are delivered through soft collaboration:

	Year 1	Year 2	Year 3	Year 4	Year 5
Cash Releasing Savings	£2,668,618	£6,131,528	£9,252,042	£12,163,325	£15,074,608
Cost Avoidance Savings	£600,000	£2,150,000	£5,100,000	£10,737,002	£10,697,002
Total Benefit	£3,268,618	£8,281,528	£14,352,042	£22,900,328	£25,771,611
Cumulative Benefit	£3,268,618	£11,550,146	£25,902,188	£48,802,515	£74,274,126
Total Cost	£5,406,042	£5,263,142	£5,263,142	£5,263,142	£5,263,142
Return on Investment	0.60	1.57	2.73	4.35	4.90

Figure 33 – Option 4 ROI

4.5.4 Advantages

The advantages of the single procurement organisation/separate finances option are:

- To some extent this option supports the aims and vision of the ICS and collaborative members;
- To some extent this option creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Establishes the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- This option ensures that to some extent policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts;
- To some extent this option ensures innovative and robust Supplier Relationship Management;
- Enables effective partnering with senior stakeholders, internal customers and suppliers;
- Ensures all staff are given the opportunity to develop their potential.

4.5.5 Disadvantages

This option does not address the following concerns with the current service:

- Separate systems for purchase orders and invoicing based on Trust finance systems will lead to procurement teams having to enter one contract onto multiple systems. This will not lead to efficiencies for the supplier and their back-office costs which could be passed onto HNYPC and would not be seen as effective SRM;

- There is a risk with this option that if the collaborative procurement function is using different systems they will be following the separate policies and processes of each of the trusts finance teams;
- P2P e-commerce processes and systems would remain separate for each organisation and would therefore require additional administration as the same information is re-keyed into separate systems. This is not a smooth and efficient processing for all purchasing requirements;
- Reporting and data management would be impacted as spend information would continue to sit in three systems which would impact Contract Management;
- Depending upon the organisational structure, the Partner Trust who hosts HNYPC may act as the Contracting Authority for all three trusts but does not control the payment of invoices. Any late payment of an invoice by another Partner Trust could see the host organisation receive a challenge or claim for costs.

4.5.6 Conclusion

This option is discounted as it does not deliver all of the efficiencies that a fully collaborative procurement function can bring.

4.6 Option 5 – Single Procurement Organisation and Finances

4.6.1 Description

Centralise the existing Trust procurement teams as well as non-pay spend so only one system for PO/invoice is required for each contract awarded.

4.6.2 Net Costs

The alternative resourcing structure would require funding for the specialist roles which cannot be resourced from elsewhere e.g. Clinical Procurement Specialists and more senior roles required to deliver change:

	HUTH	NLAG	YSTH	Total
Baseline Pay Budget	£1,152,509	£941,600	£1,636,461	**£3,730,570**
Increase/Investment	£253,436	£253,436	£253,436	**£760,307**
Option 5 Annual Pay Budget	£1,405,945	£1,195,036	£1,889,897	**£4,490,878**
Baseline Non-Pay Budget	£58,800	£31,700	£69,470	**£159,970**
Increase/Investment	£110,107	£110,107	£110,107	**£330,322**
Option 5 Non-Pay Budget	£168,907	£141,807	£179,577	**£490,292**
Capital Spend	£44,300	£44,300	£44,300	**£132,900**
Other Non-Pay Adjustments	£0	£0	(£154,773)	**(£154,773)**
Baseline Total Cost	**£1,211,309**	**£973,300**	**£1,551,158**	**£3,735,767**
Total Cost	**£1,619,152**	**£1,381,143**	**£1,959,001**	**£4,959,297**

Figure 34 – Option 5 Cost

4.6.3 Return on Investment

The return on investment for option 5 increases thought to year 5 when the benefits of supplier rationalisation reduce as they have been delivered during previous years:

	Year 1	Year 2	Year 3	Year 4	Year 5
Cash Releasing Savings	£6,248,378	£9,248,662	£12,369,175	£15,110,608	£18,064,892
Cost Avoidance Savings	£700,000	£2,250,000	£5,150,000	£10,757,003	£10,707,002
Total Benefit	£6,948,378	£11,498,662	£17,519,175	£25,867,611	£28,771,894
Cumulative Benefit	£6,948,378	£18,447,040	£35,966,215	£61,833,826	£90,605,720
Total Cost	£4,959,297	£4,816,397	£4,816,397	£4,816,397	£4,816,397
Return on Investment	1.40	2.39	3.64	5.37	5.97

Figure 35 – Option 5 ROI

4.6.4 Advantages

The advantages of the single procurement organisation and finances option are:

- Supports the aims and vision of the ICS and collaborative members;
- Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Establishes the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts;
- Ensures innovative and robust Supplier Relationship Management;
- Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements;
- Enables effective partnering with senior stakeholders, internal customers and suppliers;
- Ensures all staff are given the opportunity to develop their potential.

4.6.5 Disadvantages

This option meets all of the criteria set out so no disadvantages have been listed.

4.6.6 Conclusion

This option is supported as it meets all of the criteria in table 4.9 below as agreed by the trust's executive leads and contained in the HNYPC Procurement Strategy. However, it is recognised that this option is requesting a significant investment in back office expenditure at a time when finances across the NHS are stretched and inflation is pushing the costs higher. Not addressing opportunities in procurement however will mean that both cost and cost avoidance savings will be missed. This case evidences significant improvement and opportunity for the Partner Trusts.

The capability and grade mix of existing resource provides significant challenge to deliver a transformation in the way procurement operates and the way it is perceived by customers across the three Partner Trusts. New resource will be required to deliver change but equally importantly, new resource will be required to help change the

culture of the existing resources. This business case will fundamentally change the way procurement operates in the Partner Trusts making it much more engaging, proactive and will reduce unnecessary paper-based bureaucracy.

4.7 Option 6 – Join Another ICS Procurement Collaborative

4.7.1 Description

Speak to other ICS Procurement collaborative organisations who may be further advanced to add HNY strategic procurement requirements to their existing structures and plans. Use the existing operational procurement workforce to manage local engagement as business managers.

4.7.2 Net Costs

The cost of this option would need to be scoped up with another collaborative based on a specification of services.

4.7.3 Advantages

The advantages of the join another ICS procurement collaborative option are:

- So long as the specification of requirements clearly sets out the requirements this option could support the aims and vision of the ICS and collaborative members;
- Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts;
- Ensures innovative and robust Supplier Relationship Management;
- Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements;
- Enables effective partnering with senior stakeholders, internal customers and suppliers.

4.7.4 Disadvantages

This option does not address the following concerns with the current service:

- As this would be outsourced it does not establish the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Depending on where this service is provided it would not ensure all staff are given the opportunity to develop their potential.

4.7.5 Conclusion

This option is discounted as following discussion with NHSEI there are no other ICS procurement teams far enough advanced to be able to provide this service.

4.8 Option 7 – Outsource Procurement

4.8.1 Description

Run a competition to outsource the procurement function to a standalone provider.

4.8.2 Net Costs

The cost of this option would need to be scoped up with an outsourced provider based on a specification of services.

4.8.3 Advantages

The advantages of the outsource procurement option are:

- So long as the specification of requirements clearly sets out the requirements this option could support the aims and vision of the ICS and collaborative members;
- Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services;
- Supports supplier rationalisation and cost savings;
- Ensures standardised robust product selection and range management practices are in place;
- Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts;
- Ensures innovative and robust Supplier Relationship Management;
- Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements;
- Enables effective partnering with senior stakeholders, internal customers and suppliers.

4.8.4 Disadvantages

This option does not address the following concerns with the current service:

- As this would be outsourced it does not establish the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations;
- Depending on where this services is provided it would not ensure all staff are given the opportunity to develop their potential;
- The three Partner Trusts would need to agree how to manage the contract for the outsourced service. At present contract management is identified as an activity requiring improvement.

4.8.5 Conclusion

This option is discounted as it does not establish a commercial centre of excellence nor ensure that all staff are given the opportunity to develop.

4.9 Option Appraisal

The options which were not discounted as part of the long list have been scored against the 10 criteria as agreed by the trust's executive leads and contained in the HNYPC Procurement Strategy:

	Option 1	Option 2	Option 4	Option 5
Supports the aims and vision of the ICS and collaborative members.				

Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services.				
Establishes the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations.				
Supports supplier rationalisation and cost savings.				
Ensures standardised robust product selection and range management practices are in place.				
Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts.				
Ensures innovative and robust Supplier Relationship Management (SRM).				
Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements				
Enables effective partnering with senior stakeholders, internal customers and suppliers.				
Ensures all staff are given the opportunity to develop their potential.				
Total	**5**	**6**	**15**	**20**

Figure 36 – Options Appraisal

The ROI has also been compared across the options which were shortlisted for costing which shows option 5 outperforms other options. The as-is option is the only one which does not increase the ROI above 1:

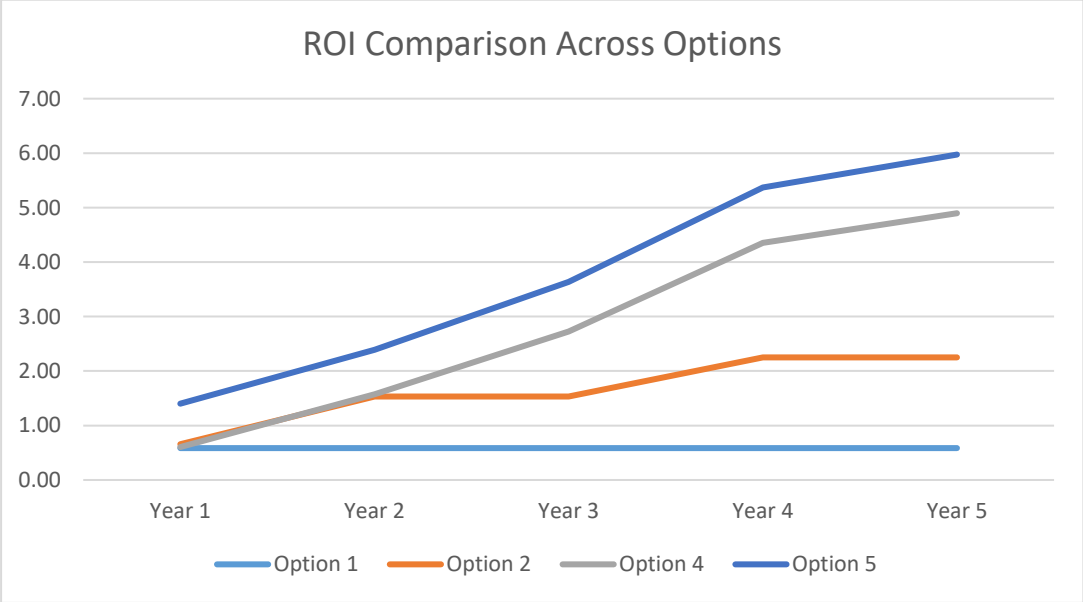


Figure 37 – ROI Comparison

The savings predictions have also been plotted over the five year period with the current estimated inflation figures included. The Bank of England expects inflation to peak at 11% during the next 12 months reducing to 2% in a couple of years' time. Only options 4 and 5 deliver financial benefit above inflation after three years:

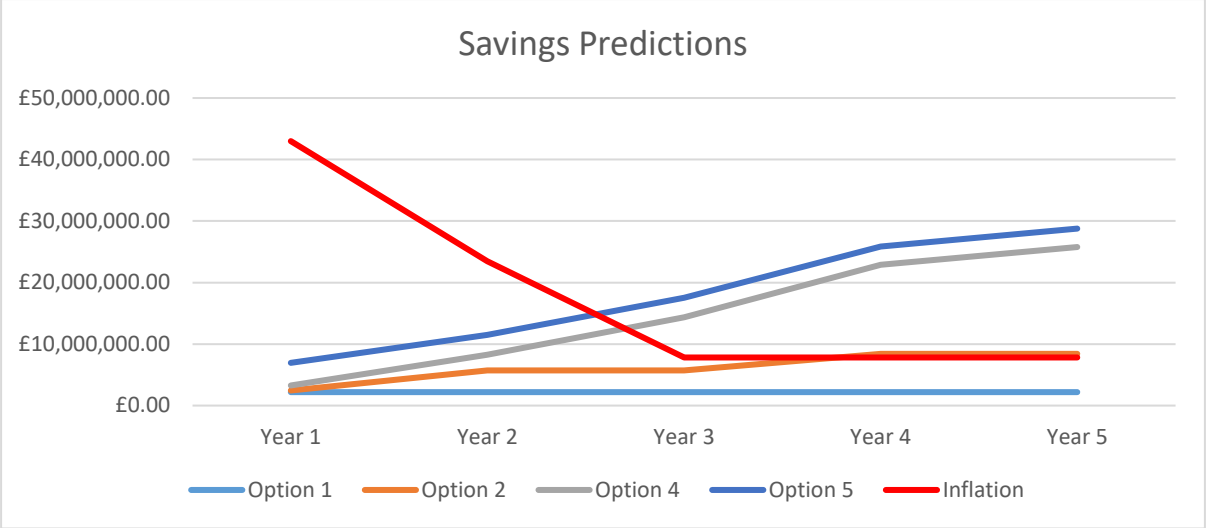


Figure 38 Savings Predictions

Based on the assessment against the criteria in table 4.9, as agreed by the trust's executive leads and contained in the HNYPC Procurement Strategy, the ROI and savings prediction, option 5 is identified as the preferred option and therefore explored in further detail in the following sections.

5. Preferred Option – Organisation Form & Governance Structure

5.1 Formal Establishment of the HNYPC

Three options have been considered as part of the organisational form in terms of how the procurement collaborative will be established and managed moving forward. Consideration is also given as to how to manage new organisations wishing to join the collaborative in the future. This ensures that a fair and transparent approach is set out at the beginning. The three options considered are:

- As-Is – individuals and costs will remain as per the current Partner Trust structures;
- Full Centralisation – all resource is moved to one Partner Trust and managed centrally;
- Transitional – centralisation happens over a period of time with elements of cost and risk being shared between Partner Trusts.

Governance processes were set out for the HNYPC as part of the MoU signed by all Trusts in June 2022. At a meeting of the Procurement Board in October 2022 it was agreed that the procurement function should be centralised under HNYPC which should be hosted by HUTH. To assure the HUTH Board around the risks and mitigating actions of this, a formal legal agreement will be established to ratify these arrangements. The development of the legal arrangement will include work with legal and finance colleagues across the HNYPC to legally formalise the governance behind the shared service (in particular with reference to the requirements of Regulation 12(7) of the Public Contracts Regulations 2015). This is also important so that suppliers are aware that HNYPC employees represent all Partner Trusts. Development of this business case has been delayed by the reluctance of suppliers to share individual Trust data with the DoP who is perceived as only acting on behalf of one Trust.

It is proposed that the agreement will set out how the three Partner Trusts will cooperate between themselves for purchasing and supplies activity. The HNYPC Board will be responsible for managing the performance of the DoP in fulfilling the service obligations. The HNYPC will provide a collaborative framework where-by purchasing and supplies activities can be delivered by and on behalf of the Partner Trusts. The remit will include recommendations as to the best commercial solution or route to market and where appropriate may include challenge to service leads in terms of demonstrating best value.

5.2 Establishment Costs

The current key financial figures per Partner Trust which could impact the decision as to how establishment costs are apportioned are:

Expenditure	HUTH	NLAG	YSTH	Total
Pay	£1,152,509	£941,600	£1,636,461	**£3,730,570**
Non-Pay	£58,800	£31,700	£69,470	**£159,970**
Total	**£1,211,309**	**£973,300**	**£1,705,931**	**£3,890,540**
Proportion	31.13%	25.02%	43.85%	
Headcount	35.38	27.62	55.54	**118.54**
Proportion	30%	23%	47%	
Organisational Income	£727m	£478m	£616m	**£1.8bn**
Proportion	40%	26%	34%	
Addressable Non-Pay Spend	£243.2m	£128.8m	£166.2m	**£538.2m**

Proportion	45.19%	23.94%	30.88%	

Figure 39 – Establishment Costs

It is therefore possible to apportion costs for HNYPC in five different ways:

- As a proportion of existing establishment cost;
- As a proportion of existing headcount;
- As a proportion of organisational income;
- As a proportion of non-pay spend;
- Equally split between each Partner Trust.

The benefits and constraints of each approach is set out below:

Approach	Benefits	Constraints
Proportion of existing establishment cost	Each Partner Trust proportionately increases its existing establishment cost equally	Partner Trusts who have funded the Procurement function to a higher level historically cover the cost of Partner Trusts who have historically underfunded the function
Proportion of existing headcount	Each Partner Trust proportionately increases its cost in line with existing headcount equally	Partner Trusts who have had a higher headcount historically cover the cost of Partner Trusts who have historically had a lower headcount
Proportion of organisational income	Partner Trusts with the greatest income from offset the cost of the procurement function	Organisational income is not linked to procurement activity so is not a fair baseline
Proportion of non-pay spend	Procurement activity is driven by non-pay expenditure so is a fair baseline on which to apportion the cost of the function	Partner Trusts who have historically underfunded Procurement activity in comparison to non-pay spend will have a greater cost to pick up
Equal between all Partner Trusts	Each Partner Trust is equally invested in the new Procurement collaborative	Partner Trusts who have funded the Procurement function to a higher level historically cover the cost of Partner Trusts who have historically underfunded the function

Figure 40 – Benefits of Scoring Approach

At the Procurement Board in October 2022 all options were reviewed and it was agreed that Procurement establishment costs (pay and non-pay) are apportioned equally between the three Partner Trusts.

5.2.1 As-Is

All current pay and non-pay costs stay with each Partner Trust. Any additional investment in establishment costs are funded by the Partner Trusts equally.

Using the costs set out in Option 5 above there is a request to increase pay spend by £760,307 and non-pay by £330,322 for HNYPC. Splitting the increase equally across the three Partner Trusts would increase existing budgets:

Expenditure	HUTH	NLAG	YSTH
Pay Budget	£1,152,509	£941,600	£1,636,461
Additional Pay	£253,436	£253,436	£253,436
Non-Pay Budget	£58,800	£31,700	£69,470
Additional Non-Pay	£110,107	£110,107	£110,107
Income Target	£0	£0	(£154,773)

Total	**£1,574,852**	**£1,336,843**	**£1,914,701**
Total Increase	**£363,543**	**£363,543**	**£363,543**

Figure 41 – As-Is Pay & Non-Pay

The benefits of the as-is approach is that it uses existing Partner Trust processes and procedures and will allow for performance reporting at a budget line and organisational level. The constraints of this approach is that it drives duplication into the system with three different budgets to manage for a single central function. Non-pay costs would need to be split in such a way that each Partner Trust picks up its proportionate cost where the requirement may be single and central e.g. a single e-commerce IT system across HNYPC.

5.2.2 Full Centralisation

All current pay and non-pay costs are centralised to a single Partner Trust and to a single budget line. Any additional investment on establishment costs are funded by the Partner Trusts equally with the additional funding transferred to the single Partner Trust and central budget.

Using the same example as above:

Expenditure	HUTH	NLAG	YSTH
Additional Pay	£253,436	£253,436	£253,436
Additional Non-Pay	£110,107	£110,107	£110,107
Pay Budget (inc. transferred)	£4,490,878	£0	£0
Non-Pay Budget (inc. transferred)	£490,292	£0	£0
Income Target	(£154,773)	£0	£0
Total	**£4,826,397**	**£0**	**£0**

Figure 42 – Full Centralisation Pay & Non-Pay

The benefits of the centralisation approach is that it brings all pay and non-pay budget responsibility for HNYPC into one reporting structure making financial reporting and management easier. The constraints of this approach is that it requires financial transfers between organisations and could leave HUTH with the risk of any non-payment or late payment by other Partner Trusts. This risk is considered as low.

5.2.3 Transitional

All current pay costs are retained in their existing Partner Trusts with non-pay and new additional costs centralised to HUTH. As pay costs are reduced at Partner Trusts through individuals leaving posts these funds would then be centralised to HUTH and a single budget line.

Using the same example as above:

Expenditure	HUTH	NLAG	YSTH
Additional Pay	£760,308	£0	£0
Additional Non-Pay	£330,321	£0	£0
Pay Budget	£1,152,509	£941,600	£1,636,461
Non-Pay Budget	£159,970	£0	£0
Income Target	(£154,773)	£0	£0
Total	**£2,248,335**	**£941,600**	**£1,363,461**

Figure 43 – Transitional Pay & Non-Pay

The benefits of this approach are that it allows existing pay costs to remain within existing budget lines and to only transfer pay costs at the point in which additional cost is approved or existing cost is released. The constraints of this approach are that it will be difficult to continually monitor and manage and will require multiple budget transfers between Partner Trusts.

The recommendation is that the transitional approach is followed with all non-pay and additional cost centralised to HUTH. Existing pay costs will stay with the current employing Trust until the post becomes vacant, at which point the vacant post funds will be transferred to HUTH. Budget responsibility for all pay and non-pay costs transfers to the HNYPC DoP.

5.3 HR & Employment

Although not essential, it would make sense for the HR and Employment options to mirror the establishment cost approach to ensure parity and fairness. Each option is however set out below.

5.3.1 As-Is

All staff remain employed by their existing Partner Trust and work collaboratively under a single management structure. New posts and roles are advertised on a rotational basis between Partner Trusts based on the agreed establishment using existing headcount.

Using Option 5 the requirement is for £760,307 pay cost which represents an additional 14 FTE these would be employed on the following basis:

Expenditure	HUTH	NLAG	YSTH
Headcount	39.15	27.12	52.17
Proportion	33.05%	22.90%	44.05%
Additional to recruit	4.63	3.21	6.17
Total	**43.78**	**30.33**	**58.34**

Figure 44 – As-Is HR & Employment

The benefit of this approach is that each Partner Trust increases its headcount proportionately to meet the needs of HNYPC. The constraints of this approach are that it becomes messy when dealing in decimal points of a FTE and that it will not promote any single team ethos across the different Partner Trusts.

5.3.2 Full Centralisation

All staff transfer to a single Trust for their employment and pay. All new roles are appointed by the single Partner Trust with funding transferred as per the agreed establishment cost set out above.

Using Option 5:

Expenditure	HUTH	NLAG	YSTH
Proportion	33.05%	22.90%	44.05%
Additional to recruit	14	0	0
Centralised headcount	118.54	0	0
Total	**132.54**	**0**	**0**

Figure 45 – Full Centralisation HR & Employment

The benefits of this approach is it provides better team cohesion as well as greater clarity to applicants around the organisation they are employed by and who they are working for. The only constraint is for HUTH to ensure that the finances flow to support the additional cost and that there is no risk of any non-payment or late payment by other Partner Trusts. There is also a considerable and unsettling HR process to go through where staff TUPE to HUTH.

5.3.3 Transitional

Existing staff stay employed with their current Partner Trust, with all new employments made by HUTH. This would include both additional resource as well as new recruitment for existing posts that are vacant.

Using Option 5:

Expenditure	HUTH	NLAG	YSTH
Headcount	39.15	27.12	52.17
Proportion	33.05%	22.90%	44.05%
Additional to recruit	14	0	0
Total	**53.15**	**27.12**	**52.17**

Figure 46 – Transitional HR & Employment

The benefit of this approach is it minimises HR process and support required to move people from one Partner Trust to HUTH. This could provide a quicker and smoother transition to the new organisation. The constraints of this approach are that it could generate the view of a split workforce.

Based on the above, the recommendation is that the transactional approach is followed. All staff will remain employed by their existing Partner Trust and would only transfer if they applied for a new role within HNYPC. All new roles and vacant roles would be recruited by HUTH with budget adjustments made as appropriate. Each Partner Trust also retains their own HR risk around any future structure.

5.4 Contracting Authority & Risk Management

Every contract entered into by HNYPC will need to be entered into by an organisation with legal standing - a Contracting Authority. HNYPC aims to generate benefit through procurement by centralising procurement, maximising the use of our resources and delivering value for money to our Partner Trusts. A collaborative procurement exercise could result in one or more contracts being awarded.

5.4.1 As-Is

Each Partner Trust will maintain its current contracts and will award its own contracts after a collaborative procurement exercise is completed. This will then lead to separate purchase orders, invoices and payments, it is therefore important this aligns to non-pay spend management set out below. The fact that separate contracts will be entered into after the procurement exercise will need to be clearly set out to bidders in advance.

As an example HNYPC undertake ten collaborative procurement exercises within the first 12 months:

Contract	HUTH	NLAG	YSTH
Waste Services	£8,000,000	£44,000	£3,700,000
Laundry Services	£3,700,000	£1,000,000	£5,200,000
e-Rostering	£1,077,964	£1,218,180	£1,002,000

Interpretation	£1,857,117	£350,000	£275,373
Car Parking Services	£6,014,385	£1,377,890	£58,000
Temporary Staffing	£6,348,780	£5,000,000	£8,000,000
Orthotics	£2,000,000	£66,500	£1,600,000
Hips & Knees	£4,075,505	£1,000,000	£1,000,000
Procedure Packs	£694,000	£450,000	£560,000
Mesh	£150,000	£80,000	£120,000
Total	**£33,917,751**	**£10,586,570**	**£21,515,373**

Figure 47 – As-Is Contracting Authority

Although £66m of contracts will have been entered into, each Partner Trust would act as the Contracting Authority and underwrite the risk of their proportion of the contract entered into.

The benefits of this approach is that it keeps ownership and responsibility of risk as is with each Partner Trust. The constraint of this approach is that it does not achieve the ambition for collaborative procurement across HNYPC. Although a collaborative procurement exercise will be undertaken, separate contracts will still be awarded and the cost of business to the supplier will not change. This could also lead to complications in contract management especially if this is not consistent between Partner Trusts.

5.4.2 Full Centralisation

All existing contracts are novated to a single Partner Trust who also acts as the Contracting Authority and takes the risk associated with future procurement activity. This is then managed through finance transfers in line with the establishment costs set out above.

Using the example above this would mean that HUTH would underwrite the risk of all £66m of contracts entered into by HNYPC:

Contract	HUTH	NLAG	YSTH
Waste Services	£11,744,000	£0	£0
Laundry Services	£9,900,000	£0	£0
e-Rostering	£3,298,144	£0	£0
Interpretation	£2,482,490	£0	£0
Car Parking Services	£7,450,275	£0	£0
Temporary Staffing	£19,348,780	£0	£0
Orthotics	£3,666,500	£0	£0
Hips & Knees	£6,075,505	£0	£0
Procedure Packs	£1,704,000	£0	£0
Mesh	£350,000	£0	£0
Total	**£66,019,694**	**£0**	**£0**

Figure 48 – Centralised Contracting Authority

The benefits of this approach are that this achieves the ambition of centralising procurement activity across HNYPC and that the cost of doing business can be reduced. This will also support contract management activity as there will only be one contract to manage, rather than three. The constraints of this approach are that HUTH takes all of the risk associated with contracting.

This however could be covered by an agreement by all Partner Trusts to underwrite the risk of their element of the contract in the background either undertaken on a

contract-by-contract basis or through a blanket approach based on income of each organisation which links to their financial ability to cover risk.

Using this approach the risk underwriting £66m as a basket would be:

Expenditure	HUTH	NLAG	YSTH
Proportion	40%	26%	34%
Total	**£26,407,877**	**£17,165,120**	**£22,446,696**

Figure 49 – Risk Underwriting

5.4.3 Transitional

Each Partner Trust will maintain its current contracts and all new contracts are entered into on a rotational basis between the Partner Trusts. This means that the risk is shared between each of the Partner Trusts on a rotational basis and it would be agreed as part of the procurement strategy which Contracting Authority would manage each contract. This would be linked as closely as possible to the proportions set out above.

Using the example above this would mean:

Contract	HUTH	NLAG	YSTH
Proportion	40%	26%	34%
Total	**£26,407,877**	**£17,165,120**	**£22,446,696**
Waste Services	£0	£11,744,000	£0
Laundry Services	£9,900,000	£0	£0
e-Rostering	£0	£0	£3,298,144
Interpretation	£2,482,490	£0	£0
Car Parking Services	£7,450,275	£0	£0
Temporary Staffing	£0	£0	£19,348,780
Orthotics	£3,666,500	£0	£0
Hips & Knees	£0	£6,075,505	£0
Procedure Packs	£1,704,000	£0	£0
Mesh	£350,000	£0	£0
Total	**£25,553,265**	**£17,819,505**	**£22,646,924**
Proportion	38.7%	27%	34.3%

Figure 50 – Transitional Contracting Authority

The benefit of this approach is that all organisations take a share of the risk of being a Contracting Authority, both the procurement risk but also subsequent contract management risk. The constraints of this approach are that it assumes all contracts cover equal risk, which they don't, and it requires ongoing management to ensure contracts fit the agreed proportion. As evidenced above the outcome is slightly different to the agreed proportion so some level of tolerance would need to be agreed in advance.

Based on the above, the recommended approach would be that HUTH acts as Contracting Authority however existing contracts are not novated to HUTH, it is only for future contracts. The reason for this is that HUTH would need to undertake due diligence on the contracts to novate which would take time and incur cost. These legacy contracts would still be managed by HNYPC on behalf of each Partner Trust. Additional legal guidance is provided to HUTH around risk and mitigations of this approach.

5.5 Non-Pay Spend Management

Spend management refers to the way in which the administration element of procurement is undertaken. Once the contracts are awarded, purchase orders will need to be raised to allow the supplier to raise an invoice and payment to be made once confirmation the goods, works or services have been received to the expected quality. Consistent feedback from supplier engagement is that spend management, the cost of doing business, needs to be considered rather than expecting savings just from saying collaboration is happening. This element is closely linked to the decision around Contracting Authority.

5.5.1 As-Is

Each Partner Trust will raise a purchase order on their own e-financial system based on the contract that has been awarded. This will allow each Partner Trust to receive an invoice and charge this to the local ledger.

Using the example above, once the contracts are awarded each Partner Trust will raise a purchase order for the contract:

Contract	HUTH	NLAG	YSTH
Waste Services	£8,000,000	£44,000	£3,700,000
Laundry Services	£3,700,000	£1,000,000	£5,200,000
e-Rostering	£1,077,964	£1,218,180	£1,002,000
Interpretation	£1,857,117	£350,000	£275,373
Car Parking Services	£6,014,385	£1,377,890	£58,000
Temporary Staffing	£6,348,780	£5,000,000	£8,000,000
Orthotics	£2,000,000	£66,500	£1,600,000
Hips & Knees	£4,075,505	£1,000,000	£1,000,000
Procedure Packs	£694,000	£450,000	£560,000
Mesh	£150,000	£80,000	£120,000
Total	**£33,917,751**	**£10,586,570**	**£21,515,373**

Figure 51 – As-Is Non-Pay Management

The benefit of this approach is that there is no change to the current finance ways of working. The constraint of this approach is that it does not reduce the cost of business to the supplier so could impact the value for money achieved. Depending upon the decision around Contracting Authority there would also be additional risk for the Contracting Authority if they were not in control of the payment process as well. Should a decision be made to either centralise or have a transitional arrangement around the Contracting Authority but retain the as-is payment process, the Contracting Authority could find themselves in breach of contract should another Partner Trust not pay an invoice on time.

5.5.2 Full Centralisation

Non-pay spend is centralised under HUTH with purchase orders, invoices and payments managed by HUTH. This approach would require each Partner Trust to agree to transfer its non-pay budget to HUTH.

Using the example above the payment process would be:

Contract	HUTH	NLAG	YSTH
Proportion	40%	26%	34%
Budget to transfer	**£26,407,877**	**£17,165,120**	**£22,446,696**

Waste Services	£11,744,000	£0	£0
Laundry Services	£9,900,000	£0	£0
e-Rostering	£3,298,144	£0	£0
Interpretation	£2,482,490	£0	£0
Car Parking Services	£7,450,275	£0	£0
Temporary Staffing	£19,348,780	£0	£0
Orthotics	£3,666,500	£0	£0
Hips & Knees	£6,075,505	£0	£0
Procedure Packs	£1,704,000	£0	£0
Mesh	£350,000	£0	£0
Total	**£66,019,694**	**£0**	**£0**

Figure 52 – Centralised Non-Pay Management

The benefit of this approach is that the cost of doing business for the supplier would reduce as there would only be HUTH to engage with and this should lead to greater value for money. This would also allow the risk for any centralised Contracting Authority to be managed as they would also manage the payment process. The constraint of this option is that HUTH would hold the risk around contract variations which lead to price changes. Other Partner Trusts may see an opportunity to increase the scope of the contract as they perceive this to be free on the basis they are not paying. This would have to be managed through the contract management function by HNYPC.

5.5.3 Transitional

All non-pay spend is funded by HUTH with budget transfers completed in the background back to individual Partner Trust budget lines. Rather than the non-pay budget being centralised at the start of the year HUTH would recharge each Partner Trust their proportion of the contract cost.

Using the example above the budget transfer process moves to the end of the process and would allow finance teams to recharge each cost centre at a Partner Trust level:

Contract	HUTH	NLAG	YSTH
Waste Services	£11,744,000	£0	£0
Laundry Services	£9,900,000	£0	£0
e-Rostering	£3,298,144	£0	£0
Interpretation	£2,482,490	£0	£0
Car Parking Services	£7,450,275	£0	£0
Temporary Staffing	£19,348,780	£0	£0
Orthotics	£3,666,500	£0	£0
Hips & Knees	£6,075,505	£0	£0
Procedure Packs	£1,704,000	£0	£0
Mesh	£350,000	£0	£0
Total	**£66,019,694**	**£0**	**£0**
Proportion	40%	26%	34%
Trust recharge	**£26,407,877**	**£17,165,120**	**£22,446,696**

Figure 53 – Transitional Non-Pay Management

The benefit of this approach is that it allows finance teams at each Partner Trust to charge non-pay spend to local cost centres. This may lead to better local management of resources. The constraints of this approach are that it adds additional cost to finance

in managing the recharging process and only allows for non-pay spend to be reconciled at the end of the commitment.

Based on the above the recommendation is that non-pay spend is centralised to HUTH and recharged to each Partner Trust to be charged at a cost centre and budget holder level so they can take ownership of all expenditure. HUTH will establish a cash account that will need to be cleared at the end of each month to ensure the transactions do not impact the financial accounts of HUTH.

5.6 Addition of New Partner Trusts

Should other trusts wish to become a Partner Trust of HNYPC then the chosen proportionality calculations will be recalculated and adjusted for at the begging of the next financial year and approved by the Procurement Board.

A decision will also need to be made around any additional cost incurred by Partner Trusts prior to a new Partner Trust joining. For example, if the Partner Trusts agree additional pay and non-pay expenditure which is funded between the three original Partner Trusts and a new Partner Trust joins within the first 12 months a decision needs to be made as to whether they should be charged a proportion of the additional establishment cost.

5.6.1 Establishment Costs

The recommendation is that all non-pay costs are fully centralised to HUTH with pay costs remaining with the existing Trust. Additional future costs are then proportioned across Partner Trusts and budget transferred to HUTH.

For simplicity the recommendation is that any new member will only be charged for the proportionate cost at the start of each financial year. They may transfer their non-pay budget to HUTH part way through a financial year on a proportionate basis.

For example, if a new Partner Trust were to join on 1st October they would budget transfer 50% of non-pay costs to HUTH. On 1st April of the following year their non-pay spend would be included as part of the calculation of the proportionate charge. This new proportionate charge would also be used for any additional funding requested by HNYPC.

5.6.2 HR & Employment

The recommendation is that the transitional approach is followed. All staff will remain employed by their existing Partner Trust and would only transfer if they applied for a new role within HNYPC. All new roles and vacant roles would be recruited by HUTH with budget adjustments made as appropriate.

Following this approach the new Partner Trust would transfer vacant posts to HUTH either to recruit into or to be subsumed in the current structure. All existing staff from the new Partner Trust would remain on their employment until applying for another role within HNYPC or leaving their post.

5.6.3 Contracting Authority & Risk

The recommended approach is that HUTH acts as the Contracting Authority however existing contracts are not novated to HUTH, it is only for future contracts. The reason for this is that HUTH would need to undertake due diligence on the contracts to novate

which would take time and incur cost. These legacy contracts would still be managed by HNYPC on behalf of each Partner Trust.

The new Partner Trust would need to accept HUTH acting as the Contracting Authority for all future collaborative contracts.

5.6.4 Non-Pay Spend Management

Based on the above the recommendation is that non-pay spend is centralised to HUTH and recharged to each Partner Trust to be charged at a cost centre and budget holder level so they can take ownership of all expenditure.

The new Partner Trust would be recharged at the cost centre level for all collaborative procurements.

5.7 Governance Structure

The current governance structure does not suit the needs or unlock the benefits associated with a collaborative strategy. Current governance aligned to individual organisations, impedes collaborative procurement operations and collaborative opportunities realisation, results in multiple inconsistent approval processes and creates a duplication of effort for HNYPC Partner Trusts. It has also been found that there is a lack of clarity on requirements amongst the Partner Trusts and there is no single forum to hold procurement accountable, inhibiting on traceability and auditability.

A new governance structure has been designed which shows how the HNYPC will integrate into its Partner Trusts. HNYPC will be responsible for all non-pay spend of Partner Trusts excluding Pharmacy and NHS to NHS expenditure.

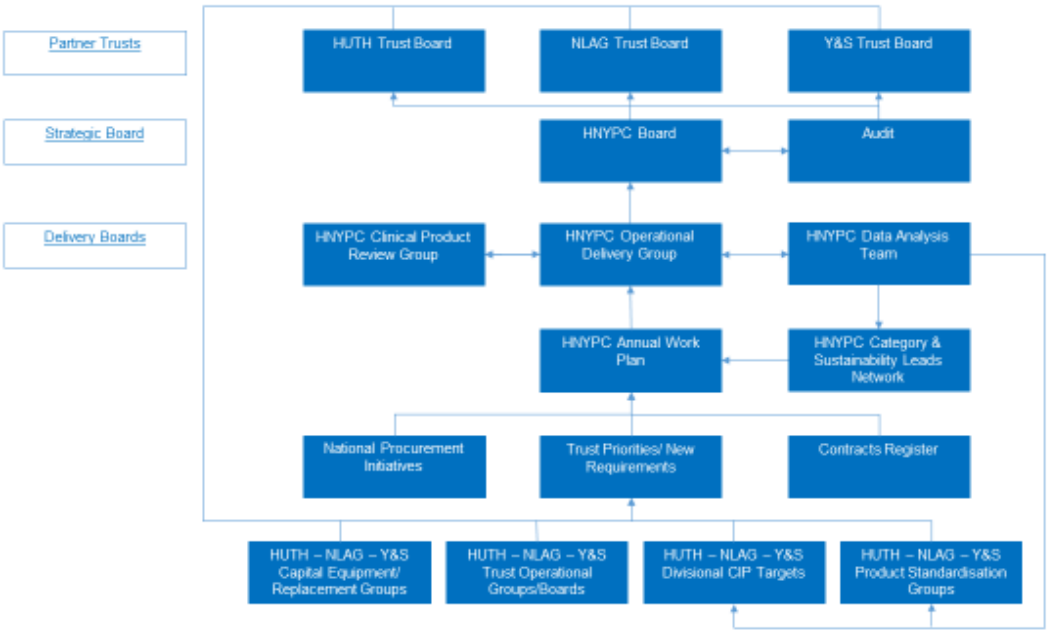


Figure 54 – Governance Structure

Each of the committees and boards set out above have defined responsibility to ensure that HNYPC delivers its procurement strategy.

Membership	Responsibilities
HNYPC Board • Director of Finance Hull/NLAG • Director of Finance York • Director of Procurement HNYPC • Medical Director • Operations Director • Nursing Director • Estates & Facilities Director	• The Partner Trusts who have signed up to the MOU are required to form an oversight body with board level executive representatives. • The Board has equal representation from the Partner Trusts. • The Board provides assurance to the respective partner trusts about the operational effectiveness of procurement activity, highlighting any risks which could impact any Partner Trust. • The Board shall agree and sign off the strategic plan for the service including the setting of key milestones, sign off and approve annual operational plans. • The Board will hold the Operational Delivery Group to account for the safe, effective and efficient delivery of the procurement service.
HNYPC Operational Delivery Group • Director of Procurement HNYPC • Deputy Director – Procurement • Deputy Director – Supply Chain • Deputy Director – Governance & Assurance • NHSSC Customer Relations Manager • NOECPC Customer Relations Manager • Clinical Leads	• The Operational Delivery Group is directly accountable to the HNYPC Board. • Accountable for the delivery of the Partner Trusts work plans and informing these work plans through reviews of data undertaken by the Data Analytics team, through national initiatives, through maintaining the contracts register or through new initiatives as required by the Partner Trusts. • Accountable for ensuing all procurement activity is undertaken in line with relevant procurement regulations and Partner Trust standing financial instructions. • The Operational Delivery Group will establish standing committees to ensure safe and effective operational delivery: Clinical Product Review Group; Data Analytics; Category Lead Network. • The Operational Delivery Group will maintain minutes of all meetings.
HNYPC Clinical Product Review Group • Deputy Director - Procurement • Clinical Procurement Specialists • Theatres Representative • Nursing Representative • EBME Representative	• The Clinical Product Review Group is directly accountable to the HNYPC Operational Delivery Group. • Accountable for reviewing opportunities for standardisation of clinical products across the Humber & North Yorkshire region. • Responsible for the delivery of clinical product trials in a safe and consistent manner. • Will provide clinical challenge where opportunities for standardisation are not being taken and escalate any issues in Partner Trusts to the Operational Delivery Group. • Support the Operational Delivery Group to minimise Partner Trust stockholding where appropriate to ensure efficient procurement operations. • Members of the Clinical Product Review Group will actively promote the work of the Humber & North Yorkshire Procurement Collaborative and the clinical benefits that can be delivered through standardisation and rationalisation.
HNYPC Category & Sustainability Leads Network • Deputy Director - Procurement • Deputy Director – Supply Chain • Procurement Business Partners (CSS, S&CC, OCA, GC, EF&C) • HNYPC Sustainability Lead	• Accountable to the Operational Delivery Group. • Responsible for the development of value based sourcing strategies which cover key categories of spend for Partner Trusts. • Will work with the Data Analytics team to build category strategies that understand suppliers, markets and Partner Trust's needs.

	• Responsible for delivery of the HNYPC annual work plan. • Will capture and report all benefits delivered through the category & sustainability work. • Responsible for the development of the HNYPC Sustainability Plan. • Works with the HNY Sustainability Lead as well as the Trust Sustainability Leads to ensure alignment of the plan and delivery.
HNYPC Data Analytics • Director of Procurement • Procurement Systems Lead • Procurement Analyst(s) • Catalogue Manager(s)	• Accountable to the Operational Delivery Group. • Provides data and analysis to the Category Leads network to inform sourcing decisions and to structure category strategies. • Supports all procurement functions in making the best use of procurement data as part of the sourcing process. • Compiles procurement data from all Partner Trusts on a monthly basis. • Manages the sharing of data with all Partner Trusts. • Reviews information within the Spend Comparison Service and other external data sources to identify opportunities. • Identifies and delivers the systems strategy to achieve system harmonisation.

Figure 55 – HNYPC Committees/ Boards

The recommended structure will enable HNYPC to work effectively with Partner Trusts at an operational level including Clinical Councils and customers, with oversight and approval from HNYPC. This provides a single approval route, compared to potentially requiring each HNYPC Partner Trust to approve each decision in the procurement cycle. The governance structure will support delivery of HNYPC objectives and will support delivery of a collaborative first approach to procurement maximising delivery of the non-financial and financial benefits.

It is noted that the role of Medical Directors is key in ensuring that the inter-lock between clinical procurement and the customers is effective. To achieve this, it is assumed that Medical Director (or deputy) attendance is mandatory at Procurement Board meetings when reviewing clinical procurement decisions.

To enable HNYPC to function effectively, and avoid substantial process inefficiency (e.g. duplicate approvals), HNYPC is dependent upon the following authorities being delegated to: (a) HNYPC Operational Delivery Group, and (b) to HNYPC Board for certain values:

- Entering contracts and agreements to a defined value, subject to meeting SFI criteria;
- Manual procurement as required, including ordering and approving ordering of goods and services for HNYPC Partner Trusts in accordance with SFIs;
- Update of prices in accordance with contract terms and conditions;
- Enforcement of contract terms and conditions on behalf of HNYPC Partner Trusts.

In the event that the HNYPC Operational Delivery Group does not have sufficient authority to approve a decision, it is assumed that this will be escalated to the HNYPC Board. This will ensure that there remains a single approving authority for HNYPC decisions, rather than requiring approvals across multiple Partner Trusts.

5.8 Procurement Strategy

A new three year procurement strategy has been devised for HNYPC which is based around the criteria used to score the options presented in section 4.

	2023/2024				2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Supports the aims and vision of the ICS and collaborative members												
Agree and embed the vision and aims within the Procurement Collaborative.	■	■										
Review progress against the vision and aims and update as required.					■	■	■	■	■	■		
2. Creates a single procurement function which will help support the sustainable provision of clinical and non-clinical services												
To have the Sustainability & Social Value Lead in post or the offer made.		■										
The Sustainability & Social Value Lead to have engaged with NHS England & Improvement and the ICS.			■	■								
Local policies and processes to be updated with sustainability and social value considerations including how to innovate suppliers to offer products and services differently.					■	■						
To have agreed a benefits realisation plan.						■						
To be regularly reporting on sustainability and social value benefits.							■	■	■	■		
To be viewed as an innovative thinking organisation around sustainability & social value.									■	■		
3. Establishes the collaborative as a centre of procurement and commercial excellence which provides procurement and commercial services to its member organisations												
To have the new structure approved with posts either recruited into or offers made.		■										
Standard policies and processes for the procurement collaborative to be written and agreed.			■	■	■	■						
A commercial systems strategy to be approved and in implementation.					■	■						
All procurement staff to be trained around being a provider of services.						■						
Members of the collaborative to speak at relevant forums.			■	■	■	■	■	■	■	■		
For Humber & North Yorkshire Procurement Collaborative to be seen as a centre of procurement excellence.									■	■		
4. Supports supplier rationalisation and cost savings												
Procurement Business Partners and Clinical Procurement Specialists in post or offers made.		■										
Procurement Business Partners to have engaged with all care groups with an			■	■								

	agreed way of working across organisational boundaries in place.												
	Product standardisation undertaken in each care group with case study created												
	Product standardisation opportunities discussed as business as usual a care group forums and being tracked through contract management.												
5. Ensures standardised robust product selection and range management practices are in place													
	Procurement Business Partners, Clinical Procurement Specialists and Governance and Assurance Lead in post or offers made.												
	Documented product selection process agreed with each care group.												
	Standardised product selection process written by the Governance and Assurance Lead for implementation by Procurement Business Partners.												
	Product selection process embedded as part of business as usual with each care group.												
	Innovative discussions with industry around technology advancements which can improve clinical care and the patient experience.												
6. Ensures that policies, practices and procedures are standardised and provide for the effective provision of procurement to the collaborative trusts													
	A full register of local policies and procedures captured with gaps identified.												
	A review of supply chain activities undertaken with efficiencies identified.												
	An individual appointed or offered the role of Governance and Assurance Manager.												
	A single set of procurement policies, practices and procedures agreed and signed off by the procurement board.												
	Standard operating procedures for stock management in place.												
	All procurement staff to have been trained in the content of the policies and procedures.												
	A process for annual review of documentation established.												
	Training for new starters and for all staff following a policy update part of business as usual.												
	Stock holding review undertaken across all areas with a materials management service provided to all appropriate clinical areas.												
	Audit completed on compliance to all policies and procedures.												

7. Ensures innovative and robust Supplier Relationship Management (SRM)													
	To have some individuals in post and to have offered on all posts.												
	To have developed a supplier segmentation tool and contract management/ SRM tool kit.												
	Establish a single record of all contracts held by the trusts.												
	To have trialled the tool kit on 5 suppliers and captured the benefits.												
	Roll out of the tool kit to all applicable suppliers.												
	All contracts, variations and modifications to be held on single contract register.												
	Develop and implement transactional relationship management which reduces the cost of doing business.												
8. Develops P2P e-commerce processes and systems to ensure smooth and efficient processing for all purchasing requirements													
	To have an established data systems and technology roadmap and secured investment.												
	Appointed people into or offered all data posts within the team.												
	Embed the data systems and technology roadmap and link to Scan for Safety.												
	Agree data standards and train all individuals to ensure compliant data entry.												
	All procurement transactions to be undertaken through systems to allow for centralised reporting and data driven decisions.												
9. Enables effective partnering with senior stakeholders, internal customers and suppliers													
	To have in place or have made offers to all procurement business partners and clinical procurement specialists.												
	Regular business partner meetings and clinical product review group meetings established across all three organisations.												
	Supplier relationship management in place for 5 suppliers.												
	Supplier relationship management rolled out to all applicable suppliers.												
	Benefits realisation undertaken on business partnering and SRM to ensure it still meets the needs of member trusts.												
10. Ensures all staff are given the opportunity to develop their potential													
	Standardise job descriptions and person specifications aligned to the strategy.												
	Existing staff transitioned into new structure.												
	New resource in post.												

	Offers made on all posts.												
	Embed graduate(s)/ apprentice(s) within the procurement structure.												
	All staff to have had a skills development analysis which informs their PDP.												
	Development to be fully embedded as part of BAU.												

Figure 56 – Procurement Strategy

5.9 Procurement Policies & Procedures

A review of the various policies and procedures in place at each of the HNYPC Partner Trusts identified the following:

- Varied thresholds within procurement policies and SFIs at each HNYPC Partner Trust, which results in a lack of consistency across the ICS;
- Reliance on contract extensions and waivers due to lack of time and resource available to undertake new projects and tenders. This is resulting in spend not being sufficiently market tested and reducing value for money;
- Duplication of workloads across the ICS due to insufficient communication and alignment of work-plans, which means there is no leveraging of the full ICS spend, reducing the efficiency of the collective;
- Little alignment of contracts across ICS; or efforts to align contract end dates to support future consolidation;
- Absence of contract owners and uniform use of Supplier Relationship Management prevents best value delivery from key contracts and suppliers;
- Little formalised contract management processes and recognised quarterly review meetings with key suppliers across ICS provide limited risk protection and financial optimisation of contracts;
- Procurement do report into some boards and have a degree of visibility with the Executive Teams, but there is not always sufficient engagement from key stakeholders to drive projects forward.

These documents tend to be published on each organisations intranet but there is no tracking around customer stakeholder engagement to ensure that the content of the document has been read or is understood.

All three Partner Trusts have separate procurement policy documentation. In total 25 documents were shared which need to be standardised into a single policy for HNYPC. These include:

- Procurement Policy;
- Procurement Strategy;
- Waiver Form;
- Conflict of Interest;
- How-to Guides.

Other policies which do not exist also need to be generated. These include:

- Contract Management Strategy;
- Modern Slavery Statement;
- Sustainable Procurement Policy;
- Savings Policy;
- Data Protection Impact Assessment.

A single set of HNYPC Policies and processes are required to give effect to the HNYPC strategies, this includes:

- The Cultural Principles and Customer Service Principles in how HNYPC delivers procurement services for Partner Trusts;
- Category Management ensuring delivery in a manner that delivers the strategy and policy, enabling aggregation of spend;
- Sourcing to be a value-adding process by planning effectively and reducing the number of sourcing activities undertaken;
- Order Cycle Management – ensuring process efficiency, minimising manual processes;
- Sustainability – the Procurement Policy & Governance lead would be responsible for working with the Sustainability Lead to ensure the sustainability policy aligns with procurement policy;
- Audit – act as the main point of contact between the HNYPC and Audit teams to ensure all audit recommendations are implemented in a timely manner;
- Contract Management and Supplier Relationship Management – ensuring that contracted benefits are delivered, and incremental value added by SRM as appropriate;
- HNYPC internal governance processes (e.g. gateways during the procurement cycle and roles & responsibilities);
- HNYPC supplier governance such as due diligence, and obligations delivery management;
- The approach to development of a consistent data architecture and reporting to inform business decisions.

The procurement policies and processes should be stored on a web portal that is structured to follow the procurement cycle, with the supporting tools for each stage stored within its specific area. Deployment of the HNYPC procurement policies will require HNYPC staff to be trained, as well as wider engagement with stakeholders impacted by the HNYPC policies.

A clear savings policy has been developed that sets out how savings are calculated, recorded and checked throughout the contract. The savings policy sets out cash releasing, cost avoidance and other savings such as sustainability benefits. This sets out the way in which HNYPC will be measured in its performance to support the Partner Trusts financial positions.

5.10 Standing Financial Instructions & Scheme of Delegation

There are differences between HNYPC Partner Trusts, and all documentation is currently aligned to customer organisations. The current SFI's require updating to reflect the revised governance structure and enable delivery of the recommended option. The current procurement thresholds are:

	HUTH (non-FT)	NLAG (FT)	YSTH (FT)
Informal Quotation	£0-£10k (obtain min 3)	£0-£25k	n/a
Formal Quotation	£10k-£50k (obtain min 3)	£25k-£50k (obtain min 3)	£25k-£50k (obtain min 3)
Tender	£50k+	£50k+ (obtain min 4)	£50k+

Figure 57 – SFI Current Thresholds

Observations from reviewing the current SFIs include:

- Not clear that you cannot waive procurement law;
- Not compliant with existing procurement regulation;
- Customers are provided a wide remit e.g. all budget holders are able to authorise contract amendments within financial thresholds. How do these individuals know it is a compliant contract amendment;
- A number of reasons for waiver shouldn't require a waiver e.g. a requirement is covered by an existing contract, this is either a compliant or non-compliant contract amendment;
- Acceptance of tenders is based on the lowest price rather than linked to the evaluation criteria;
- Not all tenders have to come through Procurement;
- List of "approved firms" for construction work. It is not clear how this list has been generated and whether it is legally compliant. The fact that it is down to the CFO to ensure their financial standing before calling off the approved list suggests the list is non-compliant;
- Procurement do not appear in the list of staff with authorisation in awarding contracts. How is compliance and records of contracts maintained;
- Personnel, agency and temporary staff contracts are excluded from procurement rules, it is not clear why;
- Requirement for every tender for the CFO to be satisfied with the financial standing of the company;
- Significant reliance upon the CEO e.g. escalating for admission of late tenders;
- Suppliers are given the opportunity by default to correct errors in their tender response, this should only be undertaken in line with procurement law;
- Far too detailed so are quickly out of date or prevent the Trust from concluding a contract e.g. there are insufficient suppliers because SFIs require a certain number of responses;
- Materials Management orders are a breach of SFIs.

A single version of the standing financial instructions relating to procurement activity have been drafted and implement the following recommendations:

- A single, simple set of SFIs relating to procurement activity should be agreed across HNYPC;
- The single set should be compliant with procurement regulation;
- Less remit should be provided to customers, procurement should sign all contracts and variations/ amendments once appropriate budget holder approval is gained;
- The waiver process should be simplified and applied only where it is legally compliant to do so and appropriate to do so;
- Approved supplier lists should be removed unless compliantly procured;
- Escalation to CEO/CFO should be minimised;
- Move to "no PO, no pay";
- Clarity around what level to publish contract opportunities;
- Ensures Materials Management activity is covered and compliant.

The revised SFIs recommends all procurement activity goes through three gateways:

1. Procurement Initiation Document – the decision as to how quotations/ tenders/ waivers/ bulk deals on existing contracts will be obtained.
2. Approval to Award/ Regulation 84 Report – the decision as to which economic operator the contract will be awarded to. This decision will need to be ratified in line with the scheme of delegation.
3. Contract Signature – the physical signature of the contract document and uploading the document onto the HNYPC central system.

The scheme of delegation relating to procurement activity is set out below:

Level of Expenditure	Process to be undertaken
Less than £10k excluding VAT	Quotations to be obtained from a sufficient number of firms/individuals to provide fair and adequate competition as appropriate to ensure value for money.
£10k to £50k excluding VAT	HNYPC to obtain formal quotations from a sufficient number of firms/individuals to provide fair and adequate competition as appropriate to ensure value for money.
£50k excluding VAT to appropriate procurement threshold including VAT	A local tender exercise to be undertaken with the opportunity published in line with Procurement Regulation.
Over the appropriate procurement threshold including VAT	A formal procurement exercise to be undertaken with the opportunity published in line with Procurement Regulation.

Figure 58 – SFI Future Thresholds

Gateway	Task	£10k	£10-£50k	£50k - PCR	PCR+
1	Approving the procurement strategy.	Senior Buyer	Procurement / Contract Manager	Procurement Business Partner	Deputy Director of Procurement
	Waiving of quotations and tenders subject to SFIs and SOs (including approval of single tenders).	Procurement / Contract Manager	Procurement Business Partner	Deputy Director of Procurement	Director of Procurement
	Permission to consider late quotations/ tenders.	Procurement / Contract Manager	Procurement Business Partner	Deputy Director of Procurement	Director of Procurement
2	Approving the decision to award.	Senior Buyer	Procurement / Contract Manager	Procurement Business Partner	Deputy Director of Procurement
3	Entering contracts and signing relevant documentation (once appropriate budget holder approval obtained).	Senior Buyer	Procurement / Contract Manager	Procurement Business Partner	Deputy Director of Procurement
	Lease Contracts.	Chief Finance Officer for each applicable Partner Trust			

Figure 59 – Approval Thresholds

All grades stated above are the minimum grade of staff who can undertake the specified action. All staff above that grade also hold delegated authority. In calculating the level of expenditure the total contract value should be used rather than the cost of a contract amendment or variation e.g. original contract value plus variation.

5.11 Procurement Planning

The current planning for procurement procedures is carried out on an ad-hoc basis, there is no combined contracts register showing expiring contracts to enable effective planning. Covid-19 has had a detrimental impact to procurement planning with 37% of the contracts held having expired and almost 50% of all contracts held on the work plan for renewal in 2022/23.

It is evident that data is requested as and when project requirements arise, and there is no standard form for requesting or capturing usage data. The absence of category specific project groups and a standard Procurement Initiation Document in use across

the HNYPC Partner Trusts hinders the ability to align and establish spend, service baselines and enable project sign-offs.

HNYPC will implement a 36-month forward view of procurement requirements reflecting both the plans to deliver business partner strategies and routes to market. This is to be based on:

- Existing contracts that are due to expire, identifying where they are to be replaced, and where they can be aggregated into other contracts;
- Engagement with stakeholders to confirm budgets allocated for external expenditure, noting revised ways of working, including the need for early engagement to add value.

It will be necessary to review the HNYPC procurement plan, and particularly changes to the plan, at the Procurement Board with changes being formally signed off. The HNYPC Procurement Plan will be used to plan HNYPC resources required to support delivery of the plan, there is a dependency on the provision of an adequate resource planning tool. This will be needed to enable HNYPC to align resources to contracts required to meet requirements and deliver category strategies and plans.

Where additional resources are required (e.g. specialist technical skills required for capital projects), this will be identified during the resource planning stage, and included within project costs. A further dependency is that a standardised Procurement Initiation Document is deployed as part of Gateway 1: this is the point at which requirements move from the HNYPC Procurement Plan to becoming live projects.

5.12 Alignment to National Objectives

The organisational form and governance structure has been established to meet the requirements of national and local objectives:

- Procurement activity will be deployed across the ICS making the most of capabilities and common policies and processes. Data will be share across all Partner Trusts to ensure data led decisions are being made;
- Although the proposed structure is not aligned to category based procurement, the structure is aligned to care groups to establish business partners with the aims of strengthening engagement and delivering value based procurement through patient pathways. Procurement Business Partners will manage the relationships with customers across the ICS and with our suppliers;
- Regular conversation is had with neighbouring ICSs and the national team to share best practice and identify opportunities for wider collaboration;
- The proposed structure removes duplication, simplifies the procurement process but enhances governance. It sets aligned targets against mutually agreed KPIs to allow performance to be measured in a consistent manner;
- Investment in data and technology to provide better visibility of procurement activity, stock management and opportunities for efficiency improvements, risk management and cost reduction;
- Dedicated resource to deliver sustainability, social value, Modern Slavery and procurement regulation requirements.

6. Preferred Option – Structure & Resource Requirements

6.1 Role Profiles

To help in the development of a collaborative procurement function NHSEI have developed a number of role profiles and associated competencies. These however cause greater confusion than help as they do not align to Agenda for Change job profiles and have only been completed for the more senior posts within an ICS Procurement function:

Band	Agenda for Change National Profile	NHSEI Guidance
Band 9		Head of ICS Procurement
Band 8D		Data & Technology Lead
Band 8C		Procurement Category Lead
Band 8B	Head of Procurement & Supply	Procurement Sustainability Lead
Band 8A		
Band 7	Procurement Team Manager	
Band 6	Procurement Officer Higher Level	
Band 5	Procurement Officer	
Band 4	Procurement Administrative Officer	
Band 3	Procurement Administrative Officer Supply Chain Assistant	
Band 2	Stores Clerk Storekeeper Procurement Assistant Administrator Supply Chain Assistant	

Figure 60 – Existing Job Profiles

Further role profiles are due to be released by NHSEI:

- ICS Supply Chain Lead – Minimum Band 8C;
- Clinical Procurement Specialist – Band to be confirmed.

All other role profiles are due to be determined by each ICS using the published competency framework. Although this sets out the expected competencies it will be down to each ICS to establish their own banding which could lead to inconsistencies between ICSs and therefore staff moving to earn more to do the same work, especially in an environment where remote working is an option.

Existing role profiles across HNYPC Partner Trusts are inconsistent despite roles being similar across the procurement teams. There will need to be an alignment of role profiles across HNYPC to create consistency.

6.2 Capability Assessment

A review of the current roles and skill mix within each Partner Trust procurement function has been carried out and has been used to inform the risk around the future structure. The capability assessment looks at the performance of an individual, their career aspirations and the likelihood of them staying in post. This exercise has shown:

Category		HUTH	NLAG	YSTH
Total Staff		36	29	59
Qualified Staff (e.g. MCIPS)		1	4	9
Performance Rating	Exceed Expectations	3	2	3
	Meets Expectations	25	27	46
	Partially Meets Expectations	8	0	10
Readiness for Promotion	Ready in 2+ Years	4	0	6
	Ready in 1-2 Years	0	0	6
	Ready in 6-12 Months	0	1	5
	Ready Now	0	5	16
	Temporary/ Short-Term Cover	0	2	4
	Content in Current Role or Not Applicable	32	21	22
Flight Risk	Content in Current Role	22	13	35
	Could Leave 2+ Years	7	4	8
	Could Leave 1-2 Years	2	4	6
	Could Leave 6-12 Months	3	6	4
	Looking Now	2	2	6
	Exceeds Expectations and Flight Risk	0	1	0
PDP in Place	Yes	36	29	42

Figure 61 – Succession Planning

The majority of individuals are meeting expectation (79%), are not looking for promotion (60%) and are content in their current role (56%). Only one individual is exceeding expectations and is a flight risk. This demographic can make organisational change difficult.

NHSEI have developed a skills development analysis tool which reviews an individual against the skills required to undertake their role. This assessment will be completed as part of any interview process for new roles and for all roles as part of the annual appraisal and development programme. It has not been completed as part of development of this business case due to the detailed nature of the tool. It is likely training and development will be required to close any gaps identified from the skills analysis.

6.3 Organisational Enablement

There is limited evidence that existing HNYPC procurement teams enable their staff to develop capability e.g. through secondment offerings. This in turn limits the opportunity for in-role staff development, and therefore hinders the growth and maturity of the ICS.

Moving staff into a single management organisation will allow for wider development opportunities and stretch projects to be offered. A procurement resourcing and activity plan can be developed allowing for individuals to shadow more complex projects as part of their development. Bringing the teams together will also ensure that there is resilience in resourcing as single points of failure can be designed out. Individually, procurement teams have struggled to justify the need for specific roles, such as data analysts, which can be justified under a collective resource model.

This includes staff nearing promotion undertaking higher grade roles to gain necessary experience at that level, including placements across HNYPC in non-procurement roles. There is also an opportunity to develop a talent exchange with relevant organisations (e.g. NOECPC, NHSSC). This will provide HNYPC staff with experience across wider industry and help them input to continuous improvement by bringing ideas to improve performance.

During Covid-19 Procurement staff were able to work flexibly and remotely to undertake their roles. It is proposed this approach continues to ensure geography does not act as a barrier to delivery.

6.4 Balance of Roles

The design for the future structure has considered the balance of roles to ensure that those who wish to progress their careers can see a career path locally rather than have to leave the organisation to seek their next challenge. The current organisational structure limits the opportunity to progress internally, this is due to various reasons such as the ratio of staff roles to the next grade and the gaps between roles and bands within the existing procurement teams. There is a pan-NHS issue in recruiting the right skills into the right specialist areas such as clinical procurement specialists which can inhibit delivery of procurement strategies.

The organisation structure of HNYPC has been designed to ensure that:

- There are no functional areas with gaps between grades (e.g. a Grade 4 reporting to a Grade 8C);
- Excessive and unmanageable numbers of staff are not reporting to the role above.

It is hoped that this approach promotes staff retention and progression within HNYPC with individuals who have deep organisational knowledge and motivates staff, with clear opportunity to develop as part of a shift to a high-skilled procurement function.

6.5 Procurement Engagement

Procurement engagement with customers is currently mixed. Whilst there are pockets of good engagement there is also evidence that the timing and amount of engagement is suboptimal, inhibiting the scope for procurement to add value.

To address this the new structure for procurement has been set up to align to the customers by way of procurement business partners. This will see the procurement team align to the care groups at each of the Partner Trusts. Procurement Business Partners will be required to create a stakeholder engagement plan for both internal and external stakeholders. They will be required to develop effective processes and procedures to ensure procurement is engaged sufficiently early to add value and develop effective monitoring to evidence success. Contract Management and Supplier Relationship Management will also be established to support closer engagement with external stakeholders post contract.

During development of the business case, there were a number of instances where it appeared that staff outside of Procurement are undertaking roles that will be undertaken by HNYPC (e.g. Estates teams placing certain contracts, and other teams undertaking Contract Management activity). To ensure that this behaviour ceases, the strategy and governance will need to be cascaded across HNYPC Partner Trusts with formal sign-off and supporting training.

HNYPC will undertake measurement of the effectiveness of procurement engagement as part of the general performance monitoring undertaken. This includes noting instances where timing has been sub-optimal preventing the opportunity for HNYPC to add value.

6.6 Monitoring Effectiveness

There is a general lack of effective monitoring throughout HNYPC Partner Trusts currently, whether this relates to the timing of the engagement being effective for procurement to deliver the best value, or seeking feedback to ensure there is continual development and lessons learnt. This can result in incorrect governance, and policies and procedures not being followed.

Effective measurement of compliant procurement policies and procedures is important to assuring that governance is being effectively followed, and to input into future process improvement.

Waivers and voluntary ex ante transparency notices can be indicative of failure to engage in a timely fashion to enable procurement to add value. As such, these should also be reviewed, with root cause analysis of instances where there is indication of poor engagement. The Procurement Initiation Document is key to identify stakeholders that are to be engaged: this will provide part of the audit trail of engagement.

6.7 Resource Planning

Current procurement planning is ad-hoc and reactive to current pressures. This results in late engagement and inadequate resources to fulfil the requirement, and limits the scope for procurement to act strategically and deliver value above compliance. Government policy requires planning at least 36 months in advance to enable aggregate spending. There are currently considerable challenges with workload exceeding resource levels, gaps in roles, challenges in recruiting the right capability, and single points of failure; these have been designed out to ensure resilience and sustainability.

6.8 Leadership, Culture & Values

The leadership, culture and values are set by each Partner Trust. The creation of the HNYPC will remove the corporate framework and in-turn readjust the current leadership, culture and values to serve the needs of all HNYPC Partner Trusts. This provides for an opportunity to develop a specific focus on the cultural and customer services principles.

The leadership, culture and values will be built into the role profiles developed and management processes, ensuring that these are embedded in HNYPC. This will be supported by a training programme with refresher training and new-starter training to ensure that all aspects of leadership, culture and values are fully adopted by HNYPC staff.

Consideration will need to be given to the branding of HNYPC to enable reinforcing the leadership, culture and values. However, this also needs to consider that some staff may identify strongly to the current organisation that they work for. Further consideration also needs to be given to e-mail addresses and other corporate identifiers.

6.9 Agile Working

From the staff engagement undertaken a key issue for staff is where they would be located. The proposition is that all roles will be assessed to establish whether they are agile or fixed. Agile workers will be based in their existing Trust but will be required to travel when working on collaborative activity. Fixed workers will continue to work from their existing base.

Agile workers will require the equipment to work more efficiently in this environment and this will include resources for hot-desking and virtual meeting facilities. The intention is to maintain positive and valuable relationships which team members have with their existing Partner Trust customers as well as provide them with the tools to develop similar relationships within the other two Partner Trusts. It is hoped that the flexibility of this approach will help to retain staff in the new organisation.

It is important that there is a level of IT compatibility across the three Partner Trusts. At the moment the three Partner Trusts work on separate networks and generally are not equipped to support agile working. For example it is not possible to join the Wi-Fi at all three Partner Trusts and it is not possible to hot desk as all three Partner Trusts use different hardware. Laptops and docking stations using the same hardware would help support agile working.

6.10 Staff Retention, Talent Development & Apprenticeships

YSTH have had success in running graduate and apprenticeship schemes within procurement utilising the HCSA sponsored National Procurement Graduate Scheme. They have also been able to establish 'run-through' posts which allow individuals to be recruited at one grade and to transition to the next grade once they have completed training. It is intended that HNYPC adopt this approach across all grades but that this is managed within the proposed structure and budget presented. HNYPC will not request further funds or posts to undertake this activity.

The training and development budget for procurement needs to be increased to align with the national average which is £217 per annum per person. This is picked up in the costing structure below.

6.11 Proposed Structure

To deliver the procurement strategy a new structure will be required. There are various options available to establishing a future procurement structure:

- Category alignment;
- Care Group Clinical Pathway/ Business Partner alignment;
- Delivery of both.

Following engagement with stakeholders it was decided not to progress with a category management approach as it was felt greater value could be delivered by aligning procurement to the care groups and patient pathways, providing a procurement business partner structure.

Existing spend information by category and care group has been used to influence resourcing structures as well as reference made to NHSEI role profiles. It is noted that spend figures used is spend during Covid-19 but these have been checked against 2019 spend levels in YSTH which show proportions are similar. There is also a need to standardise bandings for the same roles across the three Partner Trusts however this may need to be progressed in slower time due to the cost associated with alignment.

A review of spend information showed:

Care Group	HUTH	NLAG	YSTH	Total	% Split
Clinical Support Services	£103,768,627	£16,849,086	£22,727,798	**£143,345,511**	48.47%
Community & Therapies	£0	£2,613,053	£0	**£2,613,053**	0.88%
Emergency & Elderly Medicine	£131,065	£0	£6,834,883	**£6,965,948**	2.36%
Family Health	£5,071,449	£1,296,752	£1,849,705	**£8,217,906**	2.78%
Specialist Medicine	£11,453,518	£11,240,763	£7,210,155	**£29,904,436**	10.11%
Surgery & Critical Care	£10,968,421	£10,936,828	£4,621,231	**£15,558,059**	5.26%
Corporate					
Estates & Facilities	£29,583,795	£6,626,432	£25,435,676	**£61,645,903**	20.84%
Corporate General	£10,702,433	£9,029,349	£7,786,500	**£27,518,283**	9.30%
Capital/ Charity Spend	£81,459,377	£69,797,198	£91,937,275	**£243,193,850**	

Figure 62 – Care Group Alignment

Based on spend information Procurement Business Partners should be set up as follows:

- Clinical Support Services – 48.47%;
- Medicine & Healthcare – 16.13%;
- Surgery & Critical Care – 5.26%;
- General Corporate – 9.30%;
- Estates, Facilities & Capital – 20.84%.

New roles have also been provided within the structure where it believed that additional value can be added. These are further discussed below:

- Contract Management;
- Governance & Assurance;
- Procurement Systems & Data;
- Sustainability & Social Value.

The following sections address the structure and resource required by team as per option 5 explained above.

6.12 Procurement Directorate Structure & Resource

The current governance structure of the existing procurement teams is organised to align support to individual HNYPC Partner Trusts. This results in individual procurement teams with capabilities spanning the initial procurement activity of letting contracts, raising purchase orders and ensuring product is delivered to the point of consumption. Focusing on delivery at Trust level results in the absence of clear strategy and a failure to achieve aggregation of expenditure across HNYPC Partner Trusts.

Below is a summary of current WTE organisation structure by salary band.

Band	Proc	CPS	Systems	Total	Weight	Midpoint Salary	Total Cost
Band 9	1	0	0	**1**	**1.85%**	£118,928.32	**£118,928.32**
Band 8D	0	0	0	**0**	**0.00%**	£99,005.30	**£0.00**
Band 8C	3	0	0	**3**	**5.56%**	£82,946.91	**£248,840.73**
Band 8B	0	0	0	**0**	**0.00%**	£68,975.29	**£0.00**
Band 8A	0	0	0	**0**	**0.00%**	£59,184.91	**£0.00**
Band 7	4	1	0	**5**	**9.27%**	£52,769.50	**£263,847.50**
Band 6	4.78	0	0.9	**5.68**	**10.54%**	£42,580.47	**£241,857.07**
Band 5	4	0	0	**4**	**7.42%**	£39,199.08	**£156,796.32**
Band 4	16.44	0	0	**16.44**	**30.50%**	£30,672.55	**£504,256.72**
Band 3	17.79	0	1	**18.79**	**34.86%**	£26,692.56	**£501,553.20**
Band 2	0	0	0	**0**	**0.00%**	£24,309.69	**£0.00**
Total	**51.01**	**1**	**1.9**	**53.91**			**£2,036,079.86**

Figure 63 – Existing Procurement Structure

Comparison of the role titles across the three Partner Trusts shows some consistencies in job role and grade but also some inconsistencies e.g. Procurement/ Contracts Officer at both band 3 and 5:

Band	HUTH	NLAG	YSTH
Band 8C	Head of Procurement	Head of Procurement	Head of Procurement
Band 8B			
Band 8A			
Band 7	Senior Contracts Manager	Clinical Nurse Specialist Sourcing & Contracts Lead	Deputy Head of Procurement Operational Lead for Procurement
Band 6	Contracts Manager		Specialist Procurement Officer Procurement Systems Manager

Band 5	Contracts Officer Senior Buyer	Higher Procurement Officer	
Band 4	Contracts Support Officer	Procurement Supervisor	Senior Buyer Procurement Graduate
Band 3	Assistant Buyer	Sourcing & Contracts Officer Procurement Officer	Buyer Procurement Systems Officer

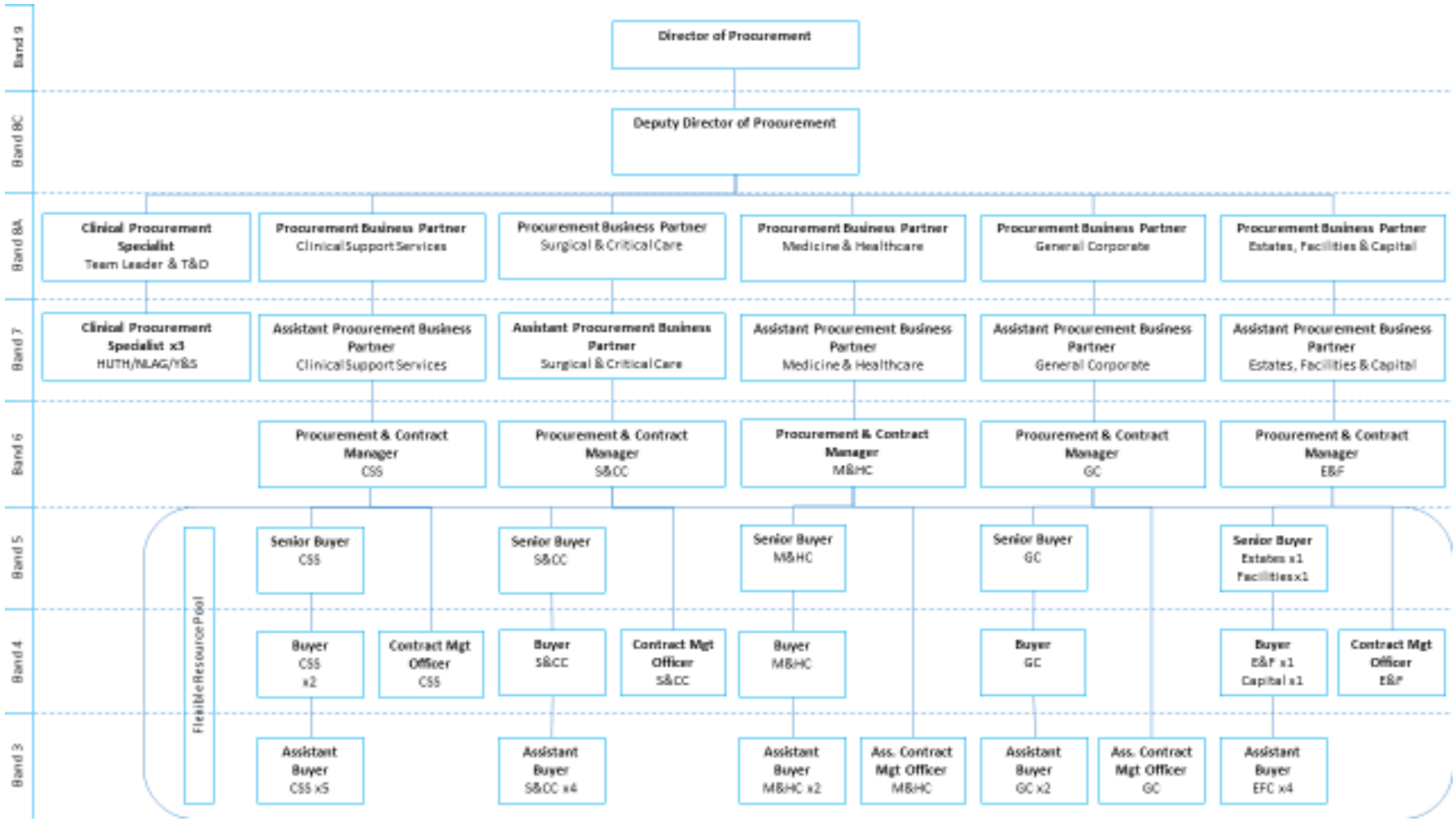
Figure 64 – Existing Job Profiles

One of the biggest challenges with the current structure is that over 65% of the Procurement function across the three Partner Trusts are band 4 or below. By consolidating contracts across the Partner Trusts the value and importance of those contracts will increase. It will require a more senior procurement resource to deliver those procurements, something that does not exist within the current structure.

NHSEI guidance that Category Leads should be a minimum of band 8C sees a significant increase from the existing band 6 staff undertaking this role at the moment. This raises a number of risks including:

- Affordability – to what extent is the future structure affordable in comparison to existing structures;
- Alignment to Agenda for Change principles – to what extent does the NHSEI guidance on roles align to Agenda for Change principles, is it possible to evidence the significant different in published job evaluated roles;
- Availability of staff – a common message from the three Partner Trusts is it is difficult to recruit staff at present. Although more senior roles may be attractive to candidates there is no evidence from NHSEI that there are 'spare' qualified and experienced procurement staff who could fill these roles. It may however be possible to attract people from the private sector who have transferrable skills;
- Consistency across ICSs – there is a risk that if the NHSEI suggested bandings are embedded in some ICSs and not others, procurement staff will move to where bandings are higher. This is a higher risk with the increase in remote working.

On reflection of the above risks the decisions has been made not to align to NHSEI role profiles. The HNYPC organisation structure has been designed following discussion with various stakeholders including Heads of Procurement from HNYPC Partner Trusts:


Band 9
Band 8C
Band 8A
Band 7
Band 6
Band 5
Band 4
Band 3
Director of Procurement
Deputy Director of Procurement
Clinical Procurement Specialist
Team Leader & T&D
Procurement Business Partner
Clinical Support Services
Procurement Business Partner
Surgical & Critical Care
Procurement Business Partner
Medicine & Healthcare
Procurement Business Partner
General Corporate
Procurement Business Partner
Estates, Facilities & Capital
Clinical Procurement Specialist x3
HUTH/NLAG/Y&S
Assistant Procurement Business Partner
Clinical Support Services
Assistant Procurement Business Partner
Surgical & Critical Care
Assistant Procurement Business Partner
Medicine & Healthcare
Assistant Procurement Business Partner
General Corporate
Assistant Procurement Business Partner
Estates, Facilities & Capital
Procurement & Contract Manager
CSS
Procurement & Contract Manager
S&CC
Procurement & Contract Manager
M&HC
Procurement & Contract Manager
GC
Procurement & Contract Manager
E&F
Flexible Resource Pool
Senior Buyer
CSS
Senior Buyer
S&CC
Senior Buyer
M&HC
Senior Buyer
GC
Senior Buyer
Estates x1
Facilities x1
Buyer
CSS
x2
Contract Mgt Officer
CSS
Buyer
S&CC
Contract Mgt Officer
S&CC
Buyer
M&HC
Buyer
GC
Buyer
E&F x1
Capital x1
Contract Mgt Officer
E&F
Assistant Buyer
CSS x5
Assistant Buyer
S&CC x4
Assistant Buyer
M&HC x2
Ass. Contract Mgt Officer
M&HC
Assistant Buyer
GC x2
Ass. Contract Mgt Officer
GC
Assistant Buyer
EFC x4

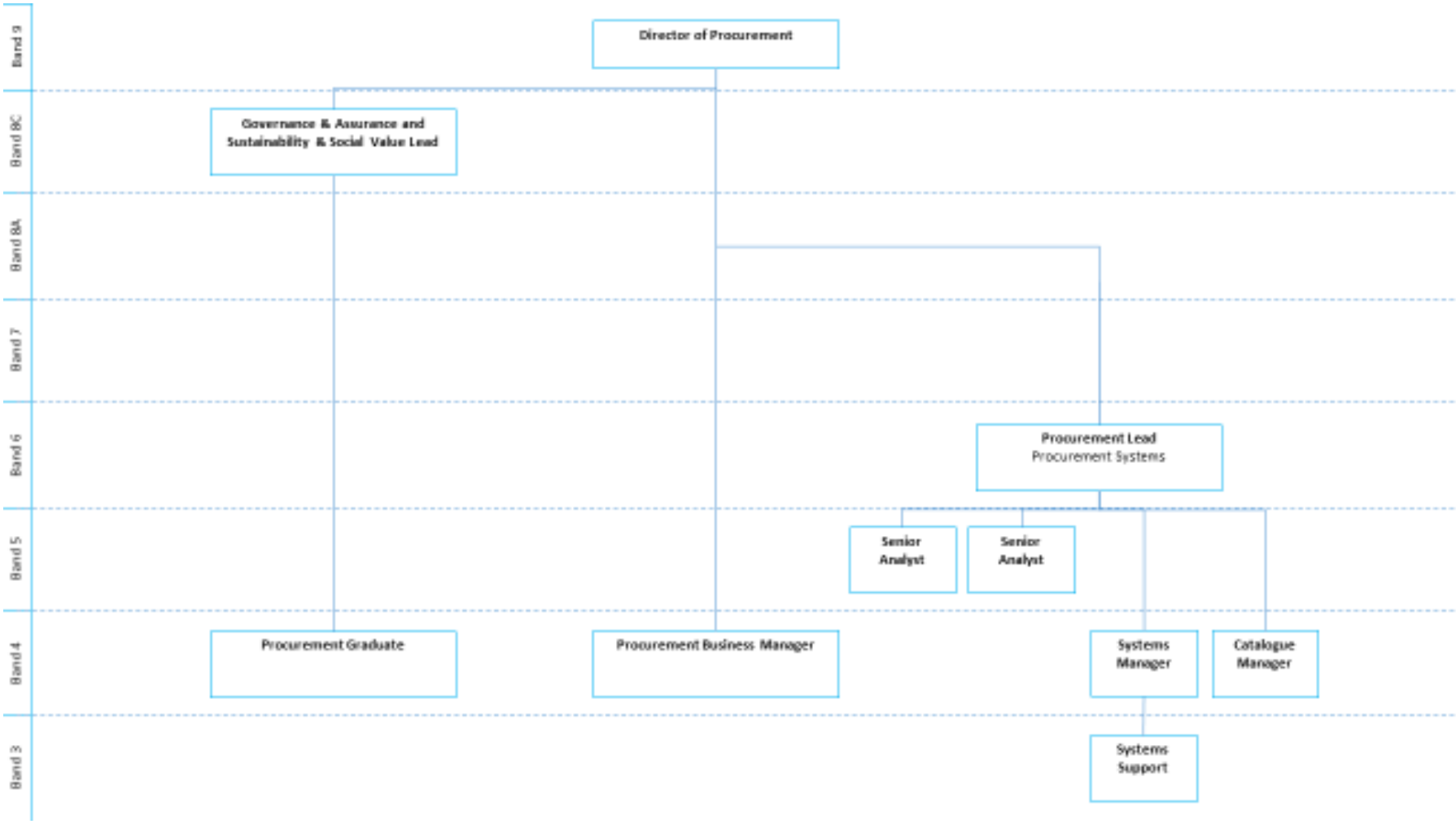


Figure 65 – Procurement Structure

This increases the procurement headcount however expands procurement to cover new and expanded responsibilities:

- Business Manager;
- Governance & Assurance;
- Sustainability and Social Value;
- Contract Management;
- Increases Clinical Procurement Specialist support;
- Increases Systems and Data support.

An overview of roles and responsibilities under the new structure:

Title	Proposed Band	Current Band	Responsibilities
Director of Procurement	9	9	Overall responsibility and accountability for the function and Procurement strategy across all Partner Trusts. Leading the senior management team, setting strategic direction and representing HNYPC at the highest level.
Business Manager	4	n/a	Provides administrative support to Director of Procurement and senior management team. Arranging diaries, organising events, minutes of meetings. Collates reports and data returns.
Deputy Director of Procurement	8C	8C	Responsible for the management and leadership of the procurement business partner function for the organisation. To identify, develop and drive 3-5 year sourcing strategies, acting as lead for all procurement business partner areas within the remit of the procurement department, through pro-active leadership.
Procurement Business Partner	8A	n/a	Responsible for strategic management of procurement activity within their prospective care group for a wide range of complex healthcare related goods and services. To identify, develop and drive sourcing strategies for their business partner area in collaboration with the stakeholders.
Clinical Procurement Specialist Team Lead	8A	n/a	Responsible for overall management of the Trust-based clinical procurement specialists. Escalating areas of non-compliance or disagreement. Taking the lead as Trauma and Orthopaedic clinical procurement specialist across all Partner Trusts.
Clinical Procurement Specialist	7	7	To act as the clinical procurement lead for a specific Partner Trust. Responsible for delivering the standardisation of clinical product, evaluating new clinical products and supporting clinical teams in the change of products.
Procurement & Contract Manager	6	6	Actively seeks to implement opportunities for added value procurement through contracting and improved cost effective supply arrangements, whilst maintaining customer service levels and compliance to procurement regulation across the Partner Trust's clinical and corporate directorates. Responsible for the creation of contracts, monitoring and continual review and management of existing contracts in collaboration with the customer.
Senior Buyer	5	5	Lead the procurement process for low to medium value supplies and services contracts. Support the procurement process for high value contracts, preparing relevant documentation, building online

			questionnaires, designing bidding, evaluation and commercial models and supporting suppliers through the process.
Buyer	4	4	Lead the procurement process for low value supplies and services contracts. Support the procurement process for medium value contracts, preparing relevant documentation, building online questionnaires, designing bidding, evaluation and commercial models and supporting suppliers through the process.
Contract Management Officer	4	n/a	Responsible for the creation of low/medium value contracts, monitoring and continual review and management of existing contracts in collaboration with the customer.
Assistant Buyer	3	3	Administrative support for the business partner team, arranging meetings, writing minutes, reviewing specifications, handling supplier enquiries.
Assistant Contract Management Officer	3	n/a	Support to the Procurement & Contract Manager in the monitoring and continual review of a portfolio of contracts in collaboration with the customer.
Governance & Assurance and sustainability & Social Value Procurement Manager	8C	n/a	Responsible for all procurement related policies and procedures ensuring they are updated in line with national policy. Provide training to all procurement individuals to ensure compliance. Provide assurance to the Operational Delivery Group that procurement is being undertaken in a compliant manner. Lead the implementation of sustainability and social value requirements ensuring best practice in all procurement activity. Developing and reporting on sustainability and social value metrics.
Procurement Systems Lead	6	6	Responsible for the technical management of a number of systems, technologies and processes in use across the Trust and partners. Management of information across the department including the gathering and reporting of performance metrics and analysis of spend information.
Senior Analyst	5	n/a	Responsible for the analysis of expenditure, benchmarking and opportunity assessment for use by the Procurement Business Partners.
Systems Manager	4	n/a	Responsible for the management of all procurement based systems ensuring they are used in the correct manner to enable accurate reporting. To arrange and deliver systems training to all stakeholders.
Catalogue Manager	4	n/a	Responsible for development and maintenance of supplier catalogues. Liaison with suppliers to ensure data is up to date and accurate. Ensures that all catalogue information is fed into the correct systems and information flows are automated.
Procurement Graduate	4	4	This individual will work with all elements of the procurement team to widen their knowledge and experience.
Systems Support	3	3	Responsibility for first line support to end-users of eProcurement system. Provide training to end users of the system to ensure consistent data entry for reporting purposes.

Figure 66 – Procurement Roles & Responsibilities

Based on mid-point salary the new procurement structure will cost £2.6m per annum:

Band	Proc	CPS	CM/SRM	Systems	Gov & Sust	Total	Weight	Midpoint Salary	Total Cost
Band 9	1	0	0	0	0	**1**	**1.54%**	£118,928.32	**£118,928.32**
Band 8D	0	0	0	0	0	**0**	**0.00%**	£99,005.30	**£0.00**
Band 8C	1	0	0	0	1	**2**	**3.08%**	£82,946.91	**£165,893.82**
Band 8B	0	0	0	0	0	**0**	**0.00%**	£68,975.29	**£0.00**
Band 8A	5	1	0	0	0	**6**	**9.23%**	£59,184.91	**£355,109.46**
Band 7	5	3	0	0	0	**8**	**12.31%**	£52,769.50	**£422,156.00**
Band 6	2.5	0	2.5	1	0	**6**	**9.23%**	£42,580.47	**£255,482.82**
Band 5	6	0	0	2	0	**8**	**12.31%**	£39,199.08	**£313,592.64**
Band 4	7	0	3	2	2	**14**	**21.54%**	£30,672.55	**£429,415.70**
Band 3	17	0	2	1	0	**20**	**30.77%**	£26,692.56	**£533,851.20**
Band 2	0	0	0	0	0	**0**	**0.00%**	£24,309.69	**£0.00**
Total	**44.5**	**4**	**7.5**	**6**	**3**	**65**			**£2,594,429.96**

Figure 67 – Total Proposed Procurement Structure

However, this doesn't take into account those working less than full time. Within Procurement there are eleven individuals who work part time. The cost of this is:

Band	Proc	Systems	Total	Midpoint Salary	Total Cost
Band 6	0.22	0.09	**0.31**	£42,580.47	**£13,199.95**
Band 4	0.56	0	**0.56**	£30,672.55	**£17,176.63**
Band 3	2.21	0	**2.21**	£26,692.56	**£58,990.56**
Total	**2.99**	**0.91**	**3.9**		**£89,367.12**

Figure 68 – Procurement Part Time Resource

The proposed Procurement structure has been calculated using full time equivalents at mid-point. The assumption is existing resource will move into the new structure on their current terms. The total proposed cost has therefore been reduced by £89,367.12 to reflect this position. When a new recruitment process is undertaken and an external candidate is successful then this will present an additional cost pressure as that individual may wish to work fulltime. To ensure that the best talent is attracted to HNYPC then a flexible approach should be undertaken to recruitment rather than restricting the hours. This will need to be managed within budget.

6.12.1 Strategic Procurement Team

The three Partner Trusts spend approximately £1bn per annum on goods and services from third party suppliers. Notwithstanding the opportunities which collaborative procurement can bring, there has been very little collaborative procurement between the three Partner Trusts and procurement leaders have not been required to demonstrate collaborative activity as part of their performance targets. It is clear that there would be economies of scale and cost benefits to each of the Trusts if we were able to maximise the impact of this leverage.

The small size of the current individual teams limits the opportunity for specialist business partnering approaches. YSTH are the closest to implementing a business partner approach having Senior Procurement Officers covering Medical/Surgical, Capital & Corporate and Estates (LLP). Most procurement staff are generalists, thereby limiting in-depth market knowledge and the benefits this brings in terms of clinical engagement and sourcing strategy.

At present there is extensive duplication of effort with each Trust procuring separately, meaning that there is significant opportunity to release capacity (i.e. procuring once rather than three times) releasing resources for more competitive market testing to achieve best value. In addition, greater capacity will allow the team to focus on areas not currently under procurement control/influence, again increasing the opportunities for savings; areas which provide opportunity include estates and facilities and agency staffing.

Complementary strengths and weaknesses across the three Trusts means that there is a strong foundation to benchmark existing systems, benefit from shared learning and work together to harmonise systems, maximise efficiency and capitalise on savings opportunities. Particular strengths recognise the focus of each organisation and how resources are deployed. Having said this, there is a potential skills and seniority gap with 75% of procurement staff band 5 or below. Bringing contracts together for collaboration will increase the number of full procurement exercises that need to be undertaken which are usually managed by fully qualified procurement staff at band 7 and above of which there are only 9.

The talent pool for good quality procurement and supplies staff is small and trusts are competing for the same staff. There are limited entry level positions for graduates or apprentices in place across the three organisations. Despite both Hull and York Universities offering summer internships or year-long work based placements for students with both Universities finding it challenging to identify local employers.

Limited resources and skills have resulted in risk averse attitudes to compliance and in some instances expediency has driven decision making. The HNYPC approach to procurement will focus on a thorough options appraisal, review of market strategy and long term value options. A collaborative approach to procurement using a consolidated establishment would provide the opportunity to create staff development programmes, develop professional expertise and create “grow your own” opportunities to develop talent and provide succession planning. The re-assertion of best practice line management principles will be core to the HNYPC, to foster a high performance culture and develop a motivated and dynamic team.

To support the strategic procurement teams, both YSTH and NLAG are members of NOECPC and utilise a number of their procurement frameworks. HUTH have not signed up as members of NOECPC. Each Trust has a good working relationship with NHSSC, however, variation of practice is seen across the trusts in terms of engagement methodology and savings opportunities can be missed or subject to significant delay in some cases. This business case sets out how these issues can be addressed via a consistent approach to NHSSC engagement with the support of Clinical Procurement Specialists in each Partner Trust.

The narrow focus on immediate savings delivery has resulted in relatively light focus given to category management, contract management, senior stakeholder/clinical engagement and market engagement and management. Further, contract compliance issues have had to be addressed within the context of limited resources, resulting in the need for expediency (reverting to existing frameworks agreements) rather than initiating competitive market tests via full tenders. In feedback from stakeholders the default position of procurement is to purchase though framework rather than test the market and select the most appropriate sourcing route. This is not a surprise given the junior nature of the staff employed. It is recognised that best practice procurement

which incorporates the elements listed above are able to deliver greater long term, recurring and sustainable savings as well as improved quality and outcomes.

There are approximately 3,000 contracts across HNYPC half of which need to be replaced within 2022/23. This quantity of contracts to be let across such a small number of procurement staff provides a limited opportunity to leverage the sourcing process to add value. There is limited evidence of experience and skills in value analysis and value engineering, which will be imperative to drive sourcing outcomes and deliver the benefits associated.

The category teams will align themselves to their stakeholders across the Partner Trusts, will meet with them regularly to discuss their requirements and will develop category strategies which can be used for any procurement within their category. These strategies will be developed with the business and suppliers and be updated on an annual basis.

The category strategies will inform the sourcing process. The sourcing process will not automatically defer to use of a framework or an open tender but will use the market information contained within the category strategy to inform the most appropriate route to market to deliver the aims of the procurement being undertaken.

Sourcing will also not assume that consolidation is the right answer to any procurement exercise. The category strategy will inform whether consolidation across Partner Trusts is the right thing to do. For example, it would not be appropriate for taxi services to be consolidated as the geography over the ICS is too large for this to provide value for money.

Sourcing expertise will reflect the shift in sourcing from being a compliance function to a value-adding stage of the procurement cycle. There will be a reduction in low-value tactical sourcing and a requirement for procurement leads to complete a Procurement Initiation Document for all procurement activity. The Procurement Initiation Document will pose a number of questions for the procurement lead which will prompt best practice requirements.

The more junior posts within the procurement team (band 5 and below) will operate in a flexible resource pool. Whilst they will be aligned to a Procurement Business Partner for management responsibility they will be able to work across business partners. This will allow HNYPC to react to changes in demand on procurement and will also allow staff to gain a greater experience across different categories as part of their development.

6.12.2 Clinical Procurement Specialists

Four posts are included for clinical procurement specialists which is an increase of three from the existing single person dedicated to this at NLAG. Rather than having the Clinical Procurement Specialists working across trusts they will be Trust based. The reason for this is twofold:

1. To be able to deliver change it will be important for the Clinical Procurement Specialists to have relationships at a Trust level, to understand the clinical practices of each Trust and any politics that may exist;
2. Clinical Procurement Specialists will be expected to maintain their clinical registration so will be required to undertake clinical practice. This is best undertaken locally.

The only post which isn't Trust specific is the Clinical Procurement Specialist team leader who will also act as Trauma and Orthopaedic lead across the Partner Trusts. The benefits for implementing this are the greater relationship and engagement with the clinical community to deliver change programmes. Although there are four posts it is not intended that these will be advertised as full time posts but will offer clinicians the opportunity to second for a period of time whilst maintaining their clinical practice. Other recruitment options will also be considered such as part-time work in procurement and part time work in a clinical setting. This may mean that it's possible to recruit more people than posts within budget.

6.12.3 Contract Management & Supplier Relationship Management

There are no resources allocated to Contract Management and Supplier Relationship Management. Contract Management is devolved to individuals within the business, those who originally identified the need for the product or service. There is no competency assessment of individuals within the business that they can manage contracts, nor is there any guidance provided as to how to manage contracts. This means that there is a risk suppliers alter the level of service they promised to provide as part of the bid process, and then tone the service down to increase their profits. Due to the lack of Contract or Supplier Management it is not possible to quantify this risk. Good contract management can ensure value obtained through the procurement process is delivered throughout the contract period.

The proposed approach is that Procurement will directly employ contract managers who also operate as Business Partners which face into the Trust Care Groups. These individuals will support the Care Groups in managing their contracts and holding suppliers to account. Contractual performance information will be collected and reported within the HNYPC procurement system.

This will require the development of clear definition of the scope of Contract Management, with supporting policies, procedures and roles and responsibilities. This includes the SFIs formalising the approach and approval to undertake Contract Management. Role profiles will need to be defined to reflect the requirements of the roles, with training developed to ensure that resources are capable of delivering their roles to the required standard. It is noted that effective systems are required to deliver Contract Management. This includes supplier reporting and obligation management, with exceptions of non-compliance highlighted to the Contracts Management team.

The Contract Management function will also be required to capture and report the benefits that they deliver to evidence the return on investment they bring.

The Contract Management function will review all contracts contained within the contracts register to ensure that the information held about the contract is complete and to score them based on value and risk. This approach will grade the contracts:

- Gold (high value/high risk);
- Silver (of moderate value/risk);
- Bronze (of low value/risk);
- Transactional (a one off purchase not requiring any management).

The current value of contracts let by procurement has a total of £445.6m over 3,000 contracts. Ensuring that the supplier delivers what they promise is therefore significant in terms of achieving value for money. Research has shown (Lifecycle Management Group 2020) that contract management can reduce costs by 5%-10%. In light of recent

events (EU Exit & Covid-19) supply resilience is another important factor that Contract Management can support.

It is recommended that HNYPC develop Supplier Relationship Management (SRM) expertise to support the delivery enhanced benefits beyond those contracted. This work will be completed between the Contract Management and Strategic Procurement teams. The objective is to provide SRM to the Top 20 suppliers to HNYPC Partner Trusts., covering approximately 48% of spend that is currently reported within the contract registers.

6.12.4 Procurement Data Analysts

Four additional posts have been requested within the data analysis team to reflect the greater importance of data driven decisions within procurement. There are a number of self-service/ automated processes that could also be considered e.g. supplier managed catalogues which go directly to the contract managers to approve for any changes. This would reduce the need for catalogue managers. This will take time and effort to manage the implementation. If successful, posts could be released, because of this the data team will move to manage other data streams such as integration with Scan4Safety or supporting the contract management team to evidence supplier performance against KPIs.

New procurement systems will need to be deployed to allow for agile working. At the moment a lot of the procurement data is captured locally on spreadsheets. This approach carries risk around data integrity and tracking changes made to data. Cloud based systems will allow all teams to log in wherever they are working and will also provide an audit trail for all changes made. The implementation of new systems will require training and new ways of working. Resource has been included in the structure for systems management and training.

6.12.5 Governance & Assurance and Sustainability

There is no resource in any of the Partner Trust procurement teams who is responsible for maintaining and updating policies and procedures despite regular updates being issued by Government and NHSEI. In 2020 Government issued 11 Procurement Policy Notes (PPNs), and in 2021 there were an additional 10. These PPNs require procurement teams to update their locally policies and processes and ensure all staff are aware of the changes. The content of PPNs can change the interpretation or meaning of the Public Contract Regulations 2015 and as such there is a legal requirement to comply with changes.

As the Partner Trusts do not have resource dedicated to monitoring procurement policy and process, these changes can often be overlooked meaning that procurement activity is not legally compliant. A recent change which required organisations with a non-pay spend over £200m per annum to publish their procurement pipelines for a minimum of 18 months in advance by 1st April 2022 was not implemented on time.

The principal aim of procurement undertaken by NHS organisations is to deliver essential goods and services and improve patient outcomes, while increasing value from every pound spent in the NHS. NHS procurement also has an essential role to play in the delivery of the NHS commitment to reach net zero by 2045, as more than 60% of NHS carbon emissions occur in the supply chain. Social value, when incorporated effectively, will help reduce health inequalities, drive better environmental performance, and deliver even more value from procured products and services.

There is a current lack of connection between sustainability policy and implementation at customer level procurement. This includes inadequate resources dedicated to developing the NHSEI framework. NHSEI have established three work streams to deliver their purpose “to ensure that every pound the NHS spends on products and services is socially and environmentally responsible. This is underpinned by an ambition to deliver net zero carbon and embed social value and eradicate modern slavery across our supply chain”. This shows how procurement is being used to deliver more than just the purchase of goods and services.

Key milestones within the NHSEI plan that HNYPC will need to embed locally include:

- April 2022 – All procurements to include a minimum 10% net zero and social value weighting;
- April 2023 – All contracts above £5m require suppliers to publish a carbon reduction plan for their UK direct emissions as a qualifying criterion;
- April 2024 – All procurement require suppliers to publish a carbon reduction plan;
- April 2027 – All suppliers will be required to publicly report targets, emissions and publish a carbon reduction plan for global emissions aligned to the NHS net zero target, for both their direct and indirect emissions;
- April 2028 – New requirements will be introduced overseeing the provision of carbon foot printing for individual products supplied to the NHS;
- April 2030 – All suppliers will be required to demonstrate progress in line with the NHS’ net zero targets, through published progress reports and continued carbon emissions reporting;
- 2045 – Net zero supply chain.

The Humber & North Yorkshire Sustainability and Net Zero programme was introduced towards the end of the 2020 and has gained momentum with the establishment of a network of organisation level sustainability leads. Initial work has been carried out to establish the HNY Partnership’s baseline carbon footprint to understand the scale of the task. Work is underway to develop a Humber & North Yorkshire climate change vision statement and green plan, which will be underpinned by green plans that are being developed by Partner Trusts.

A Green Plan and draft targets have been developed by HNYICS. There is a specific section within the plan which addresses Supply Chain and Procurement however Procurement will be an enabler to the other areas being investigated e.g. travel & transport, food & nutrition and digital transformation.

The dedicated Procurement Sustainability and Social Value Lead within HNYPC will be a strategic function, advising and directing without direct delivery beyond the formation of strategy and policy. The inward facing aspect of the role is to ensure that each stage of the procurement cycle gives effect to HNYPC requirements to deliver sustainability and social value in line with national policy. This includes:

- Providing a view across HNYPC to ensure that those categories best placed to deliver sustainability and social value are correctly identified and calibrated to deliver the required benefit;
- Advising on requirements definition to ensure that sustainability and social value requirements are properly defined;
- Establishing a HNYPC Procurement Sustainability Plan that aligns to the wider ICS strategy and national policy;
- Advising on commercial and procurement strategies to maximise sustainability and social value delivery through the supply chain;

- Setting baselines and managing reporting against delivered benefit;
- Advising on Contract Management and Supplier Relationship Management sustainability and social value aspects.

6.13 Supply Chain Directorate Structure

The current governance structure of the existing supply chain teams is organised to align support to individual HNYPC Partner Trusts. This is a sensible structure considering the work required in receipting and distributing deliveries and managing inventory locally. Each of the sites does work differently to manage this, so there is work required to standardise ways of working and ensure best practice.

A recent diagnostic completed by NHSSC showed the different ways each of the sites operate and the opportunity for standardisation:

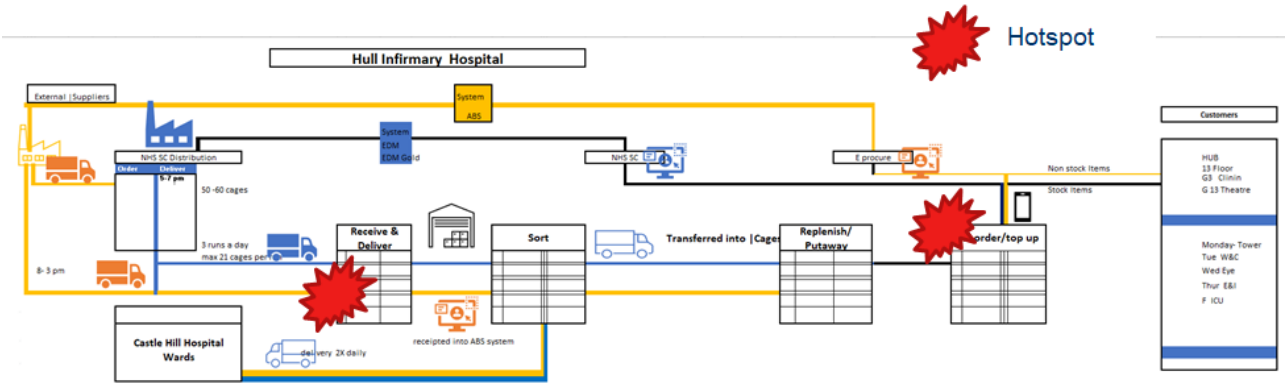


Figure 69 – HRI Materials Flow

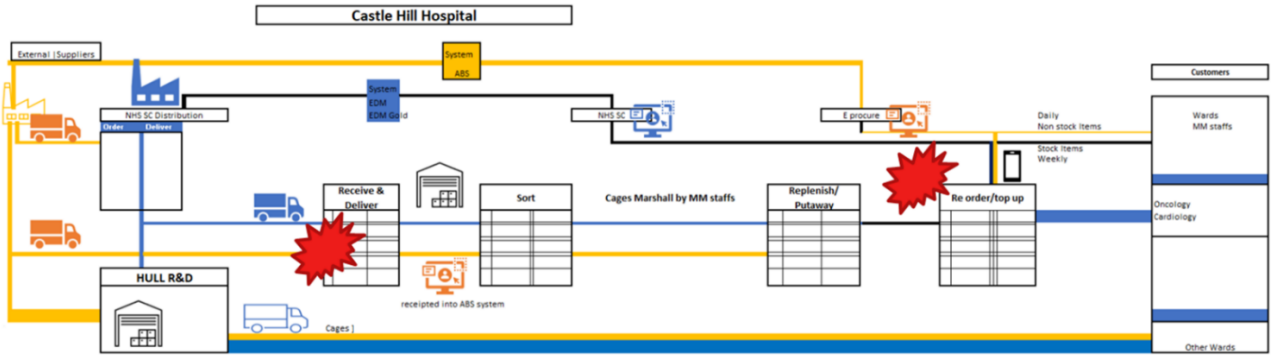


Figure 70 – Castle Hill Materials Flow

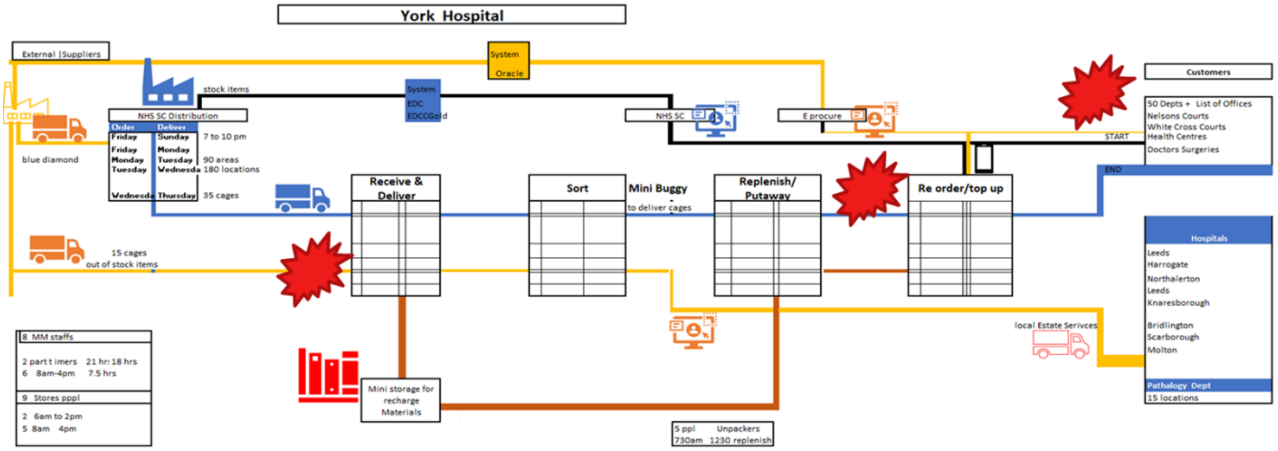


Figure 71 – York Materials Flow

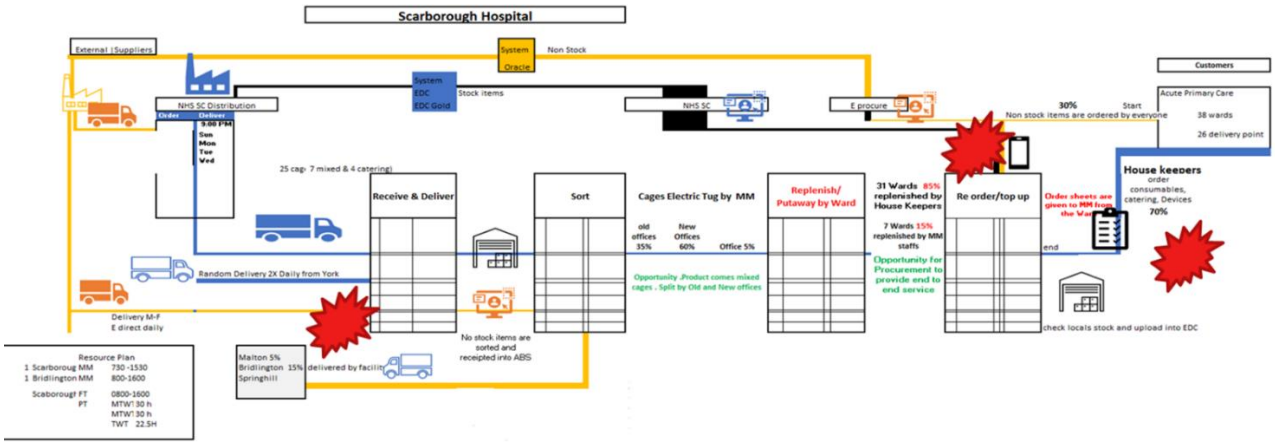


Figure 72 – Scarborough Materials Flow

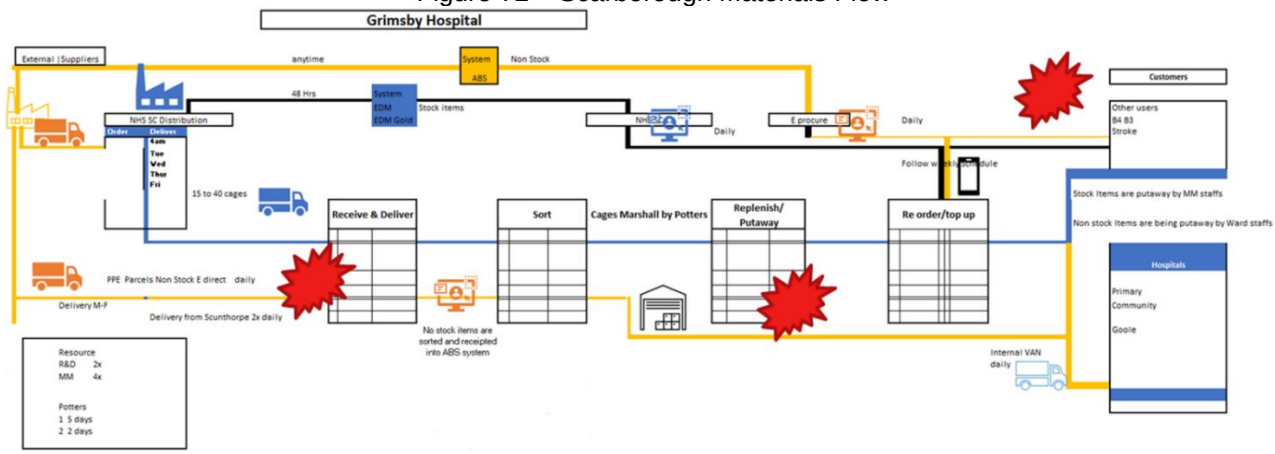


Figure 73 – Grimsby Materials Flow

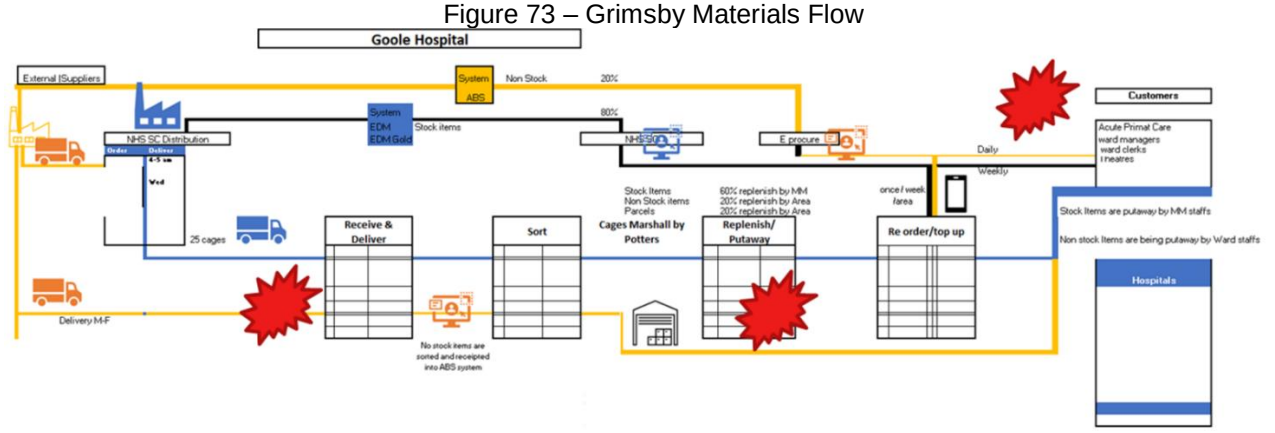


Figure 74 – Goole Materials Flow

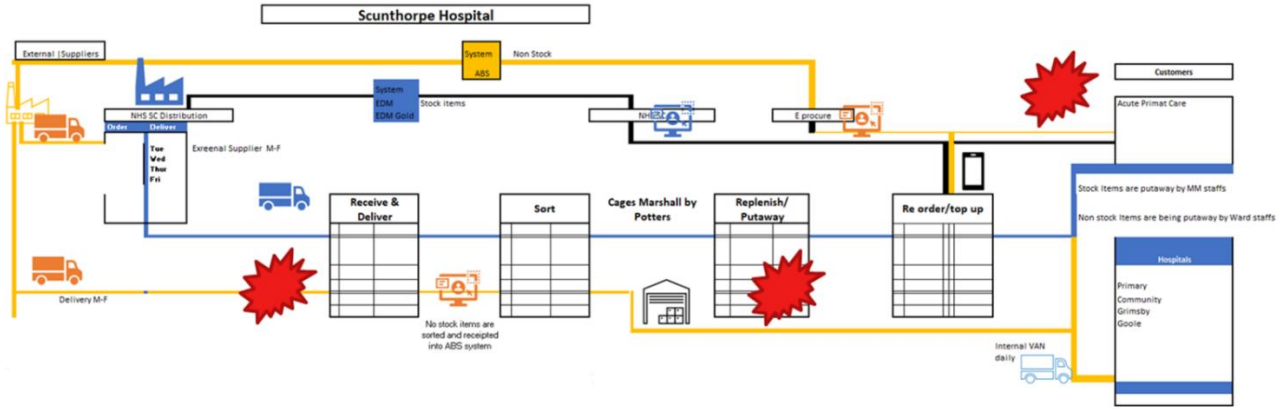


Figure 75 – Scunthorpe Materials Flow

Below is a summary of current organisation structure by salary band:

Band	Stores	Mat Man	Total	Weight	Midpoint Salary	Total Cost
Band 9	0	0	**0**	**0.00%**	£118,928.32	**£0.00**
Band 8D	0	0	**0**	**0.00%**	£99,005.30	**£0.00**
Band 8C	0	0	**0**	**0.00%**	£82,946.91	**£0.00**
Band 8B	0	0	**0**	**0.00%**	£68,975.29	**£0.00**
Band 8A	0	0	**0**	**0.00%**	£59,184.91	**£0.00**
Band 7	0	0	**0**	**0.00%**	£52,769.50	**£0.00**
Band 6	0	0	**0**	**0.00%**	£42,580.47	**£0.00**
Band 5	0	4	**4**	**6.19%**	£39,199.08	**£156,796.32**
Band 4	1	2	**3**	**4.64%**	£30,672.55	**£92,017.65**
Band 3	5	17.96	**22.96**	**35.53%**	£26,692.56	**£612,861.18**
Band 2	19.49	15.18	**34.67**	**53.64%**	£24,309.69	**£842,816.95**
Total	**25.49**	**39.14**	**64.63**			**£1,704,492.10**

Figure 76 – Existing Supply Chain Structure

Comparison of the role titles across the Partner Trusts shows some consistencies in job role and grade but also some inconsistencies e.g. Stores Supervisor at both band 3 and 4:

Band	HUTH	NLAG	YSTH
Band 8C	Head of Procurement	Head of Procurement	Head of Procurement
Band 8B			
Band 8A			
Band 7			
Band 6			
Band 5	Materials Manager	Materials Management Supervisor	Procurement & Disposals Officer
Band 4	Theatres Stores Supervisor	Deputy Materials Management Supervisor	Stores Supervisor
Band 3	Stores Supervisor	Materials Management Officer	Stores Supervisor Materials Management Officer PPE Supervisor
Band 2	Stores Staff Stock Replenisher Materials Management	Receipt & Distribution Officer	Storekeeper Supply Chain Porter PPE Porter

Figure 77 – Existing Job Profiles

The HNYPC Organisation Structure has been designed following discussion with various stakeholders including Heads of Procurement from HNYPC Partner Trusts. It has also been informed by a diagnostic undertaken by NHSSC over a 6 week period which sought feedback from all receipt & distribution and materials management staff.

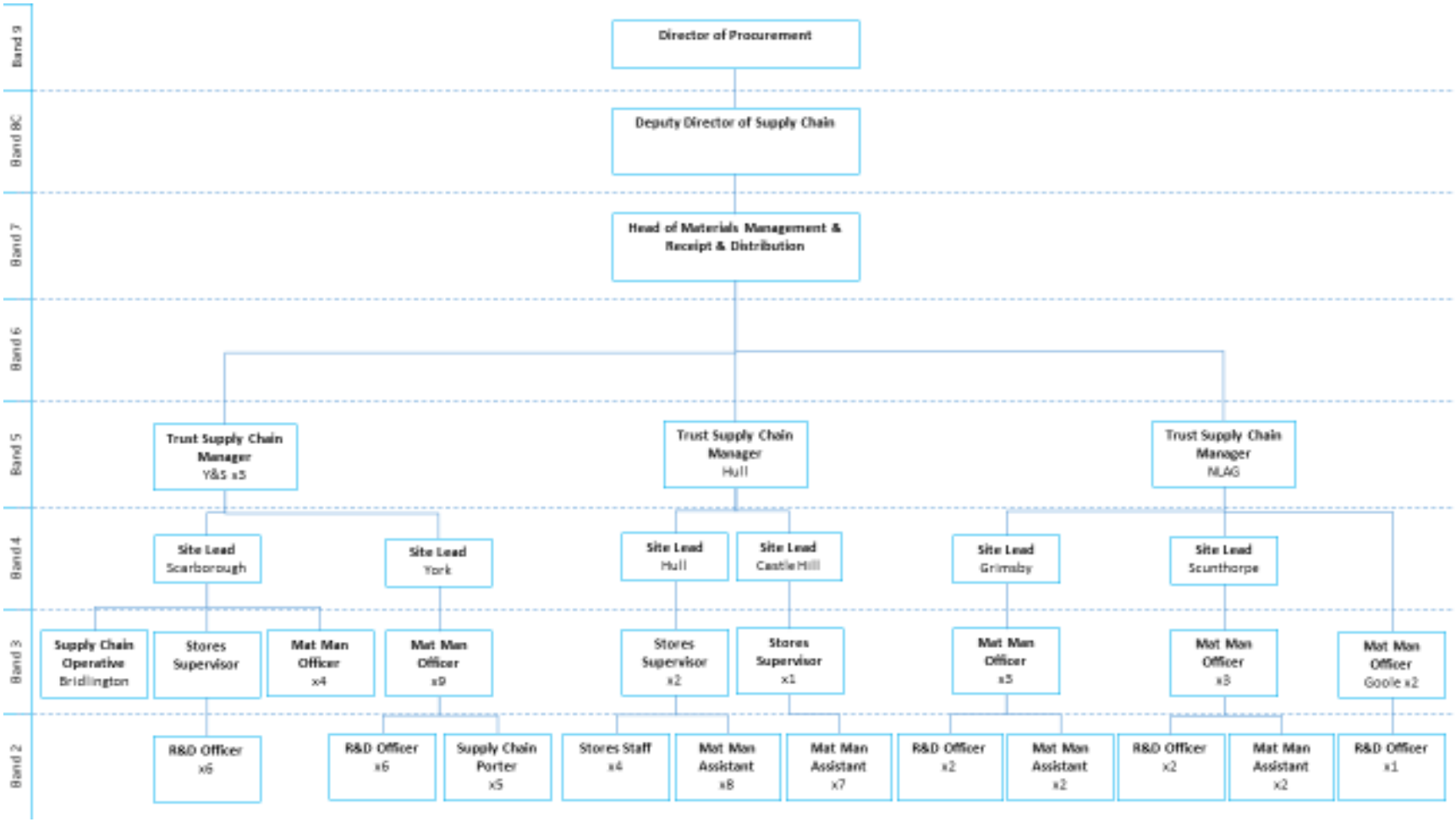


Figure 78 – Proposed Supply Chain Structure

This increases the supply chain headcount however expands materials management coverage across Partner Trusts which will enable better stock management. This requires an additional investment of £267,244.

Title	Proposed Band	Current Band	Responsibilities
Director of Procurement	9	9	Overall responsibility and accountability for the function and Procurement strategy across all Partner Trusts. Leading the senior management team, setting strategic direction and representing the alliance at the highest level.
Deputy Director Supply Chain	8C	n/a	Responsible for service and line management of the group's Inventory Management and logistics services. Provision, development & further deployment of comprehensive inventory management service, ensuring efficient and effective management of the Trust's Internal and external supply chains by utilising new and innovative methods and inventory management systems.
Head of Materials Management & Receipt and Distribution	7	n/a	Responsible for strategic management of the supply chain in a wide range of highly complex healthcare related goods and services and ensuring the Partner Trusts hold a suitable level of stock at all times to deliver clinical services.
Trust Supply Chain Manager	5	5	Responsible for the inventory management of regularly used consumables within clinical areas ensuring stock levels are managed and maintained in an efficient and cost effective manner in line with agreed procedures and processes via the Inventory Management service. Responsible for the receipt and distribution of goods throughout the hospital site. Responsible for the leadership of a team of inventory specialists and logistics officers on a single hospital site including the execution of quality audits
Site Lead	4	4	Responsible for the management of the consolidation centre. Receipting goods, storing, sorting, picking and distribution to hospital sites.
Supply Chain Operative	3	3	Responsible for providing materials management and receipt and distribution services at satellite sites.
Mat Man Officer	3	3	Responsible for the inventory management of regularly used consumables within clinical areas ensuring stock levels are managed and maintained in an efficient and cost effective manner in line with agreed procedures and processes via the Inventory Management service.
Stores Supervisor	3	3	Responsible for managing the receipt, storing, picking and distribution of stock from the consolidation centre to hospital sites. Includes delivery driving responsibilities.
Mat Man Assistant	2	2	Responsible for supporting the inventory management of regularly used consumables within clinical areas ensuring stock levels are managed and maintained in an efficient and cost

			effective manner in line with agreed procedures and processes via the Inventory Management service.
R&D Officer	2	2	Responsible for the receipt, storing, picking and distribution of stock from the consolidation centre to hospital sites. Includes delivery driving responsibilities.

Figure 79 – Supply Chain Roles & Responsibilities

Band	Stores	Mat Man	Total	Weight	Midpoint Salary	Total Cost
Band 9	0	0	**0**	**0.00%**	£118,928.32	**£0.00**
Band 8D	0	0	**0**	**0.00%**	£99,005.30	**£0.00**
Band 8C	0	1	**1**	**1.19%**	£82,946.91	**£82,946.91**
Band 8B	0	0	**0**	**0.00%**	£68,975.29	**£0.00**
Band 8A	0	0	**0**	**0.00%**	£59,184.91	**£0.00**
Band 7	0	1	**1**	**1.19%**	£52,769.50	**£52,769.50**
Band 6	0	0	**0**	**0.00%**	£42,580.47	**£0.00**
Band 5	0	5	**5**	**5.95%**	£39,199.08	**£195,995.40**
Band 4	4	6	**10**	**11.90%**	£30,672.55	**£306,725.50**
Band 3	0	22	**22**	**26.19%**	£26,692.56	**£587,236.32**
Band 2	21	24	**45**	**53.58%**	£24,309.69	**£1,093,936.05**
Total	**25**	**59**	**84**			**£2,319,609.68**

Figure 80 – Proposed Supply Chain Structure

However, this doesn't take into account those working less than full time. Within Supply Chain there are thirty three individuals who work part time. The cost of this is:

Band	Stores	Mat Man	Total	Midpoint Salary	Total Cost
Band 5	1	0	**1**	£39,199.08	**£39,919.08**
Band 3	0	3.04	**3.04**	£26,692.56	**£81,145.38**
Band 2	2.51	6.82	**9.33**	£24,309.69	**£226,809.41**
Total	**3.51**	**9.86**	**13.37**		**£347,873.87**

Figure 81 – Supply Chain Part Time Resource

The proposed Supply Chain structure has been calculated using full time equivalents at mid-point. The assumption is existing resource will move into the new structure on their current terms. The total proposed cost has therefore been reduced by £347,873.87 to reflect this position. When a new recruitment process is undertaken and an external candidate is successful then this will present an additional cost pressure as that individual may wish to work fulltime. To ensure that the best talent is attracted to HNYPC then a flexible approach should be undertaken to recruitment rather than restricting the hours. This will need to be managed within budget.

6.13.1 Receipt & Distribution

Each of the trusts has a receipt and distribution point at their main sites. This team are responsible for taking receipt of all deliveries, receipting the delivery on the e-Procurement system and taking the delivery to the order point.

There is significant resource dedicated to managing the receipt and distribution function across the 8 sites with 25.49 resources dedicated to this. Receipt and distribution for CHH is managed through HRI. This business case proposes putting that function back into CHH and removing the requirement to trans-ship product between sites, removing the duplication of double-handling product as well as the risk to HUTH from undertaking that activity.

One of the complaints around the stores operation comes from NHSSC who deliver into all three trusts using roll cages. The roll cages are taken into the hospital for ward put away but are then often not returned to stores or used for other purposes, e.g. collecting rubbish. There is also evidence that the roll cages are taken by other suppliers. NHSSC track the number of cages delivered into a Trust and the number collected. Across the three trusts there are a significant number of missing roll cages which NHSSC reserve the right to charge for.

A simple change to the way in which receipt and distribution operates will improve the roll cage position. A policy change should be made to ensure roll cages are not allowed to leave stores with all product decanted from a roll cage onto a trolley which is then taken to the put away area, emptied and returned to stores by materials management or stores employees. Not allowing roll cages to leave the stores area will ensure no cost is incurred from NHSSC for missing cages. This approach will also improve the health and safety risk of moving large and heavy cages around the hospital sites.

Overall the NHSSC diagnostic has found a lack of management control and performance management in receipt and distribution, this is not just a finding for the three Partner Trusts but across the country. Improvements in ways of working can be delivered through better management control and performance management which will help resolve the following issues which were raised by Partner Trust staff during the diagnostic:

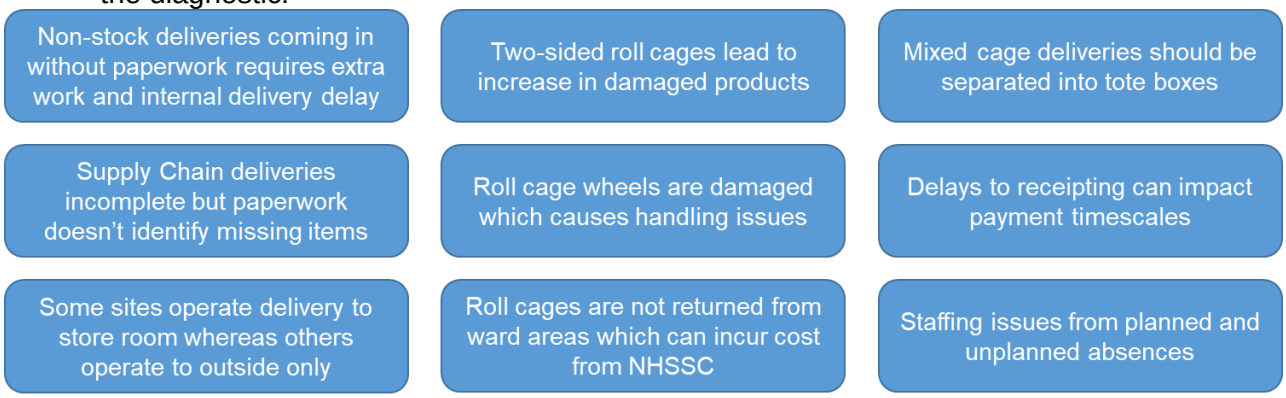


Figure 82 – Receipt & Distribution Findings

6.13.2 Materials Management

Materials Management is a core supply chain function that determines the material requirements for each stocked location by establishing inventory levels and then oversees the supply and distribution of these items. The primary business objectives of Materials Management are assured supply of materials to the optimum inventory levels and achieving a high level of ordering precision through standardisation, digitisation and commercialisation of ordering processes.

Each of the sites within HNYPC operate materials management differently. Only NLAG are close to a consistent approach across all of their sites. These different ways of working confuse customers and cause frustration. In feedback from customers one of

the main concerns was around cages being left in corridors for ward staff to empty. Despite technology solutions being in place, some sites still operate a paper based process. Stakeholders have raised concern that this has led to mistakes and over ordering which negatively impacts their budgets.

Both NLAG and Scarborough need to invest in Materials Management as the level of service provided across the sites needs to be expanded to provide a better service to procurements customers. This proposed structure addresses these service additions.

For clinical areas that have adopted Materials Management within the last 6 years at NLAG, an 11% average recurrent expenditure reduction has been achieved, as well as a 31% improvement in ordering precision. This is achieved through standardising stock levels, consolidating products and suppliers, swapping to approved products and suppliers, standardising order volumes, bulk ordering where possible and organising the stores in order to minimise wastage.

Location	Cost Centre	Period Start	Period End	Av Spend Before	Av Spend After	Precision Before	Precision After	Av Spend Change	Precision Change
SGH Ward 25	202542	01/04/2015	31/03/2016	2,469.77	1,989.86	959.95	1,130.28	-19.43%	15.07%
DPOW Theatre ENT	202325	01/05/2015	30/04/2016	42,422.46	37,072.01	15,990.66	11,561.19	-12.61%	-38.31%
DPOW NICU	202450	01/03/2017	28/02/2018	2,961.58	3,492.57	2,040.72	1,311.00	17.93%	-55.66%
SGH Stroke Unit	202611	01/04/2015	31/03/2016	1,164.19	961.28	637.02	770.08	-17.43%	17.28%
SGH Urology	202563	01/09/2016	31/08/2017	775.33	621.25	643.25	758.14	-19.87%	15.15%
Total				**49,793.32**	**44,136.98**	**20,271.60**	**15,530.70**	**-11.36%**	**-30.53%**

Figure 83 – Materials Management Benefits

There are also savings from clinical staff no longer unpacking and putting away goods, they can focus on delivering patient care. Clinical staff have also mentioned seeing significant levels of the same stock sitting in store rooms and they cannot understand why the product continues to be ordered. It is clear that there are gaps in service quality and value-addition. There is no current capability to share inventory across customer organisations, or to rationalise within individual teams in a customer organisation.

There is no single inventory management system in place at any of the three Partner Trusts which makes data driven decisions impossible especially decisions around appropriate stockholding and future forecasting e.g. the impact on demand created by an incident. This business case proposes implementation of a single inventory management system which aligns to the Scan for Safety programme.

Natural progression opportunities within the current structure are limited and there is not a consistent structure between Partner Trusts. The put away aspects of the current Materials Management Officer roles are physically demanding and the age profile of the current team is not best suited to this, a situation which will not improve with time. Some older staff members have suffered from minor physical issues linked to the general passage of time but this has impacted their ability to perform the full range of tasks at all times.

Materials Management technology and staff will be optimised to reduce the requirement for nursing staff to manage replenishment. All regularly used clinical consumables will be managed by the inventory management team, significantly reducing the time spent by clinical staff on ordering related activities.

Improvements to inventory management is expected to deliver substantial benefit to HNYPC Partner Trusts. The scope of this should include:

- Implementation and maintenance of inventory management, including GS1 bar-coding and Scan4Safety with booking of inventory to individual patient where required;
- Develop overarching stock policy (e.g. how to define stock level, shared inventories, local replenishment, economic order quantities);
- Planning suitable stock levels with customers to optimise pan-HNYPC effectiveness and efficiency and setting appropriate re-order points to manage inventory while protecting performance;
- Receipt of deliveries, including rejections and prompting supplier performance issues;
- Managing notifications for shelf-life expiry and wastage processes.

Any changes to inventory will require a stock policy to ensure consistent management. This should apply data-driven opportunities for improvement. It is noted that there are expected to be some locations (e.g. community settings) where the inventory level is unlikely to justify the full responsibility for inventory management being transferred to HNYPC. An alternative hybrid model is required to support these scenarios where HNYPC enable local staff to discharge those responsibilities. The objective is to reduce waste, including potential to reduce inventory and make balance sheet improvements.

Overall the NHSSC diagnostics has found a lack of management control and performance management in materials management, this is not just a finding for the three Partner Trusts but across the country. Improvements in ways of working can be delivered through better management control and performance management which will help resolve the following issues which were raised by Partner Trust staff during the diagnostic:

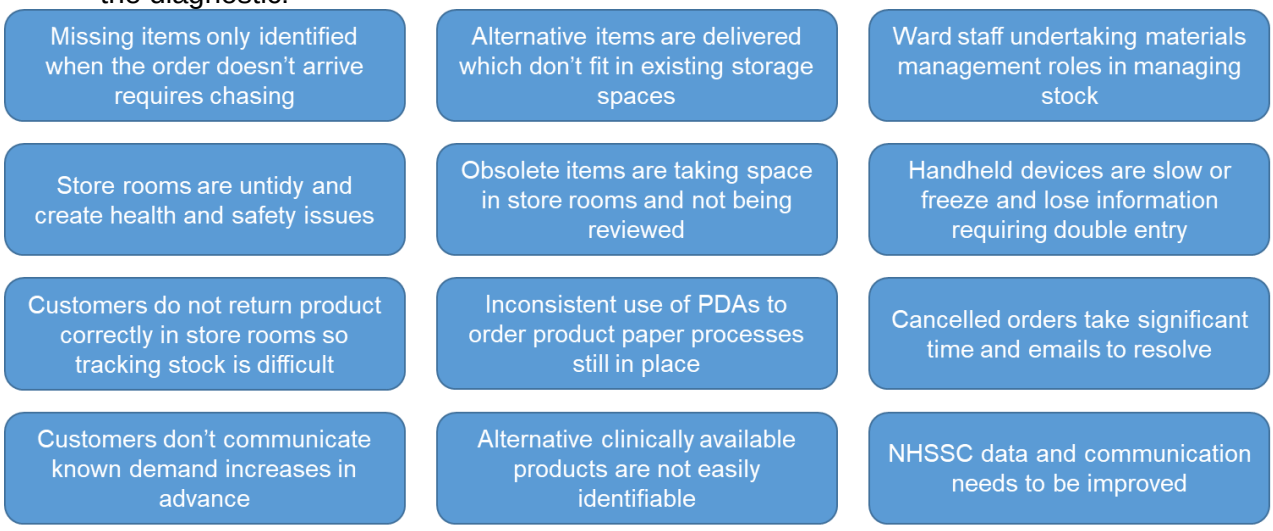


Figure 84 – Materials Management Findings

6.14 Physical Inventory

Model Hospital Data shows that the national peer average for stock holding is 36.1 days of static stock. HUTH performs well, reporting 30.8 whereas YSTH (67.2) and NLAG (69.1) sit significantly higher. A reduction in stockholding would reduce the risk of stock obsolescence and deliver cost reduction.

Although there is some evidence of stockholding reports being shared with customers on a 6 monthly basis there is limited evidence of procurement providing physical

inventory management reports and limited management of most economic order quantity. Asset tagging, and digital control of high value assets is not undertaken pan-HNYPC although HUTH are working on this as part of their Scan4Safety deployment.

It is noted that other ICSs have successfully implemented their own local physical inventory handling processes to drive sustainability improvements by reducing the number of truck rolls into a location. This is by the use of a logistics hub, with small electric vehicles completing the last leg of the journey to customers. This should also be considered as part of the NHSSC review.

6.15 Resource Changes – Impact on Model Hospital

Option 5 better aligns some of the resource to the Model Hospital average such as the band 8A's but keeps the high tail of the band 2 posts although this would be reviewed over time as vacancies arise:

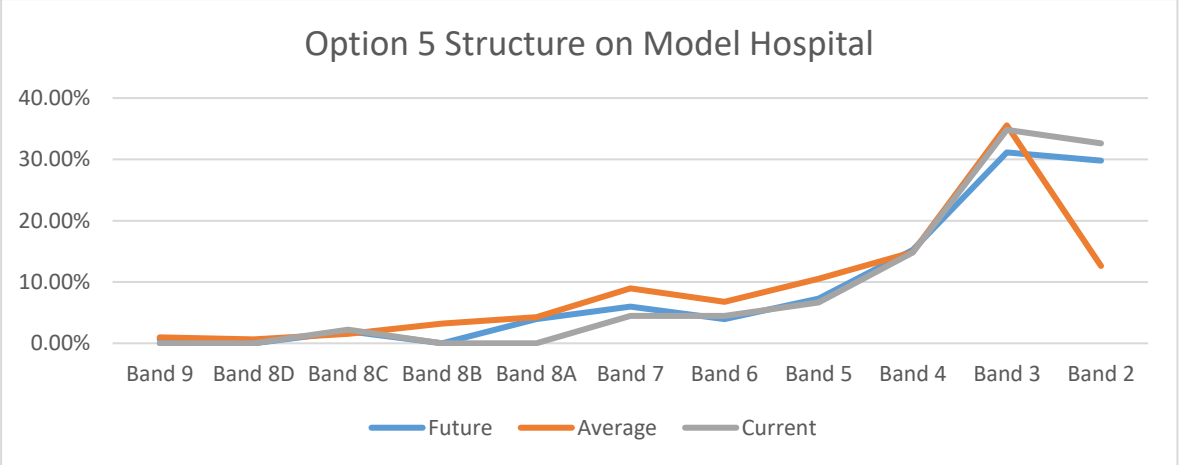


Figure 85 – Option 5 Structure on Model Hospital

7. Preferred Option - Data, Technology & Performance

7.1 Current Position

The current systems in use across the ICS for managing procurement activity are set out below:

System Category		HUTH	NLAG	YSTH
Spend analytics & price benchmarking	System	Spend Comparison Service	Spend Comparison Service	Spend Comparison Service
	Annual Spend	£3.300	£3.300	£3.300
	End Date	31/07/2023	31/07/2023	31/07/2023
Pipeline/ work plan management	System	Excel	n/a	Excel
	Annual Spend	£0	£0	£0
	End Date	n/a (Microsoft Licence)	n/a (No System)	n/a (Microsoft Licence)
eSourcing/ eTendering	System	Pro-Contract	In-Tend	In-Tend
	Annual Spend	£8,397	£1,665	£1,665
	End Date	30/09/2023	30/11/2024	30/11/2024
Contracts & Supplier Management	System	n/a	n/a	In-Tend
	Annual Spend	£0	£0	£0 (included in above cost)
	End Date	n/a (No System)	n/a (No System)	30/11/2024
eCatalogue	System	Advance Business Solutions	Advance Business Solutions	Advance Business Solutions
	Annual Spend	Included in cost below	Included in cost below	Included in Oracle Cloud
	End Date	30/04/2023	30/04/2027	05/04/2024
PEPPOL Access Points	System	n/a	n/a	Pagero
	Annual Spend	£0	£0	Included in Oracle Cloud
	End Date	n/a (No System)	n/a (No System)	05/04/2024
Requisition & Purchase Order	System	Advance Business Solutions	Advance Business Solutions	Oracle Cloud
	Annual Spend	£214,865	£69,932	£108,547.06

	End Date	30/04/2023	30/04/2027	05/04/2024
Inventory Management	System	Advance Business Solutions & Genesis	n/a	Omnicell & Ingenica for Community
	Annual Spend	Included in cost above	£0	£69,912.34
	End Date	30/04/2023	n/a (No System)	21/01/2023

Figure 86 – Procurement Systems

There are multiple systems in use across the three Partner Trusts both for individual tasks but also for the same tasks. These systems don't communicate with one another and therefore cause data discrepancy issues which make reporting difficult. As an example procurement report the use of 1,429 suppliers whereas finance data shows 7,271 suppliers. Data is also not used to inform strategy for future procurements nor to measure the success of meeting other government policy e.g. absence of data on SME (Small to Medium Enterprise) suppliers and how the Partner Trusts support their local communities.

Dedicated procurement resource currently in place to support the effective use of procurement systems, both within Procurement as well as customers across the trusts who input information is limited to 1x band 6 and 1x band 3, both of these posts are at YSHT. Neither HUTH nor NLAG have any dedicated resource in place to ensure the effective and efficient use of procurement systems and data.

7.2 Spend Analytics & Price Benchmarking

The only single instance system used across a stage of the procurement process is spend analytics & price benchmarking where all three Partner Trusts utilise the NHS Spend Comparison Service provided by NHS Digital.

Although all three Partner Trusts are inputting data into the system it is evident that the data submitted isn't consistent nor is the data within the system being used to inform procurement decisions. As an example HUTH are not including all of the Pharmacy expenditure as only £4m of annual spend is included nor is spend (VAT) with HMRC being submitted. The inconsistency of data input by the Partner Trusts questions the value of the reporting functionality available within the system which may explain why it's not being used to inform procurement decisions. This could be an invaluable repository of procurement spend information for collaborative procurement and defining strategy if spend was consistently reported. It would also allow procurement strategies to benchmark against a 'should-cost' position and identify savings opportunities in advance of any procurement.

NHSEI have built HCVPC our own version of the SCS which allows for local customisation.

In the future state there is no change in the system choice here however standardisation of the information input to the system is required to allow for standard reporting. Work will be undertaken to understand the current differences of data being put into the system with a standard operating process put in place to ensure consistent input.

7.3 Pipeline/ Work Plan Management

Pipeline and work plan management is being undertaken in Excel at HUTH and YSTH whereas NLAG doesn't have any process in place to plan procurement activity. Whilst Excel is a valid option it does contain risks around data integrity and security and does not integrate with any other part of the procurement process e.g. you cannot promote a project from the plan into live procurement.

There is also a requirement for organisations with a non-pay expenditure over £200m to publish their procurement pipeline in advance so that suppliers can see when they would expect opportunities to be published. None of the Partner Trusts are currently publishing their pipelines and are therefore not compliant with this requirement.

On review of the work plans submitted:

- 35 contracts don't have end dates;
- 145 contracts are with unknown suppliers;
- 332 contracts have an unknown contract value.

In summer 2022 DHSC through NHSEI announced that Atamis is being rolled out across the NHS and that this will be centrally funded. Implementation of a single system which allows concurrent customer access and mandates the entry of key contract information would ensure data integrity. By using Atamis publication of procurement pipelines will be automatically completed and therefore ensure that the Partner Trusts are compliant with Procurement Regulation.

A project team has been established with representatives at each Trust. The aim is to have implemented the Atamis system by 1st April 2023.

7.4 e-Sourcing/e-Tendering and Contract & Supplier Management

Both NLAG and YSTH use the same system for eSourcing/eTendering and Contract and Supplier Management (although NLAG are not using this module) – In-Tend. This system was provided as part of the membership cost to the NOECPC but this has come to an end following the introduction of a national system by DHSC. Both organisations have signed a 3 year contract with In-Tend taking commitment through to the end of 2024. HUTH are using Pro-Contract for their tendering activity but are not undertaking any contract or supplier management activity through any system. In summer 2022 DHSC through NHSEI communicated the national rollout of their system fully funded to the NHS.

Moving to a single system which is consistent with the pipeline/ work plan module will allow projects to be advanced from the plan to the live environment and will update the published work plan without additional manual intervention. As both NLAG and YSTH have signed 3 year contracts which do not expire until 2024 the proposal is this is seen as a lost cost with the benefit of changing systems before the end date exceeding the lost cost.

7.5 eCatalogue

All Partner Trusts are getting their e-catalogue solution through Advance Business Solutions. This appears to have been deployed as a financial management system rather than a procurement system as none of the organisations are utilising the Tender Management, Contract Management or Spend Analytics modules offered by Advance Business Solutions.

As the ordering processes are automated, catalogues are developed with standardised product descriptions. This ensures the ordering data that feeds the general ledger is consistent, articulate and ultimately improves financial data quality and the non-pay decisions made by budget managers and management accountants.

The proposal is to maintain the existing eCatalogue system but move to a single instance. This way the eCatalogue seen in one Partner Trust is seen across all three ensuring consistency of price paid but also combined demand which should result in a reduced price. This approach will also reduce the overhead of maintaining catalogues as only one change will be required by a supplier rather than three changes. To reduce the administrative burden of managing catalogues the use of supplier managed catalogues will be investigated. Buyers will still control whether price changes to a catalogue are accepted but will not be responsible for the loading of data.

ABS have confirmed that a managed service for catalogue management can be implemented. The proposal is that a one off cost around £10k will deliver a consistent catalogue from the existing three Partner Trust catalogues. They will then manage the catalogue for an annual cost of £20k-£25k per annum. The catalogue will then populate a front-end marketplace where users can order from.

7.6 PEPPOL Access Points

PEPPOL (Pan-European Public Procurement On Line) is a set of technical specifications that enables machine-to-machine electronic business transactions. In short, it is the ability to send electronic Purchase Orders, Invoices and other supply chain documents in a standard format and at low cost between different systems providers. At the moment this is only used by YSTH.

The recommendation is that the benefits of this system are reviewed and potentially expanded across the Partner Trusts for consistency.

7.7 Requisition & Purchase Order

Both HUTH and NLAG are using Advance Business Solutions for requisition and purchase order raising whereas YSTH are using Oracle. Both of these systems are predominantly finance systems adapted for procurement. Although HUTH and NLAG are using the same provider these are different instances and therefore the two systems do not talk to one another. The cost for the e-procurement element of the e-financial system is incorporated within the outsourced payments function and is therefore not possible to separate.

Having three separate e-procurement solutions provides additional administrative requirements for HNYPC. Although one collaborative contract may be awarded following a tender exercise, three purchase orders would need to be raised to ensure the costs are fed back into the local Trust ledger. This would then require the supplier to submit three invoices and chase three separate payments. Feedback from suppliers is that this doesn't reduce the cost of doing business with the collaborative and will therefore impact the level of benefit that could be achieved through collaborative procurement.

As such, it is recommended that a common cloud based purchase to pay (P2P) solution is purchased and installed at the front end as a layer over the Partner Trusts finance and accounting system. The P2P solution would hold catalogue content, handle web based requisitions, approval workflows, order transmission, receipting and

invoice management in a single instance, allowing for an intuitive, feature rich, customer experience.

Each Partner Trust will retain its own financial system in the short to medium term, with interfaces synchronising static and transactional data between the cloud system and the Partner Trusts choice of finance/ ERP solution with a selection of standard interface touch points. Decoupling the purchase to pay solution from the Finance system will also reduce dependencies for Partner Trusts to join other shared back office services. For example, a different group of trusts could be part of the Procurement collaboration to those engaged in a shared financial services organisation.

The long term solution should consider a single e-Financial system across the Partner Trusts.

7.8 Inventory Management

Inventory Management sees the biggest divergence in systems. Both HUTH and YSTH have two systems, Advance Business Solutions and Genesis in HUTH and Omnicell and Ingenica in YSTH.

NHSSC have undertaken a review of the Partner Trusts supply activities, this also included systems. As part of the NHSSC review it has been recommended that opportunities for automated/ semi-automated inventory management systems needs to be considered. Other NHS organisations are using cabinets which issue stock and automatically reorder based on pre-set order levels. The requirement will also need to consider automatic stock checking and automatic replenishment, as well as the returns process to provide an appropriate balance between risk and cost control.

The NHSSC review is also considering the ownership of inventory management systems and whether the centre should take the same approach to these as they have done with the Atamis programme e.g. provide a funded system for the NHS. The decision on whether to do this will take time as will any procurement process.

The recommendation is that the Partner Trusts move to the same inventory management solution to provide visibility of stockholding across the Partner Trusts and that this project is agreed and delivered in collaboration with the Scan4Safety team.

7.9 Scan4Safety

Scan4Safety is in the process of being rolled out at HUTH with conversations ongoing around implementation at NLAG and YSTH. Any decision to rollout at NLAG and YSTH will be subject to a separate business case. Although procurement is not responsible for the rollout of Scan4Safety it plays an important role when a new department is set up and is a key user of the data which the programme generates.

Procurement are required to provide a purchase order report at the start of the implementation of Scan4Safety into any area. This sets out which products have been purchased from which suppliers, at what cost and quantity. This information allows the Scan4Safety team to load product into the system and assign it to clinical teams preference cards. At HUTH around 40% of stock found as part of the Scan4Safety implementation has not been included within the purchase order data which raises questions around how the stock appears in clinical areas.

There are other issues with the process such as changes being made to product selection not feeding into the Scan4Safety team. This means that when clinical

customers scan a product against a patient it is not found. Product is then used and not associated with the procedure. Where PBR applies these costs will not be recharged in full.

To support the Scan4Safety implementation at HUTH and potentially NLAG and YSTH it will be essential to have robust policies, procedures and systems in place within procurement to ensure all products can be scanned and the cost of the procedures undertaken charged appropriately. As such this business case includes the requirement for a single inventory management system to be deployed across all three Partner Trusts.

HUTH's implementation has also highlighted that stock controllers sit outside of Procurement and that there is a communication disconnect between the stock controllers and Procurement. This means that proper stock controls are not in place leading to stock being ordered that isn't required and stock going out of date which needs to be disposed of. All stock management should be centralised into HNYPC with appropriate re-order quantities and levels being agreed with budget holders.

The information and outputs from Scan4Safety should be used by procurement to influence supplier relationship management, contract management and buying behaviours within the business. Scan4Safety should be used as a key system for driving efficiencies and improvements within the patient pathway and identifying cost saving opportunities through standardisation of preference cards. Examples of the data points we could acquire, and the associated benefits include:

- Full traceability of implantable products to patients – reducing risk from product recall;
- Freeing up clinical time to focus on patient care;
- Reducing stock holding through better stock management;
- Ongoing operational efficiencies through better stock management and identifying where stock is held;
- Improved patient level costing with a complete range of items used in each procedure;
- Engagement of clinical community from increased visibility of operational data. Understanding why different clinicians use different products for the same procedure and comparing the outcomes achieved can enable a wider range of clinical discussions about a common ways of working;
- Opportunity to drive standardisation. Savings from elimination of unwarranted variation.

HUTH are moving to a new inventory management system with the key delivery dates being:

Date	Action
November 21 – August 22	Data gathering.
January 22 – September 22	Planning stages.
May 22 – July 22	Design stages.
June 22 – July 22	Systems build.
July 22 – September 22	Systems testing.
October 22 – November 22	Cutover for testing within live environment.
November 22 – March 23	Migration of existing users to new system.

Figure 87 – Scan4Safety Timeline

7.10 Opportunity/ Future State

The current systems and applications have been assessed as having substantial performance gaps to best-in-class. In addition, the approach for systems and applications to support each stage of the procurement cycle, with integration between systems and applications, brings increased cost and reduced quality of data insights.

The recommendation is that a two stage approach is taken to the future systems strategy. The first stage is to standardise, where possible, onto an existing system for all Partner Trusts. The aims of this are that:

- All Partner Trusts use the same instance of the same system in a consistent manner allowing for accurate reporting;
- Standardised technology architecture is required to enable HNYPC to operate effectively and avoid substantial manual processes and duplication;
- Improved use of technology is required to enable delivery of the benefits anticipated by the creation of HNYPC;
- Opportunity to transform procurement work by ensuring broad availability and adoption of digital source to pay tools to make procurement automated, proactive and predictive.

The desired future systems strategy is set out below which focuses on moving all three Partner Trusts to the same instance of the same system. To select from within the existing systems and applications currently used by HNYPC Partner Trusts at each stage of the procurement cycle, and deploy that across HNYPC. By selecting from within existing systems, the need for appraisal of different systems and applications is constrained, and the speed of deployment is increased, ensuring that harmonised systems are deployed as quickly as possible. The expected timescale to achieve alignment is 12 months.

System Category		HUTH	NLAG	YSTH
Spend analytics & price benchmarking	System	Spend Comparison Service	Spend Comparison Service	Spend Comparison Service
	Annual Spend	£3.300	£3.300	£3.300
	End Date	n/a (internal NHS System)	n/a (internal NHS System)	n/a (internal NHS System)
Pipeline/work plan management	System	Atamis	Atamis	Atamis
	Annual Spend	£0	£0	£0
	End Date	n/a (centrally funded)	n/a (centrally funded)	n/a (centrally funded)
eSourcing/ eTendering	System	Atamis	Atamis	Atamis
	Annual Spend	£0	£0	£0
	End Date	n/a (centrally funded)	n/a (centrally funded)	n/a (centrally funded)
Contracts & Supplier Management	System	Atamis	Atamis	Atamis
	Annual Spend	£0	£0	£0
	End Date	n/a (centrally funded)	n/a (centrally funded)	n/a (centrally funded)

eCatalogue	System	Advance Business Solutions	Advance Business Solutions	Advance Business Solutions
	Annual Spend	£8,333	£8,333	£8,333
	End Date	30/04/2027	30/04/2027	30/04/2027
PEPPOL Access Points	System	Pagero	Pagero	Pagero
	Annual Spend	£1,667	£1,667	£1,667
	End Date	TBC	TBC	TBC
Requisition & Purchase Order	System	ABS/Oracle	ABS/Oracle	ABS/Oracle
	Annual Spend	£75,000	£75,000	£75,000
	End Date	TBC	TBC	TBC
Inventory Management	System	Tagnos	Tagnos	Tagnos
	Annual Spend	£47,500	£47,500	£47,500
	End Date	October 2025	October 2025	October 2025

Figure 88 – Future Procurement Systems

8. Preferred Option – Benefits Realisation

8.1 Current HNYPC Costs and Benefits

The current budgeted costs of procurement, materials management and outsourced procurement across the organisations in scope are as follows:

Detailed Revenue Financials

Pay	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
Band 9	£80,809.00	£80,809.00	£80,809.00	£80,809.00	£80,809.00	£80,809.00
Band 8C	£254,374.00	£254,374.00	£254,374.00	£254,374.00	£254,374.00	£254,374.00
Band 8A	£59,600.00	£59,600.00	£59,600.00	£59,600.00	£59,600.00	£59,600.00
Band 7	£341,898.00	£341,898.00	£341,898.00	£341,898.00	£341,898.00	£341,898.00
Band 6	£268,793.00	£268,793.00	£268,793.00	£268,793.00	£268,793.00	£268,793.00
Band 5	£437,660.00	£437,660.00	£437,660.00	£437,660.00	£437,660.00	£437,660.00
Band 4	£431,223.00	£431,223.00	£431,223.00	£431,223.00	£431,223.00	£431,223.00
Band 3	£1,000,790.00	£1,000,790.00	£1,000,790.00	£1,000,790.00	£1,000,790.00	£1,000,790.00
Band 2	£845,924.00	£845,924.00	£845,924.00	£845,924.00	£845,924.00	£845,924.00
Other Pay Adjustments*	-£28,620.00	-£28,620.00	-£28,620.00	-£28,620.00	-£28,620.00	-£28,620.00
Sub Total Pay	**£3,692,451.00**	**£3,692,451.00**	**£3,692,451.00**	**£3,692,451.00**	**£3,692,451.00**	**£3,692,451.00**
Non-Pay Expenditure						
Med-Surg Equipment Disposal	£10,012.00	£10,012.00	£10,012.00	£10,012.00	£10,012.00	£10,012.00
Staff Uniforms and Clothing	£5,475.00	£5,475.00	£5,475.00	£5,475.00	£5,475.00	£5,475.00
Protective Clothing	£2,625.00	£2,625.00	£2,625.00	£2,625.00	£2,625.00	£2,625.00
Cleaning Materials	£200.00	£200.00	£200.00	£200.00	£200.00	£200.00
Bedding & Linen : Disposable	£600.00	£600.00	£600.00	£600.00	£600.00	£600.00
Other General Supplies	£400.00	£400.00	£400.00	£400.00	£400.00	£400.00
Stationery	£8,108.00	£8,108.00	£8,108.00	£8,108.00	£8,108.00	£8,108.00
Postage & Carriage	£400.00	£400.00	£400.00	£400.00	£400.00	£400.00
Packing & Storage	£500.00	£500.00	£500.00	£500.00	£500.00	£500.00
Travel & Subsistence	£10,200.00	£10,200.00	£10,200.00	£10,200.00	£10,200.00	£10,200.00
Vehicle Running Costs Fuel	£2,500.00	£2,500.00	£2,500.00	£2,500.00	£2,500.00	£2,500.00
Training Expenses	£14,400.00	£14,400.00	£14,400.00	£14,400.00	£14,400.00	£14,400.00
Legal Fees	£2,000.00	£2,000.00	£2,000.00	£2,000.00	£2,000.00	£2,000.00
Professional Fees	£5,100.00	£5,100.00	£5,100.00	£5,100.00	£5,100.00	£5,100.00
Furniture and Fittings	£2,100.00	£2,100.00	£2,100.00	£2,100.00	£2,100.00	£2,100.00
Office Equipment and Purchases	£800.00	£800.00	£800.00	£800.00	£800.00	£800.00
Computer Hardware Purchases	£6,900.00	£6,900.00	£6,900.00	£6,900.00	£6,900.00	£6,900.00
Computer Software/ License Fees	£7,350.00	£7,350.00	£7,350.00	£7,350.00	£7,350.00	£7,350.00
External Consultancy Fees	£8,000.00	£8,000.00	£8,000.00	£8,000.00	£8,000.00	£8,000.00
Miscellaneous Expenditure	£11,800.00	£11,800.00	£11,800.00	£11,800.00	£11,800.00	£11,800.00
General Losses and Special Payments	£1,900.00	£1,900.00	£1,900.00	£1,900.00	£1,900.00	£1,900.00
Staff Benefits	£100.00	£100.00	£100.00	£100.00	£100.00	£100.00
Books, Journals and Subscriptions	£58,500.00	£58,500.00	£58,500.00	£58,500.00	£58,500.00	£58,500.00
Sub Total Non-Pay	**£159,970.00**	**£159,970.00**	**£159,970.00**	**£159,970.00**	**£159,970.00**	**£159,970.00**
Other Non-Pay Adjustments**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**
Total Pay & Non-Pay	**£3,697,648.00**	**£3,697,648.00**	**£3,697,648.00**	**£3,697,648.00**	**£3,697,648.00**	**£3,697,648.00**

Figure 89 – Current Budget Costs

* Other pay adjustments include budgeted pay efficiency savings and costs for agency staff.

** Other non-pay adjustments relate to an income target at YSTH for the sale of equipment which has reached the end of its useful life. Equipment is typically auctioned and either sent abroad or used within the veterinary sector.

The current return on investment for the procurement teams is:

	HUTH	NLAG	YSTH	Total
Annual Pay Budget	£1,152,509	£941,600	£1,598,342	£3,692,451
Annual Non-Pay Budget	£58,800	£31,700	£69,470	£159,970
Total Expenditure	£1,211,309	£973,300	£1,667,812	£3,852,421

Income Target	£0	£0	£154,773	£154,773
Total Budget Position	£1,211,309	£973,300	£1,513,039	£3,697,648
Saving Target	£1,072,484	£200,000	£913,322	£2,185,806
Return on Investment	0.89	0.21	0.60	0.59

Figure 90 – Current Return on Investment

It should be noted that e-Procurement costs do not sit within procurement budgets as the cost is within the finance budget for the e-finance system, if this was included the ROI for the Procurement team would be lower.

Current savings targets for the three Partner Trusts provides an annual benefit of £2.1m, 0.05% of non-pay spend. Other cluster trusts typically save 2-3% of non-pay spend with the Lord Carter report 'Operational Productivity and performance in English NHS acute hospitals: Unwarranted variations', setting a procurement savings target of 9.5%. There is opportunity for significant improvement on current performance.

8.2 Preferred Option HNYPC Costs

The proposed budgeted costs for procurement, materials management and outsourced procurement across the organisations in scope are as follows:

Detailed Capital Financials

Capital Purchase	**Value**	**Life**	**Residual Values**
Inventory Management System	£57,900.00	5	£0.00
IT & Telecoms Equipment	£75,000.00	5	£0.00
	£132,900.00		

	2022/23	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
Inventory Management System	£57,900.00	£0.00	£0.00	£0.00	£0.00	£0.00
Depreciation	£0.00	£11,580.00	£11,580.00	£11,580.00	£11,580.00	£11,580.00
Closing Value	£57,900.00	£46,320.00	£34,740.00	£23,160.00	£11,580.00	£0.00
Capital Charge	£2,026.50	£1,621.20	£1,215.90	£810.60	£405.30	£0.00
IT & Telecoms Equipment	£75,000.00	£0.00	£0.00	£0.00	£0.00	£0.00
Depreciation	£0.00	£405.30	£405.30	£405.30	£405.30	£405.30
Closing Value	£75,000.00	£74,594.70	£74,189.40	£73,784.10	£73,378.80	£72,973.50
Capital Charge	£2,625.00	£2,610.81	£2,596.63	£2,582.44	£2,568.26	£2,554.07
Totals	**£270,451.50**	**£137,132.01**	**£124,727.23**	**£112,322.44**	**£99,917.66**	**£87,512.87**

Detailed Revenue Financials

Pay	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**
Band 9	£118,928.32	£118,928.32	£118,928.32	£118,928.32	£118,928.32	£118,928.32
Band 8C	£254,374.00	£248,840.73	£248,840.73	£248,840.73	£248,840.73	£248,840.73
Band 8A	£59,600.00	£355,109.46	£355,109.46	£355,109.46	£355,109.46	£355,109.46
Band 7	£341,898.00	£474,925.41	£474,925.41	£474,925.41	£474,925.41	£474,925.41
Band 6	£268,793.00	£255,482.76	£255,482.76	£255,482.76	£255,482.76	£255,482.76
Band 5	£437,660.00	£509,587.91	£509,587.91	£509,587.91	£509,587.91	£509,587.91
Band 4	£431,223.00	£613,450.80	£613,450.80	£613,450.80	£613,450.80	£613,450.80
Band 3	£805,449.00	£1,227,857.30	£1,227,857.30	£1,227,857.30	£1,227,857.30	£1,227,857.30
Band 2	£845,924.00	£1,093,936.05	£1,093,936.05	£1,093,936.05	£1,093,936.05	£1,093,936.05
Other Pay Adjustments	£28,980.00	-£407,240.99	-£407,240.99	-£407,240.99	-£407,240.99	-£407,240.99
Sub Total Pay	**£3,592,829.32**	**£4,490,877.75**	**£4,490,877.75**	**£4,490,877.75**	**£4,490,877.75**	**£4,490,877.75**
Non-Pay Expenditure						
Med-Surg Equipment Disposal	£10,012.00	£10,012.00	£10,012.00	£10,012.00	£10,012.00	£10,012.00
Staff Uniforms and Clothing	£5,475.00	£5,475.00	£5,475.00	£5,475.00	£5,475.00	£5,475.00
Protective Clothing	£2,625.00	£2,625.00	£2,625.00	£2,625.00	£2,625.00	£2,625.00
Cleaning Materials	£200.00	£200.00	£200.00	£200.00	£200.00	£200.00
Bedding & Linen : Disposable	£600.00	£600.00	£600.00	£600.00	£600.00	£600.00
Other General Supplies	£400.00	£400.00	£400.00	£400.00	£400.00	£400.00
Stationery	£8,108.00	£8,108.00	£8,108.00	£8,108.00	£8,108.00	£8,108.00
Postage & Carriage	£400.00	£400.00	£400.00	£400.00	£400.00	£400.00
Packing & Storage	£500.00	£500.00	£500.00	£500.00	£500.00	£500.00
Travel & Subsistence	£10,200.00	£10,200.00	£10,200.00	£10,200.00	£10,200.00	£10,200.00
Vehicle Running Costs Fuel	£2,500.00	£2,500.00	£2,500.00	£2,500.00	£2,500.00	£2,500.00
Training Expenses	£14,400.00	£14,400.00	£14,400.00	£14,400.00	£14,400.00	£14,400.00
Legal Fees	£2,000.00	£2,000.00	£2,000.00	£2,000.00	£2,000.00	£2,000.00
Professional Fees	£5,100.00	£5,100.00	£5,100.00	£5,100.00	£5,100.00	£5,100.00
Furniture and Fittings	£2,100.00	£2,100.00	£2,100.00	£2,100.00	£2,100.00	£2,100.00
Office Equipment and Purchases	£800.00	£800.00	£800.00	£800.00	£800.00	£800.00
Computer Hardware Purchases	£6,900.00	£6,900.00	£6,900.00	£6,900.00	£6,900.00	£6,900.00
Computer Software/ License Fees	£7,350.00	£7,350.00	£7,350.00	£7,350.00	£7,350.00	£7,350.00
External Consultancy Fees	£8,000.00	£8,000.00	£8,000.00	£8,000.00	£8,000.00	£8,000.00
Miscellaneous Expenditure	£11,800.00	£11,800.00	£11,800.00	£11,800.00	£11,800.00	£11,800.00
General Losses and Special Payments	£1,900.00	£1,900.00	£1,900.00	£1,900.00	£1,900.00	£1,900.00
Staff Benefits	£100.00	£100.00	£100.00	£100.00	£100.00	£100.00
Books, Journals and Subscriptions	£58,500.00	£58,500.00	£58,500.00	£58,500.00	£58,500.00	£58,500.00
Additional Non-Pay Costs						
HUTH NOECPC Membership	£0.00	£30,000.00	£30,000.00	£30,000.00	£30,000.00	£30,000.00
PEPPOL Access Point	£0.00	£5,000.00	£5,000.00	£5,000.00	£5,000.00	£5,000.00
Purchase to Pay	£0.00	£75,000.00	£75,000.00	£75,000.00	£75,000.00	£75,000.00
Catalogue Management System	£0.00	£25,000.00	£25,000.00	£25,000.00	£25,000.00	£25,000.00
Inventory Management Cloud System	£0.00	£142,500.00	£142,500.00	£142,500.00	£142,500.00	£142,500.00
Helpdesk System	£0.00	£18,000.00	£18,000.00	£18,000.00	£18,000.00	£18,000.00
Training & Development Uplift	£0.00	£16,272.00	£16,272.00	£16,272.00	£16,272.00	£16,272.00
Legal Fees	£0.00	£10,000.00	£0.00	£0.00	£0.00	£0.00
Travel & Subsistence Uplift	£0.00	£7,800.00	£7,800.00	£7,800.00	£7,800.00	£7,800.00
Equipment Lease & Maintenance	£0.00	£750.00	£750.00	£750.00	£750.00	£750.00
Sub Total Non-Pay	**£159,970.00**	**£490,292.00**	**£480,292.00**	**£480,292.00**	**£480,292.00**	**£480,292.00**
Other Non-Pay Adjustments	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**	**-£154,773.00**
Total Pay & Non-Pay	**£3,907,572.32**	**£4,959,296.75**	**£4,816,396.75**	**£4,816,396.75**	**£4,816,396.75**	**£4,816,396.75**

Figure 91 – Future Budget Costs

8.2.1 Capital Expenditure

New IT and telephony equipment will be required both to support the increase in FTE allocation, but additionally to provide mobile and remote working capability for those staff that require it. Additionally, depending upon the chosen organisational entity model, the host organisation is likely to want the new organisation to use standard functionality and equipment already supported by the organisation. This expenditure is likely to be capitalised.

A single inventory management system should be deployed across the three Partner Trusts which will provide better visibility of stockholding and better stock management. The proposal is that the inventory management system being deployed at HUTH as part of the S4S programme is rolled out at NLAG and YSTH.

8.2.2 Pay Expenditure

Pay has been calculated using the mid-point of the band plus pension and NI. Efficiency targets on procurement pay expenditure have also been added back into the financial model.

8.2.3 Non-Pay Expenditure

Additional non-pay expenditure is proposed to support the implementation of the HNYPC.

An increase in technology spend is required to remove current paper based actions which will make the team more efficient but also improve access to data. The majority of the existing system cost for procurement sits within the outsourced e-Financial systems and therefore finance budgets, it is not possible to separate this. For HNYPC to work as efficiently as possible a single new system will be required that can integrate with the existing e-Financial systems. A new cloud based helpdesk and support web portal would provide a single point of contact for all ad-hoc support requests and contact from customers and suppliers. Enquiries could be routed to the relevant team electronically, whether they are based locally, centrally or are mobile, enabling customer service levels and response rates to be tracked.

Both YSTH and NLAG are members of NOECPC whereas HUTH have chosen not to join as members. Support from NOECPC will be required to deliver a number of future contracts, and to make engagement as HNYPC easier to manage the proposal is to sign HUTH up as members at a cost of £30,000 per annum. NOECPC operate a rebate model with suppliers which is shared with trusts based on usage. It is therefore expected this investment becomes cost neutral from the rebate model.

Other non-pay spend has either been maintained at existing budget levels or removed as no longer required. Additional spend is however requested to increase learning and development to the national average and an increase in legal costs to support the formation of HNYPC.

Procurement requires other non-pay spend to operate, this includes:

- Capital items such as tugs for moving goods. There are currently a number of tugs across the Partner Trusts which should be replaced every 5-7 years at a cost of £10,000;
- Maintenance of equipment such as pallet trucks. There are currently a number of items which require maintenance on an annual basis at a cost of £250.

The proposal is that redundancy will not be required. In the event that redundancy costs are needed, these will be treated as HNYPC costs and shared between HNYPC Partner Trusts on the same basis as other procurement costs.

Over five years the total additional cost of delivering the transformation and savings programme with associated non-cash and cash benefits is £5,776,643.75.

8.3 Effect on Model Hospital Data

The changes proposed to the cost of Procurement makes a minimal change to the level of investment in back office functions as set out within Model Hospital data:

Pay	Investment as a % of Income	Investment as a % of non-pay
IM&T	1.13%	3.82%
HR	0.72%	2.43%
Gov & Risk	0.54%	1.83%
Finance	0.43%	1.46%
Procurement (proposed)	0.25%	0.83%
Procurement (as-is)	0.20%	0.69%
Payroll	0.10%	0.34%

Non-Pay	Investment as a % of Income	Investment as a % of non-pay
IM&T	1.16%	3.91%
HR	0.25%	0.84%
Finance	0.11%	0.38%
Gov & Risk	0.04%	0.13%
Procurement (proposed)	0.03%	0.09%
Procurement (as-is)	0.01%	0.03%
Payroll	0.00%	0.01%

Figure 92 – Future Corporate Services Investment

This investment sees an increase in pay spend of 0.05% of income and an increase in non-pay budget of 0.02% of income.

8.4 Return on Investment (ROI)

It should be noted that delivery of a return on investment will be impacted by rising costs and inflation. NHSEI are estimating £1.5bn of cost increases that have not been budgeted within 2022/23. The Association of British Healthcare Industries has reported that suppliers are pushing up prices to the NHS after they have consumed inflation pressures in recent years. A number of cash releasing benefits that could have been delivered by implementing the preferred option could now be delivered as cost avoidance inflationary benefits. Without implementing the preferred option the cost

pressure to the Partner Trusts would be higher. As such, inflation avoidance has to be a key strategy moving forward.

For the purpose of this business case, NOECPC and NHSSC both undertook analysis of spend areas and submitted documentation outlining potential savings opportunities across HNYPC. Utilising the data available as well as benchmarking information, the data was analysed to identify potential savings opportunities:

Opportunity	2023/24	2024/25	2025/26	2026/27	2027/28
Cash Releasing					
Exiting Trust Savings Plan	£2,185,806	£2,185,806	£2,185,806	£2,185,806	£2,185,806
NOECPC Rebate	£90,000.00	£90,000.00	£90,000.00	£90,000.00	£90,000.00
NHS Supply Chain Collaboration	£151,545.00	£215,772.00	£215,772.00	£215,772.00	£215,772.00
Price Standardisation	£358,005.00	£463,628.00	£633,478.00	£633,478.00	£803,328.00
Volume Savings	£3,197,060.63	£5,888,493.94	£8,579,927.26	£11,271,360.57	£13,962,793.88
Value Based Procurement	£0.00	£50,000.00	£100,000.00	£150,000.00	£200,000.00
Capital Buyer Recharge	£116,191.76	£116,191.76	£116,191.76	£116,191.76	£116,191.76
Tail Spend Management	£43,000.00	£86,000.00	£86,000.00	£86,000.00	£129,000.00
Sustainability	£52,770.00	£52,770.00	£112,000.00	£112,000.00	£112,000.00
Stock Management Improvements	£54,000.00	£100,000.00	£250,000.00	£250,000.00	£250,000.00
Cash Releasing Sub-Total	**£6,248,378.39**	**£9,248,661.70**	**£12,369,175.02**	**£15,110,608.33**	**£18,064,891.64**
Cost Avoidance					
Inflationary	£100,000.00	£150,000.00	£100,000.00	£50,000.00	£10,000.00
Contract Management	£500,000.00	£2,000,000.00	£5,000,000.00	£10,687,002.49	£10,687,002.49
Supplier Rationalisation	£100,000.00	£100,000.00	£50,000.00	£20,000.00	£10,000.00
Cost Avoidance Sub-Total	**£700,000.00**	**£2,250,000.00**	**£5,150,000.00**	**£10,757,002.49**	**£10,707,002.49**
Total Benefit	**£6,948,378.39**	**£11,498,661.70**	**£17,519,175.02**	**£25,867,610.82**	**£28,771,894.14**
Cumulative Benefit	**£6,948,378.39**	**£18,447,040.09**	**£35,966,215.11**	**£61,833,825.93**	**£90,605,720.07**
Total Cost	£4,959,296.75	£4,816,396.75	£4,816,396.75	£4,816,396.75	£4,816,396.75
Return on Investment	1.40	2.39	3.64	5.37	5.97

Figure 93 – Return on Investment

There are a couple of caveats which should be highlighted with the savings figures presented in the figure above. Firstly, whilst the savings opportunities have been calculated using benchmarking and reference to what other ICS procurement structures have been able to deliver, it should be cautioned that the current levels of inflation could impact the cash releasing savings opportunities. This is not to say that benefits will not be delivered from implementing this recommendation, it may just result in mitigating the impacts of unfunded inflation. The second caveat is that the savings have been calculated using the accounts payable data from the three Partner Trusts. There remains some questions around data integrity and significant work is required on data quality but again, this should not stop the recommendation being approved.

8.4.1 Existing Trust Savings Plan

The existing Partner Trust savings plans and targets are maintained through future years and form the baseline for all opportunities delivered.

8.4.2 NOECPC Rebate

NOECPC charge suppliers a percentage against all work obtained under the frameworks let by NOECPC. This income is then redistributed to members based on their use of NOECPC frameworks. In 2021/22 both NLAG and YSHT received rebates which exceeded their cost of membership. The benefit listed above assumes the addition of HUTH to the membership model will deliver a rebate equal to investment.

8.4.3 NHS Supply Chain Collaboration

NHSSC identify a number of saving opportunities through moving to lower cost clinically acceptable products and through signing commitment deals across organisations that increase savings. The current savings workbook sets out around £1m of opportunity that could be delivered however this will need input from the Clinical Procurement Specialists to lead change programmes.

Many of the NHS Supply Chain contracts have price breaks by volume bands. By procuring collaboratively there is a £287k saving opportunity without having to change product, through moving the trusts into a higher volume band.

8.4.4 Price Standardisation

There is a lack of harmonisation across HNYPC which is contributing to procurement inefficiencies and missed opportunities – historically there has been little collaboration between the HNYPC Partner Trusts for the same project areas which has led to un-harmonised pricing across the trusts for the same products, with price variations ranging up to 57%. This difference has been found in a very small sample of catalogue prices. This presents a substantial opportunity for the HNYPC and highlights areas where benefit can be delivered without the need to conduct clinical trials or impact the customer.

The three Partner Trusts have historically negotiated contracts with suppliers individually which has allowed suppliers to charge different prices for the same product. Standardising the cost across the three Partner Trusts will deliver a financial benefit. The NHS SCS identifies £3.3m in opportunity moving the three trusts spend to the national median price paid (HUTH £1.9m, NLAG £537k and YSTH £960k). All of these opportunities will need to be reviewed.

Some of the opportunity here will duplicate with the opportunities identified by NHSSC so the total opportunity has been reduced by the NHSSC value to avoid double counting.

NOECPC have undertaken a review of the Partner Trusts temporary staffing expenditure and identified a savings opportunity of £3.3m in aligning the Partner Trusts rates to the national capped rates. There will also be further opportunity through demand management.

8.4.5 Volume Savings

Suppliers will often offer a lower price for the sale of a greater volume of product. Collating the requirements of the three Partner Trusts and buying once for all three should lead to a collective lower price. This will take time to deliver as existing arrangements come to an end.

An assessment of addressable spend across clinical and non-clinical categories identified several opportunities to deliver savings over a 5-year timeframe, with the analysis being undertaken by NOECPC and NHSSC. The existing HNYPC

procurement teams also have produced an initial work plan for FY 2022/23. This work plan has applied an increasing savings target between 1% and 3% annual saving opportunity across £538m of spend, across both clinical and non-clinical projects.

To avoid double counting this opportunity has been reduced by the value of the existing Trust savings plans.

South Yorkshire ICS have undertaken a review of orthopaedic implants with standardisation occurring across the ICS. This activity has saved £2m per annum based on current usage.

8.4.6 Value Based Procurement

HNYPC will implement value based procurement into the procurement decision making process. Value based procurement is an approach that delivers tangible, measurable financial benefit to the health system over and above a reduction in purchase price; and/or a tangible and measurable, improved patient outcome derived through the process of procurement (tendering, contracting, clinical engagement and supplier relationship management). This will mean that procurement also considers:

1. Reduction in consumption - A product, which is higher quality or innovative, results in lower like for like consumption of this product type;
2. In patient to day case - A product results in a pathway change, where a procedure changes from inpatient to outpatient or similar;
3. Change in patient pathway - A product or solution that enables migration of patients from an acute to a community setting;
4. Operational productivity - A product or solution or supporting service provided by the supplier enables the Trust to improve operational productivity and efficiency;
5. Reduction in infection - A product or solution causes a reduction in infection for a specific procedure or patient cohort.

It is appreciated that some of the changes could have unintended consequences such as a change in an acute setting could increase costs within the community sector or for Commissioners. Value based procurement and the consequences of change will be mapped out and understood as part of the Procurement Initiation Document. This will be undertaken through a conversation about the outcomes people want, and then a procurement strategy can be agreed. End of year spend is often a blocker to such planning with funds having to be spent at speed. Procurement activity should be linked to Partner Trust objectives as suppliers are rarely asked how they can support delivery of these.

Value Based Procurement has been undertaken elsewhere in the NHS. In one example Barts Health worked with Johnson & Johnson to review the patient pathway for elective primary hip and knee replacements and revisions. The results of this review were:

- An improvement in Oxford Hip scores from 93.4% to 95.5%;
- An improvement in Oxford Knee scores from 88.9% to 93.6%;
- 1,795 bed days saved;
- Increase in surgical utilisation by 10%;
- 23,000 extra minutes of operating theatre time which allowed an addition 192 procedures to be scheduled.

North Devon have undertaken a similar process with Zimmer Biomet which delivered:

- A reduction in length of stay on total hip replacements from 4.2 to 2.1 days;
- A reduction in length of stay on total knee replacements from 3.9 to 1.6 days;

- A theatre operational capacity increase of 40%.

8.4.7 Capital Buyer Recharge

Those buyers working on capital projects can have their salaries charged back to the projects they are working on. This will need to be evidenced through timesheets identifying the amount of time spent working on any one project. Depending on the grade of individual either their whole salary, or half of their salary, has been used to calculate the benefit.

8.4.8 Tail Spend Management

It should be possible to deliver a reduction to processing costs by moving some of the tier 4 suppliers (less than £10k) into other contracts. At the moment £187.3m is spent on transaction less than £10k.

HUTH have forecast 106,634 invoices to be paid in 2022/23 and NLAG 96,400. The cost charged by the outsourced provider to manage processing ranges between 50p per invoice and £2.30 per invoice with 53% of the invoices charged at the higher rate. Moving the highest charged invoices to the lowest cost would save £87k.

The Pan Government Policy on procurement cards suggests moving transactions under £20k with a limit per card of £100k per month onto a procurement card. Not only would this reduce invoice processing costs but this can also generate an annual rebate from the card provider based upon the volume of spend put through the card and the promptness of the settlement at the end of the month. Across the three Partner Trusts 98.2% of invoices are below £20k.

As an example of efficiencies that can be delivered YSTH have moved to consolidated invoicing with AAH and receive one invoice a month per site. HUTH receive 4,870 invoices per annum and NLAG 6,483. These are predominantly charged at £0.50 (£5,676.50) per invoice. Moving to consolidated invoicing for just one supplier can save £5,646.50.

8.4.9 Sustainability Savings

A number of changes to product, packaging and energy consumption can be made which will reduce the cost of consumption or the cost of managing waste. These actions will reduce the cost to the three Partner Trusts. Changes will take time and will need to be tracked.

8.4.10 Stock Management Improvements

Better stock management can deliver non-recurrent benefits to the efficiency of the stock management process as well as delivering cost reduction through a lower stock holding. Whilst it has been identified that removing stock management responsibilities to clinical teams would release resource in ward areas, this saving is not included in this case. It is assumed that resource will be repurposed to better focus on patient care.

NLAG have also calculated that moving stock areas to materials management which are managed by Materials Management staff can deliver an 11% saving to stock holding positions. Stock rotation is also undertaken by Materials Management staff to ensure product does not go out of date which will reduce wastage.

As of October 2022 HUTH had rolled out stock management to around 25% of clinical areas across the Trust. This identified £143k of stock which was out of date and a

further £80k of stock due to expire within the next 90 days. Other trusts who have implemented a stock management system have reported a return on investment between 3:1 and 6:1.

8.4.11 Inflationary

In September 2022 inflation was running at 10% with many suppliers seeking price increases in excess of this figure, recovering cost pressures for previous years. HNYPC will work to push back on the request for price increases. Where inflation has been budgeted for this will form a cash releasing saving, where inflation has not been budgeted for this will be a cost avoidance saving. As an example of some of the cost pressures received to date:

Product	Supplier	Increase Requested
Couch and Wiper Rolls	Essity UK Ltd	60%
Surgical Sutures	Johnson & Johnson	5%
Disposable Continence	Ontex Healthcare Ltd	8.76%
Uniforms and Workwear	MI Hub Ltd	10%
Disposable Continence Care	Attends Healthcare Ltd	9%
Electrophysiology	Johnson & Johnson	6.60%
Disposable Accessory Products	Attends Healthcare Ltd	20%
Laparoscopy Stapling	Johnson & Johnson	5%
Clinical Waste Containers	Mauser UK Ltd	TBC
Flexible Endoscopy	Pentax UK Ltd	10%
Neonatal Equipment	GE Medical Systems	10%
Uniforms and Workwear	Meltemi Limited	10%
Patient Monitoring	Draeger Medical	10%
General Wound Care	Vernacare Ltd	TBC
Haemostats	Johnson & Johnson	5%

Figure 94 – Inflationary Pressures

8.4.12 Contract Management

Good contract management can deliver benefits of 5-10% of a contracts value. The contract management team will focus on the higher cost, higher risk contracts to ensure that HNYPC Partner Trusts are obtaining the value promised from the supplier at the point of tender.

From the data currently available the trusts top 20 contracts account for around £200m of expenditure. This position will change as data is improved and centralised contracts are negotiated.

8.4.13 Supplier Rationalisation

It was identified that within multiple category areas, the spend is fragmented across a number of suppliers, which further highlights the need for pan-HNYPC projects to rationalise the supplier base and implement standardisation initiatives in order to drive efficiencies and deliver maximum benefits. At the time of producing this business case, HNYPC procurement teams had an informal project work plan in place for the upcoming financial year, however very limited pipeline visibility over the next 36 months. This lack of forward planning supports the inconsistent approach to project strategy, which in some cases regarding clinical projects, will require product trials to be undertaken, and reduces the capacity for the HNYPC Partner Trusts to cohesively manage key strategic suppliers and work collaboratively on projects.

8.5 Apportionment of Savings and Additional Costs

Savings will be calculated at cost centre level and the benefits apportioned on that basis back to the cost centre which gets the benefit. The process for covering the additional costs required to set up HNYPC and achieve the benefit is discussed in the governance section above.

Through the implementation of HNYPC increased procurement savings will be delivered, given that the structure, processes, systems and governance will be aligned to supporting and driving a cross-HNYPC approach to procurement.

8.6 Limitations & Caveats

Working through the data sets provided, in order to scope out the benefits available, the following key assumptions, caveats and limitations have been identified and underpin the opportunity assessment undertaken.

8.6.1 Data

Getting access to reliable datasets which show spend, contracts and suppliers used has proved difficult. A number of contracts listed in the contract registers do not contain details of the supplier, the expenditure or the start or finish dates. There is inconsistency between finance and procurement data regarding expenditure and also the spelling of a supplier name. One of the key pieces of work required to deliver the benefits will be the collection and cleansing of data.

8.6.2 Contract Visibility

The limited contract visibility and inaccurate information in the contract registers has proved difficult to effectively map contractual commitments and understand when, if any, contracts can be aligned and/or tendered together in the future. This also presents challenges as assumed savings cannot be profiled accurately where the contracts register is incomplete or indicates a lapsed contract.

8.6.3 Collaboration

The opportunities presented are on the basis that the projects will be undertaken pan-HNYPC with all applicable Partner Trusts involved and working collaboratively.

8.6.4 Clinical Engagement

Successfully delivering savings across the clinical categories is dependent upon providing an appropriate structure is in place to support clinical engagement, orchestrate clinical change and drive project delivery. It is noted that the role of Medical Directors is key in ensuring that the inter-lock between Procurement Business Partners and the customers is effective. To achieve this, it is assumed that Medical Director (or suitable alternative) attendance is mandatory at the Procurement Board when reviewing Clinical Category Strategies. A high level commitment from all Partner Trusts to engagement in standardisation and compliance will be required.

8.7 Non-Financial Benefits

Alongside the financial benefits outlined above, several non-financial benefits will be realised as part of the establishment of HNYPC. The creation of a new procurement service will support a multitude of areas.

8.7.1 Strategy & Organisation

Clearly there is considerable duplication of activities between the Partner Trusts, much of which can be aggregated or streamlined to reduce costs and create improved outcomes for all. The shared service vehicle will have the capacity to work at a strategic level within the Partner Trusts to support delivery of core outcomes, through transformational market management, improved engagement with clinicians and raising the bar in terms of expectations from supply chain partners. Working nationally and at an ICS level enabling and supporting system change looking at collaborative arrangements which extend beyond borders to challenge and influence supply partners. The shared service will create common spend policies and underpinning procurement processes, shared access to key data sets and have category-based procurement management in place.

There will be a greater level of spend under control, with a single accountable team for all procurement and commercial activities across the HNYPC. The improved team structure will support procurement engagement and has defined roles and responsibilities which will be fit for any future requirements to support alignment of contracts and specifications.

The appointment of Procurement Business Partners and Trust aligned Clinical Procurement Specialists will drive cultural change which will align against the cultural principles and contribute towards responsiveness, reliability, and customer satisfaction. Engaged key stakeholders to support procurement activity with clear communication channels between key stakeholders, clinicians and procurement which will reduce non-compliance.

A single procurement strategy will be deployed which will deliver increased value as a strategically aligned business partner to the Partner Trusts.

8.7.2 Policies & Procedures

Integrated and aligned procurement processes and policies that will improve customer experience and eliminate confusion and in turn improve procurement compliance with reduced uncontrolled spend and use of waivers. A single, effective, approval forum with appropriate governance and delegation to simplify approvals, enable aggregation and support delivery of HNYPC benefits will be established.

Clear policies and governance will be established to enable HNYPC to deliver projects successfully and efficiently. A Governance and Assurance Manager will ensure that the policies and procedures are updated in line with changes to Procurement Regulation and will provide training to the procurement teams.

8.7.3 Sustainability and Social Value

A Sustainability & Social Value Lead will have clear responsibility to develop processes and governance for a class-leading approach to sustainable procurement, delivering ahead of the NHSEI roadmap. This will provide improvement of environmental and social value impacts on the whole HNYPC supply chain lifecycle.

This will enable HNYPC to be proactive and leading the discussion on delivery of sustainability throughout the supply chain which will support improvement on the Green Plan development.

It is essential that for every pound spent of public money we are able to deliver demonstrable value, excellent products and services as well as contribute to the overall

wellbeing of our stakeholders through reference to Social Value. From 1st April 2022 all organisations have had to include at least 10% weighting of their tenders towards social value. HNYPC need to establish a robust approach to including social value in contracts and capturing the benefits delivered.

8.7.4 Data & Technology

A consistent data architecture to support future procurement systems changes will be put in place which will enhance data quality and catalogue management to underpin business partnering. Utilising existing assets where possible and planning for digital enablement will provide simplified HNYPC processes, reducing variance in systems and applications and better data management.

Improved performance data that supports the identification and realisation of procurement opportunities will be put in place to reduce cost, resource demand and processing costs.

8.7.5 People & Skills

A number of new roles are proposed to improve collaboration and reduced duplication of work and to motivate staff, with clear opportunities to develop as part of a shift to a high-skilled procurement function.

Procurement capabilities will be deployed across the Partner Trusts with staff having roles dedicated to delivery across all Partner Trusts rather than being Trust specific. Training and development will be core to the new offer to foster a high performance culture and develop a dynamic, innovative procurement team who are able respond to customer needs, influence senior leaders and provide creative commercial solutions which deliver best value and continuous improvement.

Managing and tracking performance of resources is also necessary. Key performance indicators, individual objectives and performance monitoring systems will be put in place. Talent performance reviews will be carried out at regular intervals and development plans put in place to motivate and increase capability. Clustering and centralising resources and activity into a larger organisation allows for clear career progression opportunities and development pathways for staff.

In addition there will be a “grow your own” strategy for talent development and retention, ensuring that we are building a resilient, sustainable team and developing leaders of the future.

8.7.6 Strategic Procurement

Managing value and performance through SRM will be key to focussing on strategic, high value or high risk suppliers and markets. Benefits will include improved engagement with markets so that they understand and are better able to meet current and future requirements of the NHS. There will be focus on key areas of improvement including whole of market strategies to support and drive transformational change.

There is currently limited evidence of proactive supply chain risk management, benchmarking is limited to ad-hoc use of NHS spend comparison tools, and there is no should-cost modelling (calculating what the cost of a good or service should be in advance to ascertain value for money). Reactive work has been established during Covid-19 where the three Partner Trusts work together when there is a stock shortage to provide mutual aid to one another.

With regard to procurement risk the HNYPC will increase the scope and level of compliance across each organisation. In terms of procurement challenge from the market, utilising existing expertise and upskilling of staff regarding high-value procurement will be required. It is essential to recognise that risk is not just a matter of potential impact but also the likelihood of a challenge and by whom. Intelligent procurers are able understand legal constraints, articulate risk and provide sound yet creative advice as to how processes can be structured to mitigate risk whilst delivering the objectives of customers.

The approach to risk, benchmarking, should-cost modelling, whole-life cost modelling and specification development will be set out in the Procurement Initiation Document for each procurement activity.

8.7.7 Supply Chain Management

A standardised and clear inventory management approach will deliver improved inventory availability and reduce amount of wastage, improved delivery to customers with reduced stock outs and deliver financial benefit.

Management information and KPIs will support materials management decision making and improve customer experience with better business decisions based on data and continuous improvement to Inventory Management.

This business case has not proposed a centralised warehouse for all Partner Trusts but this is something which should be explored in the future. Having a central warehouse managing deliveries for all sites will reduce vehicle movements at each hospital site. The central warehouse can then issue product on a just in time basis and can explore the option of using electric vehicles to minimise the impact on the environment. This approach has been undertaken across other ICS's with models ranging from Trust operated to outsourced solutions.

8.7.8 Benefits Measurement & Realisation

Savings plans are approached differently within each Partner Trust. Whether this is a target given to procurement or no target but just reporting on delivery, the approach is generally reactive and limited to one financial year. The objective is to move into a more informed planning programme for savings working with the business to identify contracts which are for renewal and review both demand and supply across a multi-year period. From this a should-cost can be established which will inform the savings plan. All savings will be recorded on a central system for reporting purposes and align to a centralised Savings Methodology Policy.

Although it has been possible to establish a work plan across the three Partner Trusts the maturity of the plans and the planning process that sits behind it is different at each organisation. It is therefore not possible to say with confidence that the work plan generated is a complete picture. The aim is to have a single work plan driven by a single contracts register which sits on a single IT system accessible to all. This will allow for one version of the truth to be presented and resource allocated to deliver the work plan.

The remit for the DoP has been to develop the business case and focus on creating the new organisation whilst Trust procurement leaders have continued to work on Trust specific savings plans. Pending approval of the business case, Trust specific

procurement leads will be required to demonstrate leadership, proactively work with their peers and release resources to create a collaborative work plan.

8.7.9 Improved Stakeholder Engagement

The structure of the HNYPC will be focussed on developing a business partner approach for customers. Procurement and SRM professionals will work with care groups. Systems and supplies teams will develop greater understanding of areas for improvement through listening to customers and a focus on continuous improvement.

Stakeholder engagement within the Partner Trusts needs to be improved to ensure all budget holders are aware of their procurement obligations and the commercial implications of their decisions and behaviours. Engagement with clinicians can be improved; at present procurement-clinical meetings are either sporadic or there is an expectation that clinical teams will come to procurement if they need their help. Better engagement with clinicians and recruitment of a Clinical Procurement Specialist role to be based in each Partner Trust will ensure that clinical outcomes and patient safety are at the heart of all we do.

In order to develop a shared procurement service which satisfies the operational and strategic targets of the three Partner Trusts it has been essential for the DoP to engage with customers and senior leaders. Feedback from this process has shaped the development of the business case and created a proposition which provides a sustainable delivery model for the future. There is considerable consensus between each professional group, and clear support for the ambitions of the HNYPC, recognising the potential to support delivery of some of their strategic and operational targets.

8.7.10 Reputational Benefit to Partner Trusts

The vision is to create a service which is regionally and nationally recognised as a centre of excellence, able to influence and lead strategic activity as well as contribute to the national procurement agenda via involvement with NHSEI. In this way the HNYPC will positively contribute to the reputation of the three Partner Trusts. The creation of a collaborative procurement team fits with NHSEIs PTOM programme as well as the future CCF.

HNYPC will put in place firm channels of communication with neighbouring ICSs across the region. Extending those channels to the National team to ensure ICS needs are met via existing (and new) nationally let contracts/ agreements where that scale will drive value.

9. The Process of Change

9.1 Key Principles

This section describes how HNYPC will be implemented and in particular how transition will be managed to ensure that business as usual continues to be delivered. A number of key principles have been agreed around the establishment of the HNYPC which influence the content of this business case.

9.2 Communication Strategy

Communications have been undertaken through the Heads of Procurement at each Partner Trust as part of the establishment of this business case. All procurement staff have also been engaged through a monthly newsletter which has aimed to provide reassurance around the changes which are to follow. The key messages shared to date include:

- Establishment of the HNYPC;
- HNYPC aims;
- HNYPC performance and achievements;
- Changes to procurement practice and process;
- Ensure Partner Trust procurement staff are informed about and involved in changes to roles.

A further communications strategy which includes all stakeholders will be required which promotes HNYPC:

- To the public and external stakeholders that the establishment of the HNYPC is a way to achieve better value for the NHS for reinvestment in care;
- The establishment of the cluster to professional stakeholders to enhance the reputation of the HNYPC Partner Trusts.

Audiences will include but will not be limited to:

- HNYPC Trust boards;
- HNYC procurement staff;
- HNYPC Trust non-procurement staff - customers;
- Supply Chain and markets;
- NHSEI;
- Staff side;
- Public Sector partners such as Local Government.

9.3 Staff Engagement

As experienced across clinical and other professional groups there is a shortage of good procurement and supply chain professionals. The public sector on the whole, has ceased to invest, train and develop new procurement and supply chain talent and generally vacancies across are filled at the expense of neighbouring organisations.

There are clear skill sets which are required to understand the Public Contract Regulations 2015 and as such there is little interest from the private sector which further limits recruitment potential, however, this sector should not be overlooked as part of the recruitment process. Further, despite contract regulations covering the whole of the public estate and the onset of devolution, there is surprisingly little migration from one sector to another. It is therefore crucially important that where possible, we retain existing high-performing staff from all Partner Trusts to ensure that we can continue to provide a good service during the change programme and support the development of the new organisation.

9.4 Staff-Side Engagement

The DoP has met with HR leads at each Partner Trust who confirmed that a formal consultation process including staff-side engagement was not required based on the changes set out within the preferred option. An informal engagement of staff-side representatives can be undertaken and would be managed through HR representatives when the time is right.

9.5 Branding & Corporate Identity

It is recognised by the Board that 'Humber & North Yorkshire Procurement Collaborative' is a working title for the collaborative programme. The DoP will work to develop a new identity, if required, for the HNYPC following business case approval.

Branding and corporate identity is a key element to the change programme and supporting the individuals within the team in identifying and having ownership of the new organisation.

9.6 Risk Management

Creating shared services can be very successful but also brings risks; working collaboratively is more complex, requires new skills, can take more time and will require compromise and trust. Development of the business case has included engagement with Executive Leaders across the Partner Trusts as well as all members of the procurement teams to ensure that key stakeholders views are accommodated and trust and understanding are embedded at the heart of the new organisation.

Risk registers have been developed through the process to ensure that all such risks are captured, mitigated and managed. Addressing such issues has been essential to the business case and has contributed to developing a structural model best placed to develop a truly shared organisation able to deliver benefit to all Partner Trusts.

9.7 Transition

Resourcing is currently not aligned to deliver collaborative objectives and it is not clear whether that necessary capability exists within the existing procurement teams. HNYPC will provide substantial changes throughout the procurement cycle, including introducing activities not currently taken at scale, or at all. Successful deployment of HNYPC will depend upon the delivery of this transition in a timely fashion.

It is noted that with go-live for HNYPC in 2023, there is the risk that transferring staff into a new structure could impact business as usual. Prior to any transfer an impact assessment will be undertaken to minimise disruption to business as usual.

Development of the procurement systems solutions is a key enabler to improving pan-Partner Trust working and the savings delivery programme. Embedding new systems, providing training and transferring existing data will take time and effort.

9.8 Implementation Plan

The proposed time plan is set out below in terms of further action.

	2022		2023											
	N	D	J	F	M	A	M	J	J	A	S	O	N	D
1. Business Case														
Finalise business case for approval process														
HUTH Performance & Finance Committee		19												
HUTH Exec Management Committee		21												
HUTH Board Meeting				14										
NLAG Trust Management Board			23											
NLAG Finance & Performance			26											
NLAG Board Meeting				7										
YSTH Exec Committee			4											
YSTH Finance & Performance			17											
YSTH Board Meeting			25											
2. Resourcing														
Write job descriptions for new posts														
New posts A4C banded														
Recruitment Process														
Candidates in posts														
Slotting-in process														
Review all existing job descriptions														
3. Systems Implementation														
PEPPOL Access Point														
Review existing service offering														
Compare to functionality within inventory management system														
Develop gap analysis														
Review position and requirement														
Purchase to Pay														
Write specification of requirements														
Discuss with existing provider(s) the ability to meet the specification														
Embed all Trust cost centres, requisition points and approval hierarchy														
System testing														
Go-lice for single purchase to pay system														
Catalogue Management System														
Review existing Trust catalogues														
Develop single catalogue for all trusts														
Review local masking decisions														
Supplier negotiation														
Go-live for new managed catalogue system														
Inventory Management System														
Place order for system														
NLAG Implementation														
YSTH Implementation														
Helpdesk System														
Write specification for system														
Agree IT standards with HUTH IT department														
Undertake procurement for system														
Contract award														
System Implementation														
4. Other non-pay														
NOECPC Membership														

IT & Telecoms Equipment														
Training and development														
Legal Fees														
Travel & subsistence														
Equipment lease & maintenance														

Figure 95 – Implementation Plan

Procurement Business Case – Committee and Board Questions and Responses

A. HUTH Performance & Finance Committee 19th December 2022 (business case updated to v1.1)

Q.	Question	Response
A1	Will this mean we are able to review IT spend? At HUTH credit card payments are made, whereas in NLAG a normal purchase order and invoice process is followed - I would hope the introduction of a single catalogue system as well as supplier standardisation will subsume all IT spend.	Yes all spend will be able to be reviewed as will the procurement route to identify whether it is appropriate. A review of credit card usage should be undertaken and where there is operational or financial efficiency from using credit cards this should be explored, as an example by implementing lodge cards with our top 10 invoicing suppliers we can save £79k and generate an income of £358k.
A2	Would there not be an opportunity to negotiate better prices also, referring to slide 127, I'm unclear where (if at all) possible savings from better prices is shown (notwithstanding that inflation will be detrimental to this)?	Better pricing forms part of multiple savings groups. Better pricing should be achieved through price standardisation, volume discounts and tail spend management but are likely to be impacted by inflationary pressures.
A3	A lot of the savings look as if they're back ended. I think the savings you just described get us up to the value which just about covers costs but there is still a leap in faith for how savings increase up to the £17/18 million. I'm not sure based on what you described what gets us to that sort of level of savings.	The cumulative savings look back ended but in terms of cash releasing savings we are increasing steadily year on year by around £3m. To date, savings of £1.1m have been identified which cover the costs set out in the case. The majority of the savings will be addressed through product standardisation and buying in volume. Cost avoidance does increase as we move towards year five. The reason for this is it will take time to embed a new contract management and supplier relationship management function and how we quantify benefits that have been delivered. It is making sure the supplier is doing what they should be doing, that doesn't necessarily mean that we're going to be seeing cash releasing savings.
A4	The business case is asking for about a quarter of a million per Trust which equates to about four or five additional people per hospital. You talked about category managers in the paper as well so I assume these are that level of person maybe 4-5 people per Trust.	In total there are five business partners but those business partners will cover all three trusts and not be linked to a specific Trust. The Clinical Procurement Specialists however will be linked to a Trust to build relationships and understand local clinical practice. There will also be shared resource for data analytics and materials management. We should see a small reduction in some of the administrative work that is undertaken as we will be doing

		this once rather than three times. This will allow us to focus on strategic work.
A5	The business case refers to a single IT solution but I'm not clear whether there are any costs included in the case to cover this as I haven't seen any substantial costs.	The costs of a standardised IT solution are included in the business case. We have been talking to suppliers in the market and there are a couple of routes we can take. The cost is low due to us only looking at an e-procurement solution rather than replacing the trusts e-financial systems. Two of the three trusts are using ABS for e-procurement and finance and all three trusts are using ABS for catalogue management. To minimise disruption moving all three trusts to ABS would be the natural solution. Other ICSs who have undertaken this consolidation have purchased a third party software solution which sits across Trust finance systems, this is as simple as just purchasing a procure-to-pay solution.
A6	In terms of the other trusts that have embarked on this journey, what's their financial success look like or is it too soon or is there anybody out there who's kind of nailed it?	The shared service which is probably closest to us in terms of structure is Lancashire Procurement Collaborative who have brought their trust procurement teams together into a shared service and they report a 2-3% efficiency from doing so. Nobody's quite gone as far as having a single ordering system in the way that we're proposing here and it is a big frustration as they think they could get greater efficiencies by doing so.
A7	Where do you expect the bulk of the savings to come through, is it better negotiation and smart purchasing or is it more efficiency?	So I expect the majority of the savings to will come through bringing our volume together and negotiating as one and being a bigger customer to a supplier than we currently are separately. But due to inflation, there is a risk that a lot of that moves down into cost avoidance rather than cash releasing. So we just need to track that carefully.
A8	We have not really invested in our procurement service for quite some time and it provides a cheap and cheerful and service, particularly around materials management, getting widgets to the wards but it doesn't strategically support the business. On page 34 you can see the historic position and we have got a very interesting structure with senior person in charge of the department, then a lot of band twos and threes with not a lot in between and that causes problems, as you can imagine. What	We've been careful to try to avoid any double counting in savings by reducing estimates where there is a likelihood schemes could overlap, for example the volume savings have been reduced by the value of the existing Trust savings plans.

	this business case is trying to do is to address that and to provide a service that will work with the clinical teams. Without this business case, you don't get any of that. Do I think that we will deliver £90 million in savings in five years, no. If you go to page 127, there's a nice little table and you'll be able to see that the volume savings and the contract management savings are by far and away the biggest elements within the table. There is a question as to double counting because on the volume side, you're saying there is 1-3% of £500 million of spend but then the contract management talks about £200 million of that £500 million being done through contract management.	
A9	My initial worry is about going to my EMC and saying I want to invest £400,000 into procurement at a time where money is very difficult and hard to come by. What I'd say is that by being a little bit smarter with the way we do things such as the procurement card and rebate is a good example, and just by acting a little smarter, a little bit more organized, the £400,000 it will cost to do this should be generated immediately or pretty quickly. So from an organisational perspective it washes its face as a result of some organizational changes within procurement itself without having to touch the frontline per se. So I ask “why wouldn't you do that” - it gives you more resource at the front line and I particularly like the procurement business partner and the clinical procurement specialist roles. With the Clinical Procurement Specialist role, and making that a part time opportunity, I think will be attractive to senior clinicians, so I think you'll be able to recruit that. I’m more worried about the Procurement Business Partners because you put them as agile people who work across the three sites, they'll need to, but they'll need to have a unique set of skills. They'll need to be procurement specialists, so need to be professionally qualified, but they're also going to have to be able to talk and engage, and sometimes those skills are not forthcoming. Are you confident you will be able to recruit those five individuals?	When you talk to the procurement teams, they all say recruitment is tough in this neck of the woods. I think having met all three teams, there are internal candidates who could step into those roles and would do a good job. I'm really keen that we attract new talent as well because this is about changing years of culture and ways of working. I'm aware having spoken to colleagues across the North East, there are people who would love to come and work on this and work with us to deliver it. So we've got people from other trusts approaching me asking when the case is approved. We've also had a recent change to the NHS supply chain offering, where the category towers that were outsourced are now being insourced and all of the people who were working in that engagement piece on procurement through engaging clinicians and procurement approached me and said we'd really like to jump ship at this point before it's all in-sourced. So I think now is a good time to do it and I'm quietly confident there's some really good people out there looking for roles. We just need to be flexible on location and not expect them to be sat in in an office five days a week.

A10	Assuming that we put this in place, there are two or three things that need to happen. One is you talked about a suite of KPIs that you would want and that would need to be built into a dashboard and reported through the Procurement Board. I suppose the first question is when will that happen? The second question is one of the big issues that we have which is how you overcome clinical preference when trying to standardise products. The third question is what impact does the investment have on national metrics as at the moment we look good as the service is cheap. I think I've spotted the table in the document, but I couldn't quite follow it. I couldn't follow whether or not it makes us the most expensive in the country or it just takes us to a more competitive place.	The KPIs will be put in place to ensure that we are delivering efficiently and effectively what each of the three trusts want us to. One of the things I'm really keen to do is that we provide the golden thread that comes out of each of the trusts, aims to objectives each year and to embed that within our procurement activity so suppliers are asked how they will help and support us in delivery. This will also come through the procurement KPIs and we'll see that go into individuals' aims and objectives. The conversations I've had with the supplies to date suggests they would hugely welcome that because they don't necessarily just want to sit there and provide product and disappear until it's up for tender again. The KPIs will be recorded in a national single system called Atamis which has been purchased on behalf of the NHS by the Department of Health and NHS England. We will put our KPIs in there and we will start building those dashboards so that we can report both at a trust level but also as a collaborative as well. We are aiming to have all three trusts up and running by the 1st of April on that system. York and Scarborough are much further ahead in achieving this with some challenges at HUTH that we will be looking to address early in the new year. In terms of how you overcome clinical preference, we will be using the knowledge and experience of the Clinical Procurement Specialists to challenge these preferences with fact. Escalation of issues can go through the Business Partners to be discussed at Care Group Management meetings and then further escalated to the Procurement Board if required. A final audited decision can be made at the Board meeting. The impact on the metrics is covered to some extent on page 113. We still look heavily resourced at Band 2 compared to the national average, but our position moves us closer to the national average for bands 5-8. Once we've got all of the changes that we are proposing in place it would only be right to re-evaluate the structure to ensure it remains appropriate. One of the things I

		know you were keen to do was to benchmark this against other trusts. Manchester had a look at the case in terms of the investment that we're looking for and the feedback was this brings us proportionately into line with what Manchester spend on their procurement function based on their non-pay spend.
A11	One of the things that I spotted when I was out and about is just the amount of manual effort staff put in raising requisitions and stuff like that. Therefore there is a big bit of efficiency in that area and removal of angst from their day-to-day work for sorting stock out.	From the clinical engagement I have had to date this is a constant message across all trusts. We need to make Procurement easier to engage with and release clinical time back to treating patients. The new structure has been developed to do this.
A12	What I do sense is that everybody's behind this direction of travel and we need to make it work. So you've got our support to move on to the next stage and getting this ready for the board meeting which I think you said is in February?	Thank you very much, yes the Board meeting is in February.

B. YSTH Business Case Panel 16th December 2022 (business case updated to v1.2)

Q.	Question	Response
B1	The BC at 140 pages is overly long, and proved difficult to easily disseminate the pertinent information that the decision-makers need to help them make their decision. This would appear to be partly due to what appears to be the inclusion of a lot of operational content (e.g. charging arrangements between organisations, etc) explaining how it might work in practice if the decision was made to proceed, which in the view of the panel could have been reserved for a later conversation once the main decision(s) asked of the EC are agreed. Using the Trust's experience of the recently established SHYPS (the joint pathology service between HUTH and York, which York hosts), a lot of the operational details were agreed between the parties after the main decision(s) of BC had been agreed, and these were captured through a series of documents (e.g. business transfer agreement, partnership agreement, SLA, etc.). The BC was therefore saved the inclusion of the operational detail. Could a similar approach be employed here? It was thought by the panel that by excluding the operational detail for later discussion and/or placing some other aspects (e.g. salary comparisons) into appendices, it may help slim the main document down and help the EC to focus more on the pertinent information linked to decision(s) it is being asked to make.	I am unsure on the basis to which the business case is viewed as overly long or what the comparator is. Five other ICS procurement business cases were reviewed in the development of this case, as well as the SHYPS Board paper. Many of these papers are over 100 pages long, including the SHYPS papers where only 2 trusts functions were brought together, not 3. In seeking feedback around SHYPS I was informed the integration had not be as successful as hoped and there are performance issues which are being addresses. As such, I would expect the Exec to ask around lessons learnt and as such there is greater content relating to the operational aspects which hopefully provides reassurance. I would argue that many of the operational details need to be addressed and agreed now as there are significant changes that the Exec need to be aware of and be able to agree as part of the business case approval process and not just discussed when they have already approved the business case as these decisions affect the efficiency of the collaborative, the savings that can be delivered and therefore justifying the investment decision. This is also reflected in the subsequent questions which also focus on the operational details and not the strategic basis of the case. Agreeing many of these operational elements also supports the three trusts is progressing against NHS England metrics for collaborative procurement which have to be reported bi-monthly.
B2	In terms of financial assessment of each option, the ultimate comparative benchmark resolves around Return on Investment. Unfortunately, the panel struggled to follow the arithmetic on how the ROIs quoted were arrived at from the figures available in the	This is calculated as the Total Benefit divided by the Total Cost in any particular year and is the same calculation throughout all options.

	case. This aspect needs to be made more transparent in the case.	
B3	Given the length of the BC, the Executive Summary is likely to be as far as the most EC will read, it is vital that this section provides sufficient summary information to enable EC members to make a decision. The ES refers to a preferred option, which we are assuming is option 5 although it's not clearly stated. However in section 1.6 (Decisions Required), the first decision still appears to keep the prospect of other options still being on the table for further analysis, which appears strange. Should the business case not have closed down the other options at this stage, and is just presenting the preferred option for approval? The other decisions appear be geared about supporting the preferred option, so why persist with the prospect of other options?	Decision 1 in Figure 1 is asking for the Trust Board's confirmation that option 3, 6 and 7 are not explored in full detail and discounted from the long list. This is why there is no cost for any of these options in 4.4.2, 4.7.2 and 4.8.2. A table with an overview of all options clearly stating option 5 as the preferred option has been included in the executive summary.
B4	It would be useful if a table could be included in the ES to provide detail behind the investment ask.	A table has now been included in the executive summary setting out the investment ask.
B5	Under section 1.5 (Benefits Summary), it would be helpful to have a summary of the projected benefits adding up to the prospect of £90m saving over 5 years…the table on page 127 should be replicated in the ES, which has the additional benefit of illustrating that there is a split between cost avoidance and cash releasing in arriving at the £90m. Depending upon inflationary pressures the cash releasing may reduce and become cost avoidance, so it is important to bring the split out and the potential impact of inflation in order to manage expectations. Without it, EC members might be forgiven for thinking that it's all cash releasing.	The table on page 127 has been included in the executive summary.
B6	Page 126, Section 8.4 ROI - in light of the £1.5bn cost increases not budgeted for by NHSE should the overall cash releasing savings be 'tempered' to reflect this?	NHS England have not provided any breakdown or impact assessment to a specific Trust on this figure. Trying to estimate the impact upon the three separate trusts and adjust the savings proportionately will prove time consuming and will be incorrect. The aim of this sentence is to make the Exec aware of the risk this poses to cash releasing savings, however, there is still a benefit to the trusts as this will deliver cost avoidance benefit.

B7	Page 135, Section 8, 8.7.8 Benefits Measurement and Realisation: our interpretation is that the Procurement Team will draw up the benefits realisation plan and this will be shared with the relevant provider Trusts, and the budget holders will be responsible for taking this forward. From a transactional point of view this is how the savings will be recognised in the provider Trust?	Procurement will not draw up the benefits realisation plan in isolation but will work with budget holders to identify opportunities. Once the benefits plan is agreed Procurement will support budget holders to deliver this but will also record missed opportunities so these can be reported. All savings and missed opportunities will be recorded at a budget level
B8	For the options that are not recommended (5.3.1 and 5.3.2) the detail as to why these options are not being considered and the risks appears light. For example, for 5.3.2 to just say that it will be unsettling process, when logically it is the most simple approach, is not sufficient risk on its own to discount the option. There must have been other reasons not to explore this option further?	HR and Employment – leaving staff as-is was discounted on the basis that it would be impractical to recruit to vacant posts which are spread across three separate organisation and the impact this would have on a single team ethos. Full centralisation was discounted on the unnecessary need to put individuals through a TUPE process when the majority (54.5%) will see no change to their role or base (receipt and distribution & materials management staff).This was discussed and agreed with all three trust HR teams.
B9	There are potential risks with the recommended approach (5.3.3) that have not been articulated. Section 5.3.3 does not appear to address the risks of having a variation in employment practice e.g. new staff working under Hull's policies and procedures whilst existing staff work under York's. This might see York managers having to use two sets of policies: one for new, and one for existing staff. How might this be mitigated?	Personally I think the risk assumed within the question is overstated. All staff are on NHS Agenda for Change terms and whilst there will be some minor local policy changes, the underlying principles are the same. In my previous role I managed staff on two completely different set of terms and conditions, one public sector, the other quasi-public/private. The line manager will know which organisation that individual is employed by, which policies to follow and therefore which HR team to speak to if they need support. This was discussed and agreed with all three trust HR teams.
B10	There also appears to be a lack of clarity regarding if the Hull HR team would deal with all new starters based at York who would fall under their policies and procedures, which would have to happen as the York HR team would not be familiar with these. For example, if Manager A (existing York employee) needs to address a grievance raised by Employee B (a new hire and therefore a Hull employee), who does the manager go to for HR advice as the member of staff will be employed under Hull's T&C's and so the grievance will need to follow Hull's? This	Please see response to B9.

	manager will need to be familiar with both processes as they will also have existing staff. This has the potential to get complicated and messy. We accept that as primarily an operational issue, this would probably need sorting out after the BC has been approved, but is an example of the type of issues that would need addressing before the BC went live.	
B11	There also appear to be potential support costs that are not covered, or not immediately clear in the costings. We know from the creation of YTHFM LLP, SHYPS and other hosted alliances that these entities always require an increased level of corporate function support, always initially, and sometimes longer term. Given Hull is to host this venture, this may not be an issue for York's corporate teams, but is it realistic that Hull's corporate services can support HNYPC at their current levels of resourcing? Has this been considered in the option costings?	All current support costs will be transferred centrally to the single entity. This can be picked up with the HUTH corporate services teams however HUTH employ around 11,000 staff with the total procurement staff in YSTH and NLAG representing an increase of less than 1%, with the decision not to TUPE all of the staff, the majority sitting in Receipt & Distribution and Materials Management unlikely to ever transfer, there is a possible increase of 37 staff who may transfer in. Given the savings we have already identified in corporate areas (over £500k) I would hope this could offset any support costs on such a small number of staff.
B12	It states that it is likely the host org will want to use the same IT hardware for support and they have put some costs in for this however if we follow the model adopted for SHYPS then it is more likely that each organisation continues to use its own hardware and this is then supported under an SLA between the Trusts and the procurement org. An amount for replacement of this kit (PCs in the main) will need to be budgeted for on a 3 – 5 year replacement cycle.	This will form part of the trusts IT replacement cycle. Budget has been requested to use the same hardware. Procurement is not a heavy IT user in the same way SHYPS is.
B13	Other considerations would be who provides service desk support, are smartcards needed to log in and who manages this.	Service desk support would be provided by HUTH and agreement will need to be reached around network access and issues. Smartcards are required to access personal information such as payslips but this would be managed as and when individuals move across as an employee of HUTH.
B14	Reference has been made in the executive summary to accounts payable data being used, which year?	Business case updated to make it clear this is for calendar year 2021.
B15	What does addressable spend mean?	Business case updated to define this.
B16	The executive summary says 41% of this expenditure is with the top 10 suppliers. Does this refer to the addressable spend?	Business case updated to make it clear this refers to addressable spend.

B17	In the executive summary it says 60% is covered by contract. Is this 60% of the 41% or 60% of the total addressable spend?	Business case updated to make this clear it is 60% of the addressable spend.
B18	It should be made clear within the executive summary that a reduction in stockholding would deliver a one off cash benefit rather than a “cost reduction”.	Business case updated to “one-off cash benefit”.
B19	What does SME mean?	Please refer to the list of abbreviations on page 13.
B20	The investment in the executive summary from the three partner Trust's over 5 years doesn't appear to add up to this sum...what else is included? Could a simple summary table be added to show how this built up in a transparent way?	Wording updated and table added to the executive summary to make the investment clear.
B21	On the basis that this is such a long document which the EC are unlikely to read in full, probably just looking at the Executive Summary, it would be useful to provide a simply summary to show from what initiatives the £90m will accrue...perhaps replicating the table on page 127 here. For transparency, it may also worth drawing out that of the £90m approx. is cash releasing v £30m cost avoidance.	Business case updated and the table from page 127 included in the executive summary.
B22	In section 1.9 update “£10.9” to “£10.9m”.	Business case updated to address typo.
B23	1.6 decision 3 - The three organisations are of different size...should all input equally to any additional costs, or should it be proportionate to size? Also, should outline now what the arrangements will be in the event of a closer alliance between HUTH and NLAG managerially and organisationally, which is being actively considered. How will this alter any contributions from the parties, and how can we ensure there remains an equitable contribution between the parties.	Section 5.2 shows all of the options which were considered for how the additional cost could be shared between the trusts but the Finance Directors agreed this should be split equally. Section 5.6 sets out how future changes to structure will be managed. At this stage HUTH and NLAG will only be sharing an Executive, they will remain two separate legal entities.
B24	1.6 decision 8 - singular...I assume this referring to HUTH Board as the host?	No, this is singular as the Trust Board reviewing the case will be confirming it meets the needs of their Trust Board only and will not be speaking on behalf of all three Trust Board’s.

B25	1.6 decision 11 – can we say what the assessed degree of risk of this is – high, medium or low?	This is on the risk register as a high level risk which is being escalated by the Directors of Finance to the NHS England Director of Finance. We will continue to monitor this risk. Business case updated with additional wording.
B26	1.6 decision 19 – confirm that this will have links into the respective resource management teams?	Business case updated with additional wording.
B27	1.7 section 4 – remove an additional “the”.	Business case updated to remove typo.
B28	2.1 - I appreciate there is an abbreviation glossary at the front, but it interrupts the flow of the reader in having to check back to another part of the document to find what an abbreviation means. Where an abbreviation is used first time around can it be spelt out in full to help the reader maintain flow?	This was spelt out in full 4 lines above this question where the abbreviation was first used.
B29	2.2 – in listing the HNYICS footprint reference is not made to Harrogate?	This is taken directly from HNYICS published material.
B30	Figure 9 – “£ per WTE” should be changed to “£m per WTE”.	Business case updated to add the “m” into the row description.
B31	Figure 22 - Is this a good basis for comparison? It does not recognise that the Trusts' other corporate services may be over/under resourced, and their grade mix different to national averages.	This is why the comparison to other corporate services is made in Figure 21 above.
B32	4 - Has the cost of any transitional support been built in i.e. dedicated finance, HR, legal, etc.? What about long term dedicated support…FM, HR, etc.	It has been assumed that the current cost for support is built into existing budgets which will be centralised. Additional legal cost has been included within the business case to support the transition.
B33	Figure 26 - How is ROI calculated, I can’t see the figures from which the resulting ROI is derived? Same applies to ROI for options below.	This is calculated as the Total Benefit divided by the Total Cost in any particular year and is the same calculation throughout all options.
B34	4.4.2 – need to explain why it is unlikely to be approved although this is explained in the conclusion.	As the conclusion is only half a page away from the statement no change has been made to avoid unnecessary duplication.
B35	Figure 30 - Assume reduction over year 1 down to one off capital in year 1? If so the difference here is £142,900, whereas capital above stated as £132,900	There is also a one off legal cost of £10k for year one as part of the transition and implementation.
B36	4.9 - May be worth stating for clarity that option 5 is the preferred option on which the following sections are based.	The current text reads “option 5 is identified as the preferred option and therefore explored in further detail in the following sections”.

B37	5.7 - Do we need a Finance Manager presence (if a host Trust) at this or the other Groups below? What about dedicated HR resource, particularly during transition/ implementation…has this been built into the costs?	The governance structure presented is the future state and not a transitional/ implementation board. We will review all groups on an ongoing basis to ensure representation is appropriate with the terms of reference and extend the invite list where required.
B38	6.1.2 - What about corporate support from the host Trust e.g. finance, HR, OD, etc.?	This is assumed to be already budgeted by each Partner Trust and will therefore transferred into the central function.
B39	This is a long business case. The Exec Summary would really benefit from a summarised position (comparison table) of all options considered and reference to the preferred option. The summary does go into the investment of the preferred option, but doesn't clearly state that the figures used in this section are relevant to the preferred option. In relation to how I can see the preferred option has been identified: Option 1 - discounted as doesn't meet objectives Option 2 - as above Option 3 - discounted as wouldn't get approval Option 4 - discounted as insufficient benefits Option 5 - preferred option Option 6 - discounted as no other collaborative sufficiently advanced Option 7 - discounted as wouldn't provide a centre of excellence and staff development opportunities. It was difficult to see a summary of the options scored against the objectives to clearly show options 1 & 2 were discounted. There is a table in 4.9 that assesses the options against some criteria, are they Critical Success Factors? They don't appear to match the objectives in figure 8, which is what I assume options 1 & 2 were discounted against? table 4.9 Scores options 4 - 7 between 13 & 20, and whereas options 6 & 7 have scored a red	Business case updated to include a summary table of options in the exec summary. As per 4.1 the options were scored against criteria set out by the Trust Executive Leads which were stated as part of the recruitment of the Director of Procurement. These will be the critical success factors for delivering the Procurement Collaborative. Table 8 takes the published objectives of the three Partner Trusts to establish overarching objectives for the Procurement Collaborative to ensure that these align back to the Partner Trusts and the golden thread can be followed. The table in section 4.9 has been updated to make the scoring of the options clearer.

	against some of the criteria, options 3 & 4 haven't so this doesn't seem to support the discounting of these options. There's a lot of needing to jump back and forth in the case to understand why options have been discounted and why 5 comes out on top. This could be made clearer for the reader from the outset.	
B40	Exec summary – check wording "On average across Partner Trusts back office functions have 1.86% of non-pay spend invested and 0.39% on their non-pay budget."	Business case updated by removing the second reference to non-pay.
B41	Exec summary - Equal regardless of size? Investment figures of preferred option only. Figures differ for each option. Table to summarise all this?	Please see response to B23.
B42	Exec summary - Is this for the preferred option? It's not clear? The preferred option (option 5 has an ROI of Y1 1.40 / Y2 2.39 / Y3 3.64 / Y4 5.37 & Y5 5.97? Also, £5.8m investment I assume is pay and non pay above x 3 Trusts x 5 years plus NR capital of £44.3 per Trust? This is £5.6m? However costs included in option 5 are relatively static year on year (some discrepancies), which would suggest the £44.3k capital cost has been included recurrently? This would be a total investment over 5 years of £6.1m?	Wording in the business case has been updated.
B43	1.5 - Option 1 - Cumulative Benefit £10.9m - however option 1 is discounted, and most other references to figures in this exec summary are in relation to option 5 so this is confusing. Option 5 (preferred option) cumulative is Benefit £90.6m.	Wording in the business case updated to make this clear.

B44	Why is option 3 discounted if it scored 13 against the criteria (4, 6 & 7 each scored 15 and only 6 & 7 are discounted)?	The table in section 4.9 has been updated to make the scoring of the options clearer.
B45	Figure 8 - Where is the assessment against these objectives for each option which then goes on to discount options 1 & 2	The options are not scored against the Trust objectives but are scored against the criteria set out by the Trust Executive Leads which were stated as part of the recruitment of the Director of Procurement. These will be the critical success factors for delivering the Procurement Collaborative.
B46	2.4 - Do Manchester have the standards HNYPC are trying to achieve? Would 132.92 WTE be recommended over 118.54m per the table above?	Manchester has been working collaboratively for a number of years and were used by the Finance Directors as a benchmark for the investment ask. 118.54 in the table above represents the 'as-is' position and therefore a higher level of resource is recommended.
B47	4.2.6 - Not because it doesn't meet all of the criteria in 4.9?	Wording in the business case updated.
B48	4.3.6 - Not because it doesn't meet all of the criteria in 4.9?	Wording in the business case updated.
B49	4.4.1 – update "York Facilities Management LLP" to "York Teaching Hospitals Facilities Management LLP".	Wording in the business case updated.
B50	4.4.5 - Approval has been granted before? Are there not further advantages of setting up through an LLP? Has the potential to transfer to YTHFM been considered?	This was discussed with the Finance Director for YSTH who discounted the option due to the requirement to get special approval from NHS England and the Treasury and felt that this was unlikely to be given.
B51	Figure 30 - Amount before offset of other non-pay adjustments? Options 1-3 included this adjustment? Why the change?	This is included in table 29 above which is consistent with options 1-3.
B52	Figure 30 - Where is this figure in the above table? What is the change in costs?	The total cost figure was incorrect, all component parts within the cells were correct. The total figure has been updated and this now cross references to figure 31 which had the correct total.
B53	Figure 31 – change the word "increase" to "investment".	Wording in the business case updated.
B54	Figure 32 - Total cost in table above is £4,804,523? Figure is before other non pay adjustments of £154k? Why?	The total cost figure was incorrect, all component parts within the cells were correct. The total figure has been updated and this now cross references to figure 33 which had the correct total.
B55	Figure 32 - Where is this cost in the table above? What is the change? £11.8k as per option 4 when compared with total costs, or £142k compared with Year 1 costs?	The total cost figure was incorrect, all component parts within the cells were correct. The total figure has been updated and this now cross references to figure 33 which had the correct total.
B56	4.6.6 – add wording "Criteria in table 4.9 as agreed by the Trust's executive leads and contained in the HNYPC Procurement Strategy".	Wording added.

B57	4.9 – add wording “Criteria in table 4.9 as agreed by the Trust's executive leads and contained in the HNYPC Procurement Strategy”.	Wording added.
B58	Figure 33 - Where options 3-5 have not scored red in any element, why have options 3 & 4 been discounted? Option 3 - as this would not receive approval? Although this isn't in the summary table above? Option 4 - due to insufficient benefits? Also not included in table above? Both appear to be discounted as they do not meet criteria that is not summarised and assessed here?	The table in section 4.9 has been updated to make the scoring of the options clearer.
B59	4.9 - In summary - based on the assessment against objectives / criteria and an assessment of investment costs, cash releasing benefits and cost avoidance. Option 5 is the preferred option... A statement to summarise section 4 would be useful here, including a table with each option assessed against each element to clearly show option 5 as preferred, this could then be replicated in the exec summary.	Additional wording added to the business case. A separate table only replicates the information already contained in section 4. A separate table has been added to the executive summary.

C. Collaborative of Acute Providers 16th January 2023 (business case updated to v1.3)

Q.	Question	Response
C1	Completely supportive of the case having invested in Procurement previously, can endorse this pays back many times over if you do it correctly and at scale. How will savings from clinical spend and engagement be delivered – do the Clinical Procurement Specialists become the gateway to the clinicians.	Yes the Clinical Procurement Specialists will become the gateway to the clinicians. There is also a governance structure in place which allows escalation of issues to a Procurement Board which has clinical representation from each of the trusts and then further escalation into the Trust Boards if required.
C2	Engagement is the key to success and having visibility of value for money and resource availability.	It is important that Procurement are measured on more than just savings and we start talking about value. If we spend more on a product which reduces length of stay or theatre throughput then these should be explored.
C3	What regular reporting is required to the Collaborative of Acute Providers to update on progress?	A monthly reporting template can be shared.

D. NLAG Trust Management Board 23/01/2023 (business case updated to v1.4)

Q.	Question	Response
D1	Will specialist support be offered to the Estates & Facilities team and is receipt & distribution included within the scope of the future procurement structure?	Yes, specialist support will be provided to Estates & Facilities colleagues through a dedicated Procurement Business Partner. Receipt and distribution colleagues are in scope of the future procurement structure although the nature of their role will mean very little change to the way they currently work.
D2	Will the future approach take learning from current organisations and roll it out further, for example taking the benefits from GIRFT and implementing locally?	Many of the quick wins will come from taking best practice from one organisation and rolling it out across the other two, this is the reason why Procurement Business Partners have been aligned to care groups across the three trusts rather than working Trust specific.
D3	Engagement with the clinical teams is imperative to delivering the proposed benefits, how will this be managed?	This will be managed through dedicated Procurement Business Partners who will engage at a care group level but also through the Clinical Procurement Specialists who will be Trust based to ensure strong local engagement and who will be able to understand local working practices.
D4	How are the staff currently feeling based on the proposed future structure?	The main concern from staff has been what this means to their current role and what they will be doing in the future. All staff have been engaged through newsletters and regular face-to-face visits. Many staff are excited by the proposed changes and see an opportunity for them in terms of career progression through the collaborative.

E. HUTH Productivity & Efficiency Board 25/01/2023 (business case updated to v1.5)

Q.	Question	Response
E1	Is it possible to identify at a granular level the savings opportunities for each Trust?	At this stage it is not possible. Work is underway reviewing the data but the ability to deliver the savings is linked to the appointment of the additional staff to further scope the projects and deliver the financial benefit. The detail behind the savings within the business case can be shared with the group.
E2	Is funding agreed yet and when do savings start	Funding is not yet available but would follow approval of the business case from the three Trust Boards. We will try to deliver some of the savings as early as possible e.g. buying as one rather than three, but the more complex change programmes will take longer, especially as staff to deliver these projects are unlikely to be in post until September/October 2023.
E3	What regular reporting is required to the Productivity & Efficiency Board to update on progress?	Report back every 3 months.

Agenda Number: NLG(23)028

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7th February 2023	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance & Performance Minutes, November 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	The Finance & Performance Committee Minutes from the meeting held on Wednesday 23rd November 2022, and approved at its meeting on Wednesday 21st December 2022, these are for information only.	
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 23 November 2022, 1.30pm TEAMS

Present:	Gillian Ponder	Non Executive Director (Chair)
	Fiona Osborne	Non Executive Director
	Simon Parkes	Non Executive Director
	Ian Reekie	Lead Governor
	Shaun Stacey	Chief Operating Officer
	Richard Peasgood	Executive Assistant to COO
In Attendance:	Simon Tighe	Deputy Director of Estates & Facilities (rep J Johal)
	Jennifer Grainger	Head of Compliance & Assurance (Item 6.1)
	Matthew Clements	Assistant Director of Finance (rep Lee Bond)
	Peter Reading	CEO
	Ivan McConnell	Director of Strategic Development (for item 8.3)
	John Awuah	Interim Deputy COO (for item 7.3)
	Ashy Shankar	Assistant Director Planning & Operations (for item 7.5)
	Ashley Leggott	Emergency Planning Manager (for item 7.4)
	Lynn Arefi (Minute Taker)	Executive Assistant

ITEM

1. Apologies

Apologies for absence were received from Jug Johal, Lee Bond, Brian Shipley.

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 19 October 2022

The minutes of the meeting held on the 19 October were reviewed with one amendment noted: page 7 second paragraph should read " Fiona Osborne referred to the forecast and *asked for assurance* ……following this the notes were agreed.

5. Matters Arising / Action Log

5.1 The action log was reviewed and updated as follows:

24/08/22 5.3 – on November agenda **Closed**
21/09/22 5.5 – still to be completed
21/09/22 7.1 - **Closed**
19/10/22 5.4 - **Closed**
19/10/22 7.2 - Daily monitoring and reporting continues
19/10/22 7.2 – **Closed**

5.2 F&P Committee Workplan

The Committee received and noted the F&P Workplan.

5.3 Terms of Reference

The Committee received the revised Terms of Reference and agreed the proposed changes for Board approval.

5.4 Action Plan

The Action Plan was not available for the meeting. It would be circulated to the Committee.

ACTION: Richard Peasgood

1.50pm Ivan McConnell joined the meeting.

The next item was taken out of sequence on the agenda.

8.3 Business Case Assurance – CDC Update

Ivan McConnell was welcomed to the meeting. A presentation had been circulated which provided the Committee with an update on the progress of the Community Diagnostic Centre, (CDC), Programme within Northern Lincolnshire. Ivan McConnell went on to note that the CDC Programme had been designed and implemented by the HNY HCP, following a National Policy Initiative in response to the Richards Report. The CDC programme aims to increase diagnostic capacity, access and improved diagnostic waiting times within local areas. The initial Programme Business Cases had a primary focus on site selection, equipment, and infrastructure costing.

Ivan McConnell noted that the Programme was now moving to Phase 2 which would look at the detailed design, patient pathways and capacity/demand (staffing) within the local health economy. The funding currently available within HNY HCP is circa £36mil, with a Programme ask of circa £107mil.

Initial business cases have been developed to look at static CDC provision within Scunthorpe and Grimsby Town Centres. This work had been undertaken in partnership with NLaG Estates and Diagnostics teams, Place Directors and Local Authority Partners.
The initial business case had highlighted a cost in excess of £29mil for the Scunthorpe scheme with a similar forecast cost of £28mil for Grimsby.

The Trust is working with Place Directors and teams to review the submissions made to date and to examine potential alternative delivery options and funding routes. Ivan McConnell added that there were a significant number of risks associated with the Programme and its current status – workforce/future demand/impact – these needed to be evaluated in more depth with plans being developed prior to any decisions being taken.

It was noted that there were no timescales for delivery at present but was working towards the end of March 2023. Ivan McConnell asked the Committee to note the progress that had been made to date, the current issues/risks and the plans that were being put in place to address these.

Dr Peter Reading expressed his thanks to Ivan McConnell for agreeing to manage this scheme amongst a very difficult political and economic period and added that it was important that the Trust is sighted on any potential risks as it moves forward. Ivan McConnell confirmed that there was one major issue associated with capital funding to 2025 and revenue funding beyond that date.

The Committee thanked Ivan McConnell for the update.

2.05pm Ivan McConnell left the meeting.

6. CQC Report

Jennifer Grainger joined the meeting and spoke to the circulated CQC Progress Report noting that the format of the report had been amended to allow it to show what actions had changed in month within those marked as green. Jennifer Grainger went on to note that the draft CQC report following the inspection in June/July had been received by the Trust in October. Following the factual accuracy checking process, a response had been returned to the CQC and the Trust anticipated publication of the final report in December.

The current position indicated that 85% of 145 actions were currently rated as blue or green. Jennifer Grainger added that a previously closed action had been re-opened; this related to Diagnostic reporting. Previously this action was closed (an assurance paper was submitted to the CQC in February 2022) however, as part of the quarterly review process for previously closed actions, within the 2022-23 quarter 2 update it was recommended to re-open this action (at an amber rating) for increased monitoring.

The service was now experiencing a significant increase in radiology reporting backlog, currently there were approximately 6055 cases unreported with the longest routine case at 10 weeks since examination. This was a result of a change in outsourcing capacity from approximately 550 per week to approximately 150 per week. It was noted that the main factor in this reduction was due to a reduction in radiologists available to report via the outsourcing company. Many of these radiologists were not undertaking additional work as it was not financially beneficial for them to do so. Gill Ponder asked how the Committee would gain assurance with actions to enable this to be resolved. Jennifer Grainger confirmed that Ruth Kent was currently working on a paper that would detail the mitigations, this paper would be brought back to the Committee. Shaun Stacey went on to note that this action would not be able to be completely closed until we reached the previous level of resourcing to be able to manage the reporting. Issues were currently workforce impact on earnings and attracting individuals to undertake the work.

The Committee thanked Jennifer Grainger for the update and received and noted the report.

2.20pm Jennifer Grainger left the meeting
2.20pm John Awuah joined the meeting

7. Review of NLaG Monthly Performance & Activity Delivery (IPR) (SO1.2 / SO1.6)

7.1 Unplanned Care

The IPR Access and Flow report was taken as read. Shaun Stacey went on to note that overall, ED continued to be very challenged with demand versus capacity, particularly around admitted patients, creating continued issues with flow. The impact of the poor flow continued to be shown in the ambulance handovers and patients waiting over 12 hours. This remained an area for improvement. Recently the Trust had engaged in the “perfect fortnight” during the beginning of November. From the audit of the assessment from this, the Trust would look to move into a much better approach to flow along with the system in terms of discharge.

Shaun Stacey went on to note that staffing remains a particular pressure with continued high levels of agency and medical spend along with the continued need to support unfunded beds which created a pressure. Recruitment was ongoing but at a slow pace.

Covid and Flu continued to be well managed and was not currently impacting upon the flow.

LoS remained good for both non-elective and elective work with the 7, 14- and 21-day position remaining positive, with further improvement shown in November.

Shaun Stacey went on to note that the biggest discharge issue remained in the area of Greater Lincolnshire and East Riding.

7.2 Planned Care

Shaun Stacey took the report as read and went on to add that the Trust had continued with the approach to planned care and mutual aid although it was noted that there was limited assurance within the IPR especially around cancer and 52ww. Risk stratification continued on admitted and non admitted patients. The waiting list had increased in month, partly, along with the 52ww, directly linked to mutual aid. Shaun Stacey added that DM01 had made a small performance improvement that month with further improvements within the diagnostic access locally for cancer; however there remained a challenge around cancer diagnostics. As mentioned in the CQC section of the agenda, radiological reporting and delivery was a continued concern. Workforce was particularly challenging and due to the tax implications, staff were reluctant to do more reporting. It was agreed that a solution to address that was required.

Shaun Stacey acknowledged that GIRFT actions were demonstrating improvement and work continued in Ophthalmology under new leadership. Hopefully, by December, we should begin to see good outputs.

Shaun Stacey went on to note that the cancer position continued to demonstrate poor performance namely in:

- Management of patients with “a no treatment requirement” to get them off the list
- Tertiary access to diagnostics
- Anaesthetic pre assessment concerns/capacity issues

The Humber Cancer Board had requested a piece of work between NLaG and HUTH to specifically look at capacity and demand; this would feature in a report for the December meeting. It was noted that more work within GIRFT had been requested in relation to the pre-assessment concerns.

Shaun Stacey added that staff sickness at 12% and to continued restrictions due to Covid risk assessments continued to be an issue and was creating significant problems across the elective specialties. Occupational Health continued to provide support, but it was proving challenging.

Gillian Ponder went on to note her concern relating to the cancer performance, despite all the good work there seemed to be very little improvement. Gillian Ponder asked if there was there any further support that the Committee could request from the Trust Board to progress this. Shaun Stacey acknowledged that the Trust’s performance remained a concern but added that the Regional performance also remained poor on cancer. The Humber Cancer Board work on diagnostic access and improvement on MDT pathways continued. A report would be presented at the JDB and the CiC on cancer in November. Locally we were nearer to a 7-day cancer diagnostic access but there was an issue with specialist diagnostics capacity at HUTH. The national workforce issue within Oncology was also a concern. Shaun Stacey added that there would be continued focus on the three main concerns.

3.00pm Ashy Shankar and Ashley Leggott joined the meeting

7.3 Patient Flow Improvement Group

John Awuah was welcomed to the meeting and went on to briefly outline the circulated presentation. John Awuah advised that the Trust continued to work closely with partners as part of the perfect fortnight and were beginning to see results in the D2As. Significant improvements had been made with North Lincs and transformation work was underway with Lincs. Work continued on the Virtual Ward concept to aid flow and Lloyds Pharmacy had been approached to provide a 7-day service for OPAT.

John Awuah went on to advise that the NLAG Home Healthcare Service was ongoing for patients in North Lincolnshire with North East Lincolnshire having a care-at-home service already in place. Recruitment of staff had been completed, with onboarding and training underway. There would be capacity to care for 15 patients at home simultaneously once all staff were fully trained. Currently bank staff were being used to commence the service. There had been a significant reduction in outstanding D2As at SGH which was partly due to this service.

Fiona Osborne asked if the ambulance handovers had improved as there was a deadline on several actions to have happened by September 2022, and where did this sit currently. Shaun Stacey responded to the question and noted that actions indicated in the report had been done and implemented through the Ambulance Handover Group. It was fair to say that there had not been an improvement; handovers cannot improve without a cubicle to offload. Following on from the "perfect fortnight" we had now seen improvement; a report would be put together to demonstrate continued improvement.

Fiona Osborne then went on to ask about ED and category 2,3 and 4 and had there been any improvement. Shaun Stacey referred to a piece of work led by John Awuah around onboarding, taking extra patients in a "safe way". A ward by ward risk assessment would be undertaken before taking on any extra patients. This would be included within the overall Trust wide Hospital protocol. John Awuah went on to note that System wide working continued with regular meetings being held. Shaun Stacey added that category 3, 4 and 5 activity was taken by North East Lincs SPA. All this combined working was leading to improved ambulance handovers.

Simon Parkes added that there was now much greater awareness and recognition within the media of the role that Social Care needed to play in improving hospital A&E and ambulance handover performance.

Gillian Ponder thanked Shaun Stacey and John Awuah for the update and added that the "perfect fortnight" seemed to have been a very successful exercise and produced good results with plenty to build upon. She looked forward to seeing the improved results in November's IPR.

7.4 EPRR Core Standards

Ashley Leggott was welcomed to the meeting and took the circulated paper as read. Ashley Leggott noted that the Trust was required to carry out a self-assessment of the position against 64 core standards within the field of EPRR with a selected deep dive subject that changed each year. A return of 91% substantial was submitted with 6 partially compliant; this was noted as the joint highest across the ICB. Areas of partial compliance were the duty to maintain plans; evacuation plan and lock down policy; work to test these would be carried out. The ICC would be fully reviewed and re-stocked. Robust loggist network training would be commenced to ensure full compliance. Ashley Leggott went on to note that two areas to highlight related to decontamination capabilities, this was historically a difficult area to reach compliance and was on a rolling programme of training.

Fiona Osborne asked how the training was monitored. Ashley Leggott noted that unfortunately at the moment it could not be placed onto the mandatory training list, but this was being looked in to.

Simon Parkes added that it seemed the Trust was in a very good place and added did everyone who needed training receive the appropriate training and could we be confident that those who did need the training had sufficient time to complete it. Shaun Stacey confirmed that he could give the Trust Board assurance that staff knew what to do if called upon in the event of an emergency.

Shaun Stacey thanked Ashley Leggott for the hard work he had put into this. Gillian Ponder reiterated Shaun Stacey's thanks and asked about timescales to deliver full compliance. Ashley Leggott confirmed that the early part of next year seemed realistic with the loggist training being a rolling programme.

Gill Ponder asked for assurance that plans were regularly tested to ensure that they would be effective in a real emergency.

Action: Ashley Leggott

3.15pm Ashley Leggott and John Awuah left the meeting.

7.5 Winter Planning Timetable

Ashy Shankar spoke to the circulated Winter Planning Timetable which provided an update on Winter Planning in NLAG. A summary showing the key highlights and risks relating to managing the pressures expected over the next few months was contained within the presentation.

Fiona Osborne went on to ask about External Stakeholders, the strategy was not clear within the document. Ashy Shankar noted that there were regular 2 weekly meetings and discussions on the OOH services were ongoing. However, PLACE level conversations needed to develop further. Fiona Osborne then moved on and questioned if divisions had indicated that staff sickness could be problematic. Ashy Shankar confirmed that that was the case and was an ongoing issue. That should feature within the divisions' annual plans but was work in progress. Shaun Stacey added that the workforce continuity plans were tested throughout the year. The bigger issue was the reduced uptake in vaccinations for COVID and flu by both staff and members of the public. Shaun Stacey was confident that the business continuity plans would allow the Trust to meet the winter plan.

The Committee received and noted the Winter Planning Timetable.

3.30pm Ashy Shankar left the meeting.

7.6 Assurance Confirmation & Board Highlights

Gillian Ponder advised that the highlight report to the Trust Board would now focus upon issues and actions we were asking the Trust Board to address. The following would be included:

- Cancer – no change in metrics for a variety of reasons
- EPRR – positive news
- Ambulance handovers
- Good position on Winter planning – concerns over ability to discharge patients who no longer needed to stay in hospital continued

8 Review of NLAG monthly Financial Position Finance Report (SO3.1/SO3.2b)

Matthew Clements was welcomed to the meeting and provided an overview of the Month 7 financial position from the circulated report which was taken as read.

The Trust had a £0.46mil surplus in October which was £0.27m better than plan. However, the in-month position was supported through the release of £1.59m of non recurrent technical reserves. The Trust now had a £3.55mil year-to-date deficit which was £4.63mil worse than plan. The Trust was formally forecasting a balanced financial position but was highlighting a deficit risk of £8.5mil. Matthew Clements added that that was predominantly driven through an increased usage of temporary staffing, escalation beds and pay award pressures. Loss of Elective Recovery funding and non-achievement of CQUIN income were further risks but at that stage not included within the headline forecast deficit risk of £8.5mil.

Clinical income was £0.37mil above plan in month at £3.53mil YTD, this was mainly due to £4.14mil pay award funding.

As at Month 7, the Trust had spent £38.7mil on agency, bank and locum variable pay, £2.83mil more than the corresponding year-to-date period in 2021-22. Whilst COVID19 specific expenditure had reduced as planned, Non-COVID expenditure had increased.

With the Trust finding achievement of the activity target challenging, improved productivity through its theatre and outpatient initiatives was highly unlikely to provide cash releasing efficiencies but instead enable delivery of additional activity. The main cost driver for financial efficiency was pay and specifically agency costs. Delivery of the cost improvement programme in full would be dependent on the ability of the organisation to drive down its pay bill and this was therefore the principal risk. Matthew Clements reported that at the end of October, the Trust had delivered £5.93mil of savings against its core year to date plan of £6.40mil, an under delivery of £468k. Expenditure on COVID was high in month meaning that the usual mitigation was not available. However, further non-recurrent in-year support had been provided through technical adjustments. As a result of these changes, the year to date position for the full programme was £13.76m delivered against the plan of £12.46mil.

It was noted that the Trust's capital funding for 2022/23 was now £43.0mil. The Trust had received notification of additional funding of £5.83mil relating to TIF funding for theatres at DPOW and SGH and further funding of £0.13mil for MRI software upgrade and Endoscopy training simulator. The details of EPR funding of £1.2mil were still to be confirmed.

In conclusion, Matthew Clements added that the material issues for the Trust over the coming months were:

- Maximising its planned care activity delivery, with a requirement to return to 19-20 productivity and activity levels within its core capacity and budget, reducing reliance on IS and WLI premium costs
- Delivering a challenging stretch CIP programme, mitigating risks to delivery and conversion of non-recurrent savings into recurrent delivery schemes, plus identifying new schemes
- Reducing its additional Covid-19 expenditure as soon as possible.
- Reducing its material cost pressures, including additional beds and additional spend on both Nursing and Medical temporary staffing

Fiona Osborne referred to page 7 and the medical staffing figures. Based on the information within the report how would we get this under control so we would only be £10.6 mil over by the year end. Shaun Stacey went on to advise that for both Medicine and Surgery there were recruitment plans which should be realising over the next few months. There was also a revised contract with HOLT which hopefully should control this. The usage of high cost agency staff would also be reviewed.

Gillian Ponder noted that it had been agreed that it would be useful for System level performance to be included within the finance reports, but this had not been done. Matthew Clements confirmed it would be included going forward.

ACTION: Lee Bond System Level Performance to be included within the Finance monthly report

Simon Parkes queried how confident were we that the Trust would be able to achieve a balanced position at the year end, as looking at available mitigations he was not convinced. Dr Peter Reading responded that at the moment with the current projections and mitigations and increased financial grip we had a "certain degree" of confidence. However, given the uncertainty of the National NHS financial position there was less predictability than there had been in previous years. Matthew Clements added that CFO and team had some degree of

confidence we would reach the predicted target. The Trust did, however, need to show an improvement in the Trust's exit run rate.

The Committee received and noted the Month 7 Finance Report and the highlights and risks contained within it.

8.2 Recovery Support Programme Letter

Letter received and noted at October meeting.

8.3 CDC Update – discussed earlier on agenda.

8.4 Assurance Confirmation

The Committee agreed they were assured on actions being taken, but agreed that the following should be brought to the Board's attention in the highlight report:

- Position – mitigations take us closer to year end position
- Discussions ongoing around reduction of agency spend

The next item was taken out of sequence on the agenda

10.2 BAF Report (Finance)

Matthew Clements advised that he had met with Helen Harris, Trust Secretary, and the following key issues were highlighted:

- Inherent risk, current risk and target risks are 20
- Key issue was the year end forecast and associated risks
- High level risk register section added
- Assurance column added
- Some CIP plans not included

It was noted that Internal Audit did an audit on the BAF and Lee Bond and Helen Harris reviewed the controls to ensure the correct ones were in place.

Fiona Osborne went on to make a general comment on the BAF document format as a whole, that she found it difficult to see how they all correlate together in the current format; especially linking the gaps and controls, assurance and links to the high level risks. Gillian Ponder re-iterated Fiona Osborne's comment.

9 Estates & Facilities

9.1 Civils Infrastructure

Simon Tighe was welcomed to the Committee and went on to briefly outline the Estates and Facilities Assurance on Infrastructure. The report provided the Finance and Performance Committee with an update on the Estates and Facilities assurance model and focused on the Infrastructure Management in terms of risks and associated assurance on gaps in control and mitigations. Previously the E&F assurance report had focused on the engineering specialities that were supported by an Authorising Engineer (AE) and/or a legal authority such as Fire compliance and asbestos management. As such, there were several buildings and engineering speciality areas that had not been highlighted and this report aimed to update the Committee on those risks in one overarching document.

A high risk had been closed with the £1.0mil investment in a new CCTV system, which had been fully installled. Work was also underway on improvements to the water reservoir at Scunthorpe hospital.

The report was taken as read and received and noted by the Committee.

9.2 Assurance Confirmation & Board Highlights

The Committee agreed that they were assured on the infrastructure but recognised the ongoing risks due to lack of funding for Backlog Maintenance.

10 Finance & Performance Governance Documents

10.1 SO1-1.4 BAF Review (Deep Dive) Estates & Facilities

Gillian Ponder reminded the Committee that a BAF strategic risk was reviewed each month in detail by the Committee, using the latest version of the BAF as the basis for the review. Gillian Ponder asked about the risk appetite which was described as 4 – 6. As the risk tolerance was shown as 20 – 25, there seemed to be a "mismatch" and she therefore questioned whether the Trust's risk appetite was higher than stated. Simon Tighe apologised as he had not had sight of the latest BAF report. It was noted that the full BAF had been circulated at the previous meeting.

Gillian Ponder posed the following questions. Could the risk appetite versus tolerance be reviewed. The risks and BLM figures quotd on the BAF were for 2020/21, but what wass the BLM figure currently and did it include provision for inflation? Simon Tighe confirmed that the 20/22 figures were concluded a few months ago but had not been finalised. The figures included a circa 40% uplift which included VAT, design costs and staff which was a recognised methodology. Gillian Ponder went on to ask the Committee that, based on information available on Estates and BLM, did the Committee believe the very high-risk score was the correct score, given the critical nature of some facilities and the lack of funding. Simon Parkes added that this was an ongoing issue that was being managed on an ongoing basis and we had to accept the high level of risk and continue to run the hospital sites to provide a service to our patients to the best of our ability.

The Committee suggested that Jug Johal and Ivan McConnell should be invited to a future Committee meeting for a discussion on possible sources of additional funding for essential backlog maintenance.

11 Items for Information

11.1 Performance Letters to Divisions – PRIMS.

Received and noted by the Committee.

12 Any Other Urgent Business

None raised.

12a **Matters to Highlight to other Trust Board Assurance Committee**

None identified.

13 Matters for Escalation to the Trust Board

Already discussed within the assurance section of each agenda item

13a Review of Meeting

The Committee agreed that the meeting had included a lot of open and productive discussion, but there had been a tendency to focus on under-achievement against constitutional standards, rather than how well NLAG was doing in comparison with local and national

performance levels. Late papers and quality of papers were recognised, in particular from Operations and Sean Stacey would be working with his team on those.

Simon Parkes went on to add that Committees need to focus upon issues they could make a significant difference to. That was a general comment for all Committees.

14 DATE & TIME OF NEXT MEETING:

Wednesday 21 December 2022 1.30pm TEAMS

Agenda Number: NLG(23)028

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7th February 2023	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Finance & Performance Minutes, December 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	The Finance & Performance Committee Minutes from the meeting held on Wednesday 21st December 2022, and approved at its meeting on Thursday 26th January 2023, these are for information only.	
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 21 December 2022, 1.30pm TEAMS

Present:	Gillian Ponder	Non Executive Director (Chair)
	Fiona Osborne	Non Executive Director
	Simon Parkes	Non Executive Director
In Attendance:	Jug Johal	Director of Estates & Facilities
	Lee Bond	Chief Financial Officer
	Brian Shipley	Deputy Director of Finance
	Ian Reekie	Lead Governor
	Jennifer Grainger	Head of Compliance & Assurance (Item 6.1)
	Richard Peasgood	Executive Assistant to COO
	Ashy Shanker	Assistant Director Planning & Operations (rep S Stacey)
	Jackie France	Associate Director of Patient Services (Item 9.4)
	Annabelle Baron	Observer -Compliance & Assurance (Item 6.1)
	Lynn Arefi (Minute Taker)	Executive Assistant

ITEM

1. Apologies

Apologies for absence were received from Shaun Stacey, Ashy Shanker was available to deputise.

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 23 November 2022

The minutes of the meeting held on the 23 November were reviewed and agreed as a true record.

5. Matters Arising / Action Log

5.1 The action log was reviewed and updated as follows:

23/11/22 5.4 to be closed as the action plan had been circulated
23/11/22 8.1 to be closed as the System Level Performance was now included within the regular report

5.2 F&P Committee Workplan

The Committee received and noted the F&P Workplan. It was suggested that line 5 within the report should just say “deep dives” and not “monthly”.

5.3 Terms of Reference

The Committee received the revised Terms of Reference and agreed the proposed minor changes for Board approval.

Fiona Osborne commented that there seemed to be a “consistency” issue across all of the sub committee’s and the referrals between the committees. These need to be addressed and it was agreed that this issue would be raised at the next NED’s meeting with Helen Harris.

ACTION: Committee ToR consistency to be discussed at the next NED meeting.

5.4 Action Plan

The Action Plan was received and noted by the Committee, acknowledging that work continued on improving the quality of reports. Actions 3, 4 and 6 were noted as completed.

The next agenda item was taken out of sequence on the agenda.

9.4 Outpatient Administration Transformation Delivery

Jackie France was welcomed to the meeting and went on to outline the supporting PowerPoint presentation which highlighted the month 8 position of the Outpatient Transformation Programme covering:

Patient Initiated Follow Up (PIFU) – continued to improve
Outpatient Follow Up Backlog – continued to reduce
Connected Health Network (CHN) – local PCNs were now directly involved with at least 1 pilot; 5 specialties currently running pilots/going live.
Non face to face (Virtual Consultations) were improving
DNA Rates – had significantly reduced
Digital Communications – 258k digital portal messages sent from April to Nov 22. Savings continued to be seen with work ongoing.
Patient Knows Best would go live early 2023.
Risks and mitigations were noted.

Fiona Osborne asked how PIFU was being assessed for suitability on a condition by condition basis. Jackie France confirmed that this work was ongoing with clinicians and clinical leads around details and evidence-based information.

Following brief discussion, the Committee received and noted the presentation and agreed that the highlight to the Trust Board would include the CHN funding along with system funding and working.

2.15pm Jackie France left the meeting. Jennifer Grainger & Annabelle Baron-Medlam joined the meeting.

6. CQC Report

Jennifer Grainger joined the meeting and spoke to the circulated CQC Progress Report. Highlighted changes to note in the report since last month were as follows:

There was one action that had progressed from amber to green due to increase in compliance (all staff groups now compliant) 20OG Obstetric Emergency Training (Family Services Division). Jennifer Grainger noted that there was one action that had decreased from green to amber, this was due to reduced training compliance: 22EoL Equipment used to deliver end of life and palliative care (Community and Therapies Division).

It was highlighted that two assurance papers had been submitted to the CQC: 34OG WHO Checklist and 30OG Maternity Record Keeping (both Family Services Division). Both ratings had moved from green to blue.

Jennifer Grainger went on to advise that the new CQC inspection report was published on 2nd December 2022 and the main highlights from that report included:

- No longer rated 'Inadequate' for Safe, the Trust now rated 'Requires Improvement'
- Maternity, Surgery and Diagnostic imaging had all moved up to 'Good' for responsive
- Outpatients moved up to 'Good' for well-led
- GDH was rated 'Good' overall
- Diagnostic imaging was highlighted for 'outstanding practice'
- There were no concerns around fundamentals of care and no requirement notices were issued
- Inspectors said they saw good examples of patients receiving compassionate care, with staff ensuring patients' privacy and dignity was maintained
- The report noted most people were happy with the care provided and it was evident staff worked hard to achieve the best possible outcomes for people throughout the services they inspected
- The report recognised improvements in leadership, culture, safety, complaints and the elective backlog
- Commitment to learning and quality improvement was highlighted
- Improvements to data management were recognised, as was strengthening of operational financial management and governance arrangements

Jennifer Grainger went on to highlight issues included within the report:

- Pace of improvement needed to improve more quickly in some areas
- End of life care, whilst moved up a rating to 'Good' for caring and up to 'Requires Improvement' for well-led, had dropped to 'Inadequate' for responsive. It was noted that End of Life remained 'Inadequate' overall
- Repeated themes from previous inspections remained. These included long waits for patients, insufficient staffing levels and mandatory training & appraisal compliance.

Jennifer Grainger went on to add that 87 actions had been identified; this was a 40% reduction since the last report where there had been 145. The Main theme for actions was around documentation with 14 actions broken down to recording patient information, checklist/prescription/assessment completion and storage/management/version control.

It was noted that 11 actions related to facilities and environment including cleaning, equipment, storage/stock, fire doors and general theatres. The following actions were also noted:

- 9 actions related to staffing and appraisal rates
- 9 actions related to staffing numbers including skill mix and qualifications
- 8 actions related to medication management including storage & reconciliation
- 7 actions related to governance
- 6 actions related to culture including visibility of leaders
- 5 actions related to performance including the management of cancer times and waiting lists as well as the reporting of performance information
- 3 actions related to IPC
- 3 actions related to the establishment of processes

A further 12 actions were categorised as miscellaneous. Jennifer Grainger then went on to outline the next steps which the Trust were required to take by the CQC which included:

- The CQC required an initial response to the report 4 weeks following publication. This would comprise of 2 parts: the oversight action plan containing all actions (listing action leads, monitoring committee and expected timescale to completion) and a detailed response to the 'MUST DO' actions (listing how the action would be achieved, how improvements would be made sustainable, what measures would be in place to ensure sustainability, what resources may be required, whether these resources were available and how patients would be affected by not meeting the action). This was being working through with clinical divisions as well as corporate directorates as appropriate. A final version would be presented to TMB on the 19 December prior to submission to the CQC.
- An exercise was being undertaken to compare existing open actions from the 2019 report to the actions within the new report. A plan was being developed to deal with existing actions, being mindful to ensure actions remained embedded with appropriate monitoring mechanisms in place and amalgamation with any existing actions that feature in the new report. This would ensure the overall Trust action plan remained manageable and divisions were able to focus on their priorities without being overwhelmed by volume.

Jennifer Grainger went on to note that regular progress meetings would be scheduled with all action leads to commence work looking at details of each action, developing sub-actions, planning measurable KPIs and collating supporting evidence on the journey to completion. Detail around this progress would continue to be provided within the monthly report presented at the Trust sub committees and TMB.

Lee Bond asked what the resource implications for these actions were as previous resource cost ran into millions of pounds. Lee Bond then added that he would need to understand the risk from the recent report. Jennifer Grainger confirmed that the team would be working on a costing paper early January 2023.

Fiona Osborne referred to the divisional updates where they stated there had been no movement and added that a rough indication of their timescales from an assurance point of view would be very helpful. Jennifer Grainger acknowledged that and noted that work in those areas was ongoing.

The Committee thanked Jennifer Grainger for the update and received and noted the report.

2.25pm Jennifer Grainger and Annabelle Baron-Medlam left the meeting.

7. Review of NLaG Monthly Financial Position (SO3.1 / SO3.2b)

Gill Ponder invited Brian Shipley to outline the Month 08 Finance Report which had been circulated to the Committee. Brian Shipley went on to note the key headlines contained within the report, the Trust had a £0.33m surplus in November which was £0.65m better than plan. However, the in-month position was supported through further release of £1.09m of non-recurrent technical reserves. The Trust was also behind its improvement trajectory in month by £0.52m.

Brian Shipley went on to note that the Trust now had a £3.22m year-to-date deficit, which was £3.99m worse than plan. Therefore, the Trust was formally forecasting a balanced financial position but was highlighting a deficit risk of £7.6m. That was predominantly driven through increased usage of temporary staffing, escalation beds and pay award pressures. The cash balance at 30 November 2023 was £36.71m, an in-month increase of £4.24m.

Brian Shipley went on to highlight the material issues for the Trust over the coming months which included:

- Maximising its planned care activity delivery, with a requirement to return to 19-20 productivity and activity levels within its core capacity and budget, reducing reliance on IS and WLI premium costs
- Delivering a challenging stretch CIP programme, mitigating risks to delivery and conversion of non-recurrent savings into recurrent delivery schemes and identifying new schemes
- Reducing its additional Covid-19 expenditure as soon as possible. - Reducing its material cost pressures, including additional beds and additional duties in both Nursing and Medical Staffing

Fiona Osborne referred to section 11 conclusion and queried what the additional duties in both Nursing and Medical Staffing referred to. Brian Shipley confirmed that they were additional duties that had been added to the shift patterns. A clearer understanding as to why these additional duties had been added and further investigation to mitigate any potential poor controls would be required.

Fiona Osborne then referred to page 62 – temporary staffing and the compliant cost coming in at 16.1%, Fiona Osborne asked how the Trust was tackling those that are not compliant with rates. Brian Shipley added that it was very much what the market dictated; whilst the Trust did have breaches it was not an outlier, but it was acknowledged that within specialist areas the Trust were paying more. Fiona Osborne asked why the Trust was negotiating when the vast majority of rates would be charged outside negotiated rates; should the focus be on other control means. Brian Shipley confirmed that the Trust did negotiate for improved rates, but those rates still might not be compliant with the national framework rates.

Fiona Osborne noted that at the Q&S Committee recently, it was discussed that there should be a triangulation between nursing establishment review, business planning process and the recruitment team having plans in place to get people in post. Ashy Shanker confirmed this was the intention.

Lee Bond went on to note that due to impending strike action, it had been advised from Ops division that they planned to spend in excess of £100k over 3 or 4 days on agency staffing in the emergency department and additional beds. The Trust's financial plan was reliant on the ability to extract whatever it could from the balance sheet. Medical staffing was the major issue for the Trust, with continued increase in spend compared to last year.

Lee Bond then went on and added that he had little confidence in the recruitment and retention process currently; it was proving to be a difficult and critical issue. Lee Bond went on to highlight that the Trust had a £7.5m forecast problem, a set of national pressures driven by the acute pathways and strike actions, together with a "rapidly running out level of resource". The biggest area of spend continued to be temporary staffing.

Gill Ponder asked, given the risks to the financial recovery trajectory and the issues the Trust had around recruitment and retention, what was going to be done differently to tackle those issues. Lee Bond confirmed that the Trust were looking at nursing apprentices, where the Trust would need to work closely with the University. The other main concern was medical staffing.

Lee Bond went on to add that there was a developing agenda from BMA which could potentially see doctors' pay rates increase substantially. Discussions were in the early stages with unions, but it was noted as a concern which the Committee needed to be aware of.

Gill Ponder suggested that this be highlighted to the Trust Board; what more could be done and what could be done differently to tackle these issues. Simon Parkes agreed with the previous comments and added that the Trust Board should be sighted on these issues, understand the risks and take a proper and serious view about the mitigations.

Lee Bond added that he was reasonably confident of the financial position for that year but the release of reserves could not be repeated in future years. He went on to add that if plans were not improved then the Trust would not be able to deliver its plan going forward.

Fiona Osborne went on to summarise the discussions thus far noting that the Trust started the year on a very small margin of error for targets that year, an improving forecast was presented to the Committee month on month, however none of that was as a result of changes in behaviour within many divisions/departments within the organisation; all of it was down to Lee Bond and the Finance team in terms of technical balance sheet management – that was the message that needed to be highlighted to the Trust Board.

On another point, Fiona Osborne went on to note that she had recently left the Workforce Committee, where a monthly dashboard was received; Fiona Osborne expressed her concerns as it did not have mature enough forecasting on retention, so was of limited value from a business planning perspective.

Lee Bond suggested a short meeting to discuss what information the Committee required to be included in the monthly report going forward.

ACTION: Meeting Lee Bond/Gill Ponder to discuss report format going forward

The Committee received and noted the Month 8 Finance Report and highlights and risks contained within.

7.2 Recovery Support Programme Letter

Lee Bond advised that a letter received by the Trust from NHS England on 19 December had been circulated for the Committee's information. Lee Bond briefly outlined the contents of the letter and noted that, following the Recovery Support meeting a further relationship meeting had taken place and the Trust was informed that it would need to meet the month 12 break even position to exit special measures; it would also need to submit an acceptable first draft financial plan for 2023/24. Lee Bond went on to add that that would be a "very tall ask". The Committee agreed to highlight that to the Board for discussion on RSPF exit criteria in the context of the current extreme operational pressures.

7.3 Business Case Assurance

Nothing for discussion.

7.4 Assurance Confirmation

The Committee agreed they were assured on actions being taken.

8 Estates & Facilities

8.1 High and Low Voltage Electrical Management

Jug Johal spoke to the circulated paper which provided the Finance and Performance Committee with an update on the Estates and Facilities assurance model and focused on the safe management of the High and Low Voltage Electrical systems in terms of risks and associated assurance. Jug Johal went on to note that the paper also provided an update on the Improvement notice issued to the Trust by Anglian Water.

Jug Johal highlighted that the 5-year maintenance contract was in place for both LV and HV; once the Trust start to work closer with HUTH the value of these contracts could be substantial with joint procurement being a potential opportunity for both organisations.

Jug Johal went on to refer to a couple of recent issues which had occurred: Electrical cable failure which led to breaker issues within IT, this was not connected to the UPS issues and therefore was not covered within the report. A paper on UPS had been presented at the Capital Investment Board and it had been agreed that a feasibility study would be undertaken in order that the UPS at SGH and DPOW were completed by the end of the financial year. Contingency plans were in place until the work was fully completed. Capital Investment Board also agreed to extend the scope of the work to cover NICU and ITU areas.

Gill Ponder thanked Jug Johal for the update and noted that a more detailed discussion on this was due to take place at the January Finance & Performance Committee.

Gill Ponder then went on to ask if the UPS was installed, would it take 24 weeks per theatre per site. Jug Johal confirmed that option 1 had been agreed which would provide a UPS for the 3 theatres at SGH and 3 at DPOW; theatres would continue to be operational during the works.

Gill Ponder asked for confirmation why the Trust was mitigating a UPS risk if the problem had been caused by the faulty fuel gauge. Jug Johal advised that had we not had the fuel gauge issue, the full extent of the problem would not have been identified.

The Committee was asked to note the report on the safe management of the Trust's Electrical Systems management and to note the report and mitigation actions that were being undertaken by the Directorate.

It was agreed to highlight to the Trust Board that F&P had received the initial paper on the recent electrical issues and had agreed that a further deep dive would be discussed at F&P in January. Gill Ponder requested that the report included the IT aspect from Shauna McMahon for business continuity purposes.

The report was taken as read and received and noted by the Committee.

ACTION: Jug Johal to bring the deep dive report to the F&P Committee in January

8.2 Assurance Confirmation & Board Highlights

The Committee agreed that they were assured on the mitigations and actions being taken.

9 Review of NLAG Monthly Performance & Activity Delivery (IPR) (SO1.2/SO1.6)

9.1 Unplanned Care

Ashy Shanker took the circulated paper as read and went on to draw out the key themes on unplanned care noting that the urgent and emergency care performance had improved in November but was decreasing in December, with increased attendances over recent weeks and acuity, particularly of walk-in patients. The Urgent Care Service performance remained steady, with its 4-hour performance currently at 98.6% for December. The 12-hour waits in ED and ambulance handovers had reduced in November but unfortunately there had been an increase in December, with additional measures in place to support this but the ongoing pressures were causing operational difficulties.

Ashy Shanker noted that there was a continued level of agency and medical spend to continue to support the unfunded escalation beds. Currently there were over 80 doctor vacancies across both medicine and surgery which impacted upon delivery and performance. There were processes in place to try to reduce the high cost agency spends.

UCS performance was still strong and SDEC, although not operating 24 hours, had made a huge difference to the LoS. There was a need to look at extending SDEC hours with system partners.

Ashy Shanker went on to note that COVID and Flu were well managed with regular winter planning meetings.

Fiona Osborne referred to ambulance handovers; in previous months it was noted that we had experienced some inappropriate conveyancing to the hospital. She asked if that was still a problem. Ashy Shanker confirmed that the issue had been addressed and those had been re-routed to SPA, therefore the numbers were reducing.

Fiona Osborne then went on to ask that, due to the huge operational pressure and the largest number of escalation beds in place than ever before, what would the Trust see in the numbers based on the current position going forward. Ashy Shanker advised that that month had been very difficult due to industrial action and associated pressures which had been developing over the last few weeks. As much as elective activity as possible was not cancelled. It would depend upon the industrial action and acuity of patients. Any beds that were not required would be closed once the peak had been managed.

Lee Bond noted his concern over the increase in overdue follow-ups and those patients who were not having a risk stratification carried out and asked if the Trust were building up a level of unidentified risk.

Lee Bond noted that it may be useful to provide the Committee with the volume of patient numbers into urgent care, emergency department and SDEC. Ashy Shanker confirmed that a dashboard had been created to show that information and that would be provided to the Committee.

ACTION: Ashy Shanker to add the dashboard to the Committee papers for future meetings

9.2 Planned Care

Ashy Shanker noted that the Trust currently had four 104 weeks plus waiters. All of those were Urology mutual aid patients.

RTT remained stable and there had been a slight reduction in 18ww; 52ww had increased, with mutual aid the major contributor to that position.

Ashy Shanker went on to highlight capacity issues within MRI including ICS level, those were being picked up with a plan in place to mitigate.

Ashy Shanker then moved on to cancer noting that this area remained with the highest level of risk. We were currently separating out the issues which could be managed internally. Risks included:

- Oncology - clinician capacity
- Tertiary – capacity
- Diagnostic – reporting

Additional capacity had been put into pre-anaesthetic assessments (elective) which would hopefully improve waiting times and have an impact upon inpatients.

Ashy Shanker added that challenge remained in theatre capacity, which was currently running at 83% due to refurbishments planned to be completed by July 2023.

Fiona Osborne referred to the 62 day GP referrals, where it was mentioned that this Committee had been advised there would be a series of pathway deep dives and asked where those would take place. Ashy Shanker confirmed that there was a group led by Abdi Abolfazl which met regularly to address those issues which would be included within the action plan for assurance which would be brought to the Committee in January. Gill Ponder went on to note that one of the comments within the IPR around the 62 day GP referrals referred

several times to “patient non-compliance”. It would be useful to understand what this meant and what could be done to assist the patients to comply if this was a cause of failure to meet the standards. Ashy Shanker went on to confirm that when a patient is offered an appointment on the cancer pathway, those appointments were often not accepted. Gill Ponder asked if the Trust could work more closely with GP partners so the patient fully understood the need to attend and early appointment. Ashy Shanker added that work was ongoing to address that issue.

Simon Parkes referred to the next item on the agenda and the fact that the Trust had an agreed plan to deliver the 62 day target. Although the Trust had a plan, the concern was whether that plan could be delivered in the near future. Ashy Shanker agreed and acknowledged that the Trust was doing what it could to address the issues.

9.3 Elective Recovery Self-Certification

The report was taken as read and it was noted that it was in response to the NHSE letter dated 25 October 2022 regarding next steps for Tier 1 and Tier 2 hospitals in relation to the elective recovery programme and to ensure that phase 2 objectives around 78-week waiters and 62-day cancer waits were met. It was noted that, whilst we were not a Trust in either Tier 1 or Tier 2, NHSE had asked that all providers in the ICB undertake the self-certification.

Gill Ponder acknowledged Simon Parkes’s recent concern over delivery of the 62 day standard; she went on to add that if the Committee were to give assurance to the Trust Board on theatre productivity, then a report would need to be presented to the Committee. Gill Ponder also added that she had noticed in the report that she had been named as NED sponsor for this work, which she was unaware of before reading the report. She would be happy to discuss the requirements of the Sponsor outside the Committee meeting to agree the way forward.

Action: Ashy Shanker/Gill Ponder to arrange a meeting to discuss the Sponsor role

Simon Parkes went on to add that the Trust should be clear that we did not yet have a plan to deliver 62 day standard and be transparent on the reasons and how we were managing any risks.

ACTION: Ashy Shanker to discuss the requested amendments to the Self-Certification Draft with the author.

9.4 Patient Admin Transformation Delivery

Discussed earlier on the agenda

9.5 Operational and Business Planning Timetable Progress Update

The paper was taken as read which provided an update on the progress of the Annual Business and Operational planning processes for 2023/24 and highlighted the risks that were being managed in the Trust. The next step was to amend the Operating Plan to a version that would align with workforce plans, demand and capacity. During January, the plan would be finalised, then through February the business plans would be taken through a confirm and challenge process to triangulate workforce, finance and operational plans. The Trust Board and sub committees would then receive Trust level business plans. Ashy Shanker added that there were timescale pressures, but everything was currently progressing.

9.6 Assurance Confirmation & Board Highlights

The following were agreed to be included in the highlight report to the Trust Board:

- Self-Certification Draft – asked for amendments to the report
- A & E continued pressure which impacted upon planned care

- Signs of improvement across a number of performance measures – positive feedback
- Funding for Connecting for Health Network (System Level)

10 F & P Committee Governance Documents

10.1 SO1-1.6 BAF Review

Gill Ponder noted that she had reviewed the Business Continuity BAF entry and had noted a gap in assurance on testing at an operational level and assurance on whether all staff were aware of Business Continuity plans in their areas and were confident they could enact the plans at short notice. This was particularly relevant in the context of the recent issues with the IT cable and back-up electricity supply and she suggested that this assurance was included in the deep dive report on the recent incldents due back to the Committee in January.

ACTION: Jug Johal to ensure this was included in the deep dive report

Simon Parkes added that there clearly had been some challenges with a target risk of 8 by the 31 March 2023. There should be a combination of controls and actions to take the Trust to that score by then, but those were not obvious in the BAF. He asked what else the Trust needed to do to address those gaps. Fiona Osborne queried if there was a rating of 16, why there were no high-level risks on the risk register. Gill Ponder agreed to raise these concerns with Shaun Stacey and request assurance.

ACTION: Gill Ponder to contact Shaun Stacey and Ashley Leggott to raise those concerns on behalf of the Committee.

11 Items for Information

11.1 Performance Letters to Divisions – PRIMS

Received and noted by the Committee.

12 Any Other Urgent Business

None raised.

12a **Matters to Highlight to other Trust Board Assurance Committees**

None identified.

13 Matters for Escalation to the Trust Board

Already discussed within the assurance section of each agenda item.

13a Review of Meeting

The Committee agreed that the meeting had included a lot of open and productive discussion. Lee Bond added that he thought the usual 3 hour meeting was rather long, but acknowledged that the agenda was extensive. Gill Ponder hoped that rotating the agenda continued to help ensure that Committee members were able to focus in detail on items in each Directorate on a regular basis.

14 DATE & TIME OF NEXT MEETING:

THURSDAY 26 JANUARY 2023 9.00am to 12.00pm TEAMS

NLG(23)029

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	7 February 2023	
Director Lead	Kate Wood, Medical Director Ellie Monkhouse, Chief Nurse Fiona Osborne, Non-Executive Director	
Contact Officer/Author	Fiona Osborne, Chair of Quality & Safety Committee	
Title of the Report	Quality & Safety Committee Minutes – November and December 2022	
Purpose of the Report and Executive Summary (to include recommendations)	The paper includes the minutes of the Quality and Safety Committee (QSC) meetings for November and December 2022.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 20 December 2022 from 1.30pm to 4pm
Via MS Teams

Present:	
Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Kate Truscott	Non-Executive Director
Susan Liburd	Non-Executive Director
In attendance:	
Dr Kate Wood	Chief Medical Officer
Ellie Monkhouse	Chief Nurse
Dr Peter Reading	Chief Executive
Jennifer Granger	Interim Associate Director of Quality Governance
Ashy Shanker	Deputy Chief Operating Officer
Jan Haxby	Director of Quality & Nursing, North East Lincolnshire Health & Care
Ian Reekie	Governor (Observer)
Jane Warner (item 322-24/22)	Associate Chief Nurse, Midwifery, Gynae & Breast Services
Donna Smith (item 325/22)	Associate Chief Nurse, Community & Therapies
Ant Rosevear (Item 325/22)	Associate Chief Operating Officer, Community, Therapies & Family Services
Jo Loughborough (item 327/22)	Patient Experience Lead Nurse
Vicky Thersby (item 329/22)	Head of Safeguarding
Fiona Moore (Item 331/22)	Head of Quality Assurance
Laura Coo	PA to the Chief Medical Officer **(minute taker)**

312/22 Welcome and Apologies for Absence

Apologies for absence were received from: *Shaun Stacey (Ashy Shanker to rep), Mr Kishore Sasapu*

313/22 Opening remarks

Fiona Osborne welcomed members to the meeting and advised that there were two papers deferred to January; Risk Stratification and the Head and Neck Cancer update. Also due to the meeting being earlier the MIG and QGG minutes were not ready. As there was limited time at the meeting Fiona asked for a two minute

introduction of the papers emphasising any key points before moving on to questions.

314/22 Declaration of Interests

There were no declarations of interest related to any agenda item.

315/22 To Approve the Minutes of the Previous Meeting held on 22 November 2022

The minutes were accepted as an accurate reflection of the previous meeting.

316/22 Matters Arising

There were no matters arising.

317/22 Review of action log

197/22 and 202/22 – Referrals to the Workforce Committee - Sue Liburd reconfirmed receipt of the requests and advised that the Workforce Committee were going to submit a formal response to this Committee to close the actions.

258/22 Risk Stratification – this item had been deferred to the January meeting

259/22 CNST update – Sue Liburd clarified that she had raised a query about the training, numbers of attendance and when that training was going to be undertaken.

Action: Laura Coo to chase for a response with Preeti Gandhi.

262/22 Nursing Assurance report and Pressure Ulcer Deep Dive – The workplan is being revised and will be available in January. A Pressure Ulcer Deep Dive would be included.

263/22 Annual SI report, reporting in Ulysses – Fiona Osborne is waiting for confirmation from Kelly Burcham that Shauna McMahon's team had been in touch to confirm that Ulysses had the reporting capability.

274/22 BAF – Fiona Osborne raised the discussion with Helen Harris and it was discussed at Trust Board in December. It was agreed to close this action for this Committee as it had been escalated to the Board. **Action closed**

290/22 End of Life (EoL) – Sue Liburd wanted to meet with Kate Wood and the EoL team for an overview of the EoL work

Action: Laura Coo to set up the meeting, and to include Kate Truscott too.

294/22 Newborn Audiology Issue - this had been added to the revised workplan but the action would be left open until the workplan had been approved.

Regular Reports

318/22 Risk Stratification

Paper deferred to January

319/22 Head & Neck Cancer

Paper deferred to January

320/22 CQC Framework

Jennifer Granger referred to the paper distributed which was taken as read and gave a brief overview of the changes since the previous report.

One action had progressed from amber to green due to an increase in compliance in Obstetric Emergency Training.

One action had decreased from green to amber linked to EoL care and the syringe drivers.

Two assurance papers had been submitted to the CQC for Maternity changing both ratings from green to blue.

This month's report included highlights and lowlights from the CQC inspection report published on 2nd December 2022. Overall, the new report showed a 40% reduction in the number of actions.

Next steps - a spreadsheet had been put together based on a request from CQC to show details of what we were doing, actions etc, a copy was sent to all the NED chairs of subcommittees to gain agreement that they were in the right places. Jennifer was also in the process of comparing the old to the new action plan to avoid duplication and would be putting a very simple paper together showing what was being done to deal with those actions that remained open and regular progress meetings would be ongoing.

Jennifer invited any comments or questions.

Fiona Osborne referred to the action plan which showed there were two oxygen prescription actions that Medicine ED were leading on which stated that there were no updates in the month. Fiona was hoping for some feedback on what actions that had taken place in the month..

Kate Wood reminded everybody of the immense operational pressures the Trust was currently facing and therefore expected there would be some slippage on the work that was being undertaken as people were needed on the frontline. Medicine took this to their performance meeting last week, for ED two clinicians had been identified to lead the improvement work for oxygen and they identified some immediate changes that needed to be made which they would be using that in January through Symphony when it would be re-audited. For the Wards the lead clinician identified was Dr Alkhazraj, who was going to meet with the QI team to discuss if there was some way they could support a project to move that forward. The team were thinking about using EPMA for oxygen prescribing and were providing an oversight perspective through spot audits on the wards, utilisation of the WAT tool and regular checking the process was in place.

321/22 Key SI Update including Maternity

Jennifer Granger referred to the report distributed which was taken as read summarised the key points.
Although the report stated there were no new maternity SI's, a maternity SI had been declared after the report was written.

Recently a Never Event was recorded surrounding a retained BERT bag post procedure, which was discovered when the patient underwent surgery at Hull University Teaching Hospitals (HUTH) and an investigation was started at HUTH. It was felt improvements had already been made given this was a year ago and for re-assurance they had checked and the patient was well.

All incidents had deadlines and the team were working to get them closed.

Jennifer invited any comments or questions

Fiona Osborne asked for more clarity on the maternity SI that Jennifer had mentioned, however Kate Wood advised that the SI report had not been put together yet so would rather the details were clarified before discussing it at this assurance committee. Fundamentally Fiona had a question around the understanding of the process flow and asked if Jennifer could arrange a meeting for Kate Truscott, Sue Liburd and Fiona to walk them through the process flow. Once this meeting had taken place it may be there is a slight change to the way things are presented to provide greater clarification for the Committee.

Action: Jennifer Granger to arrange a meeting as above

322/22 Ockenden update (to include safe staffing in Maternity)

Jane Warner joined the meeting at 1.50pm

Jane Warner referred to the document distributed which was taken as read.

Jane summarised with respect to Ockenden that work continued and the actions discussed last month were still being progressed although there was an overlap with CNST and Ockenden. There had been a lot of work put into this and Jane expected the original report would be signed off at the end of January. With respect to the second Ockendon report and the East Kent report they were still waiting to know exactly what was expected.

323/22 Safe staffing in Maternity

Jane Warner referred to the document distributed which was taken as read and highlighted the key points for the safe staffing in maternity element.

It was very important to have safe staffing in maternity and to comply with Safety Action five of CNST which stated that there was a requirement for Trust Boards to demonstrate effective workforce planning and provide evidence of funded establishment being compliant with outcomes of BirthRate Plus (BRP) calculations. BRP had been used in the proposed staffing levels alongside a long drawn out process of looking into every birth, admission etc and every contact the midwife made. Ellie Monkhouse had undertaken an audit of workforce, activity and patient safety data which triangulated the BRP.

The Trust has a duty to ensure Midwifery staffing levels are safe, which is monitored every day in the safety huddles. Where staffing levels are not the Red Flag process is applied which are looked at in the MDT. The service utilises the support workers to address red flags where appropriate.
Since the Trust last undertook the BRP calculations, our birth rates had reduced however the complexity of the women had increased. The calculations of BRP excluded all registered midwives with supernumerary status including our Consultant Midwife.

Page six of the report showed how we compared now to 2016. The chart also provided assurance from the Midwife to birth ratios.

Jane reported that the Trust had been able to manage its Midwifery Continuity of Carer teams. There were originally three teams but due to the Midwife vacancies it was reviewed and the decision was made to pause one of the teams at SGH to maintain the safest conditions for patients but had continued with the two teams at DPoW who continued to flourish. At this stage the team were not in a position to continue with a Continuity of Carer team at SGH.

Page eight showed the outcome of Ellie Monkhouse's Chief Nurse review. It showed a requirement to have a Diabetes Midwife Specialist to support the high numbers of diabetic pregnant women as there were more and more women coming through with diabetes.

There are still several vacancies, just over 25 wte. Vacancies are monitored daily to ensure safety. Student Midwives had been recruited from Lincoln and we are awaiting the start date of four of them (two for each site) and it is planned that another four would be joining us in a few months' time, hoping for sixteen in total.

The BRP showed that at the point we revert back to Continuity of Carer teams across both sites there would be a variance of two over our current establishment. Jane reported that there would be a point in time when those two would be needed and then some temporary additional staff to enable roll out.

Ellie Monkhouse added that this was brought here for the Committee's information and had already been through TMB. Fiona Osborne appreciated Ellie's comments but as an assurance committee, members needed to ask questions but appreciated that changes would not be made.

Jane invited any comments or questions.

Sue Liburd referred to the number of Midwifery vacancies and asked if the new students taken on would be classed as supernumerary. Jane advised they would be but a Care Camp is put on for new Midwives, then they have a period of four weeks supernumerary on the Ward so that would not reduce the 25 vacancies.

Ian Reekie commented that at their last Governors Assurance Group Linda Jackson stated there was a potential risk for Maternity Services in the coming months and that would necessitate changes. Ian asked how confident Jane was now. In response Jane informed that they had been in a position where they had to close their units to maintain safety, one occasion was around staffing and the other around numbers of patients. Jane was assured that on a day to day basis they

were safe, they had undertaken the Maternity Opel status that could change throughout the day and they report into the SITREP status daily.

Ellie added that Jane had described the mitigation in place but the other thing to note was that Maternity Services did not always have to staff all 27 of the beds as numbers of patients varies by need. It was difficult to sustain staffing two quite small Maternity Units and that may not be sustainable every day. There might be days when we had to be on divert and there might be days when we had to close Units but it was important for the Committee to be mindful of that.

Given the population and the increase in gestational diabetes Sue Liburd asked if there were any mitigations in place. Jane confirmed there would be a business case going forward.

Fiona asked how confident Jane was about the ability recruit the specialist roles across the two sites. In response Jane advised that they already had a lot of Specialist Midwives working in cross site posts and it did not seem to phase anyone so did not envisage it being a stumbling block.

Fiona asked if having the two teams for Continuity of Carer was likely to be re-assessed given the SGH model had to be stood down. Jane advised it would be but the reason it was stood down was the vacancy factor and that needed to change before it could be re-introduced. Three and a half years ago NLaG did not have any Continuity of Carer teams and a lot of Trusts do not have them. Going forward, when we do have more staff Jane would not want to look at shift based modelling as they knew it had worked at Grimsby. Jennifer Granger added that she was the Continuity Matron at Hull and all those teams had stopped so it was a credit to NLaG that they had continued.

324/22 CNST Update

Jane Warner referred to the document distributed which was taken as read and highlighted the key points.

Jane hoped the Trust were going to achieve full CNST compliance. The date had been extended to February and some of the final evidence was received however the information moved daily. By exception they were awaiting the Neonatal Medical Workforce action plan which was being collated currently for compliance of BAPAM. An action plan around medical staffing for the Neonatal Unit was in place, which was not where it should be although they were safe.

Safety Action 3 – ATAIN – Evidence was required with respect to the existing transitional care activity and that care was embedded in the organisation. Jane had that transitional care action plan and was now green

Safety Action 6 – Saving Babies Lives V2 - had full evidence, had changed a lot of practices and embedded a lot of work and was now green

Safety Action 10 – NHS Resolution - just waiting for evidence from the Trust Legal team to provide assurance that all qualifying cases had been reported as expected. The evidence was needed to support that.

An Extra Ordinary Trust Board was in the diary for 5th January 2023, had already a confirm and challenge with Ellie Monkhouse and another was in the diary with the LMNS and ICB.

Fiona asked if the summary of the current situation was that we are collating and gathering the final evidence and that actions were complete. Jane confirmed that this is the case.

325/22 Community & Therapies Update

Donna Smith & Ant Rosevear joined the meeting at 2.15pm

Donna Smith referred to the document distributed which was taken as read and highlighted the key points.

Significant progress had been made with the CQC actions and there was only one open action to progress.

Staffing capacity and demand continued to be a risk and was already on the risk register but they were seeing more patients and these patients were being allocated their visits in a timely manner.

Donna advised the team had introduced a new risk assessment tool for Pressure Ulcers.

Donna invited any comments or questions.

Fiona Osborne liked the conciseness of the report and noted that in the last update in June a dashboard development was discussed and Donna was hoping to bring that here. Donna clarified the dashboard was in relation to End of Life (EoL) and the dashboard would be included in that paper.

Fiona also asked for any areas of concern to be included in the next report, Donna had previously mentioned that staff were tired and raised a concern around the continence waiting lists. Donna felt that with the improving position in terms of unallocated visits had improved staff morale and Donna clarified that there were not any patients waiting for a continence assessment. Donna agreed to include areas of concern on the next update.

Fiona asked about pain assessment and management. Donna noted that was also related to EoL but there was also a pain assessment tool being introduced through the quality improvement plan.

Fiona asked for further clarity about Pressure Ulcers. Donna explained that was detailed in the summary in terms of the way Community and Therapies assessed risk, there was an opportunity to introduce a risk assessment tool, so they undertook a thematic audit and tried to streamline the process to investigate harm when it happens and found in the large proportion of cases there were no lapses in care and they were starting to drive those numbers down.

Kate Truscott asked about 'Blue Fish', Kate had noticed the contract was not being renewed although it sounded like a useful tool. Ant Rosevear informed the Committee that there was a three year contract with Blue Fish and that community

services were run in SystmOne. The purpose of Blue Fish was to extract that data into power BI. They were very good at the data extraction but not so good at the front end reporting so only data extraction had been used. The Trust was now at a point to bring that work in house so did not need the additional cost of Blue Fish.

Fiona thanked Donna and Ant for the update.

326/22 Medicine Update

Kate Wood informed the Committee that Dr Anwer Qureshi passed on his apologies that he was not able to attend today's meeting as he was trying to put contingencies in place for the ambulance strike due the next day. In his absence Kate could take any questions.

Fiona Osborne asked Kate about DPoW ED in November as it was marked as intensive support and asked if that was due to teething problems with the opening of the new department. Ellie Monkhouse asked if that was related to the 15 steps, as that was nothing to do with the new department and was historic before the opening of the ED. Ian Reekie confirmed he had been involved in that and it was the case

Fiona queried the Sepsis screening compared to the June report and asked what work was on-going to address concerns. Kate Wood felt as though data was being collected for the sake of it and that there was no assurance in the data. Kate did not have a huge amount of faith in the data we had. For the Trust to be able to make improvements we needed to look at what we had, sepsis was not flagging as a quality of care issue within the organisation but Kate did not have the data to support that. Sepsis had been a quality priority for years now but whilst we are asking the medical staff to extract the information from each set of case notes we were not going to get that assurance it was just not working and Kate thought a refreshed approach was needed. When the quality priorities are worked through for next year the team are going to look at what actions are going to be meaningful to get the information needed. Although Kate could not provide the evidence to give that assurance she was not concerned that this was a risk to patients and this was a data collection issue.

Jennifer Granger reiterated what Kate Wood had said they were looking at the root cause and why the data did not match what they saw in patient care.

Fiona agreed this was not coming through in the incidents or complaints but the IPR was showing there was an issue. Kate Wood did not believe there was a problem, but that did not provide the assurance which was why it needed to remain a quality priority. Fiona would highlight the concerns to Shauna McMahon, but Fiona's understanding was that the quality priorities were about the quality of care to the patient whereas this seemed to be an evidential issue too.

It was agreed this would need including in the Highlight report to the Board.

327/22 National Inpatient Survey & Patient Experience Report

Jo Loughborough joined the meeting at 2.30pm

Jo Loughborough referred to the reports distributed which were taken as read and highlighted the key points.

For Jo the main highlight in the report was the compliance for closed complaints, it had decreased in quarter two but coming to the end of quarter three it had changed, the Team had seen the Complaints Manager return to post, had a temporary PALs Manager in post at the moment and had seen an improvement in PALs being closed down. The other thing contained in the report was a summary of the inpatient survey. The Trusts 2021 survey was positive, there was a summary of the maternity survey which was also very positive and actions had been embedded into the action plans. They had addressed additional things that had mattered most to the patients.

Kate Truscott thought it was a good report, which gave a clear picture of the improvements that had been made. Kate knew the physical PALs office at Grimsby had closed and asked what the impact of that was. Jo advised that surprisingly it had not had the impact they had expected, they still received a lot of PALs through email and telephone and it had not been raised as a concern.

Fiona Osborne thought the 'you said we did' was a powerful message and asked Jo to explain how that message was put out. Jo informed that historically they had the boards which would be updated with quality improvements. That was being refreshed at the moment but there was a bigger piece of work which Ryan Sutton's team was starting on an internal platform and then on a public platform to share some of the patient led changes. Fiona thought that external communication plan was a good innovation.

Fiona queried when the Committee last received the information the explanation of the conditions for the patient were included but the mitigations in the report seemed quite impersonal rather than focussed on an individual patient's individual needs. Jo thought that the softer information had not been captured in the action plan and they needed to build on the quality aspect they were including in the action plan.

The Committee also noted previously that there was no response from the BAME community and Fiona asked if that had been looked into. Jo advised they had looked into it and found that the random sample included only a tiny amount of BAME patients that and it was just how the random sample had worked but it was continually being looked at.

Jo Loughborough left the meeting at 2.45pm

328/22 Nursing Assurance Report

Ellie Monkhouse referred to the report distributed which was taken as read and highlighted the key points.

Ellie reiterated that the pressure on the frontline was quite significant and through this report they were able to demonstrate there was significant oversight but it was a huge challenge on a daily basis. It was difficult to quantify some of the data, as the number of escalation beds fluctuated daily. Additional seating was being risk assessed.

There had been some delays in recruitment and complaints were a consequence of the relentless pressures the teams were facing.

Kate Truscott's concern was around the additional one to one care as well as the increase in total numbers and how that impacted on the staff and asked if that was related to anything in particular i.e. the frail, elderly or respiratory. Ellie thought it was a combination but was erring more on the mental health side of things and thought that our staff gave great care based on the level of cognitive need. The float tool had been introduced which was a holistic assessment which meant there was oversight as to what support was needed at a senior level so when a one to one was requested it had been through a vigorous process. It was quite a complex picture but Ellie thought it might be possible to draw out that data.

Sue Liburd noted in the report there was an increase in staffing red flags and asked if there was a pattern/rational of that. Ellie explained that the red flags seemed to come and go and depended on what the theme was at that time, some Wards reported better than others, some areas reported straight away without looking at the mitigations so it was difficult. Ellie had been working on ways to try to encourage people to use the process more and was difficult to quantify but they were discussed at every nursing matrix meeting but it was a difficult concept to try to get the thematic information.

Fiona Osborne thought overall the vacancies looked better but for the HCAs vacancies. She asked if there was anything included or planned such as another recruitment day. Ellie advised that was a one stop shop, but Ellie thought it should be reproduced regularly however they were reliant on the recruitment team to move things along which was not always quick. This was recommended as a referral to the Workforce Committee to look at the recruitment programme. There was a learning from last year to this year to look at the recruitment levels.

Peter Reading agreed that Ellie was right to raise recruitment delays as the time taken to recruit was a problem at NLaG. Christine Brereton was aware of the issues and had commissioned a full review of recruitment. That review was reported into TMB a few months ago and Peter thought it would be appropriate for Nico to report back to the Workforce Committee to see if that review had made a difference so would support a referral across to Workforce.

Action: Fiona to raise a referral to the Workforce Team to seek assurance on managing/reducing the time to recruit for vacancies

Ashy Shankar added that they had their Workforce team meeting today and the idea was to design a template for the teams to look at the gaps in activity and to triangulate that. The risks of course being timescales and capacity.

Fiona noted that the day shift rates within Women and Children's on page six were showing a downward trajectory for the fill rates. Ellie thought that represented the same mood as the rest of the Trust it was difficult to record given the opening and reopening of the escalation beds. Ellie thought there was enough information provided from Jane Warner in her report to give enough assurance

Jan Haxby left the meeting at 3pm

329/22 DoLS & Safeguarding

Vicky Thersby referred to the report distributed which was taken as read and highlighted the key points.

The Monitoring visit to North East Lincolnshire Council Children's Services happened on 8th and 9th of November which was the second monitoring visit since the local authority was judged inadequate in November 2021. NLaG and the ICB would support the NELC improvement plan once this plan was shared.

Had a meeting with the Director of Children's Health and Social Care and another meeting was planned for three months' time the DFE wanted 100% compliance in two months' time but Vicky did not know if that would be possible.

The Named Nurse for Looked After Children had oversight of all the outstanding looked after children that had not been completed.
In contrast to North East Lincolnshire Council Children's Services, North Lincolnshire Children's Services had their inspection and were rated as outstanding.

Vicky reported they Had seen quite a large increase in Strep A related attendances and they were keeping oversight of that

The MCA DoLs was being reviewed in line with Bournemouth

Vicky invited any comments or questions.

Fiona Osborne referred to section three of the report which talked about the improvement plan for N E Lincs, given the fact that this plan would directly affect us were they asking for our input when putting the plan together. Jan Haxby represented us as a health partner, Ellie Monkhouse thought it would be PLACE owned and not necessarily our accountability. As a stakeholder Fiona felt we needed to be involved. Ellie added that there would be the opportunity for input through the Safeguarding Boards.

Comfort break 3.10pm – 3.20pm

Ellie Monkhouse left the meeting meaning the Committee from this point was no longer quorate for any decision making.

330/22 IPR

Kate Wood referred to the paper distributed which was taken as read and invited any comments or questions and none were received.

331/22 Quality Priorities & Quality Account

Fiona Moore referred to the paper distributed which was taken as read and summarised the key points.

This year they were taking a different approach; a multidisciplinary bottom up approach which involved the Information Team, Medicine, Nursing etc to identify what those drivers were to work together to come up with solutions to move those forward. Workshops would be held to hopefully get more engagement so

everybody was on the same page starting off collectively with a clear common aim to improve the quality. Kate Wood added there had been a lot of other engagements with stakeholders and FM had taken that into account too.

Given the current pressures Fiona Osborne asked if they had enough representatives to have a good wide example for those collective discussions. In response Fiona Moore advised they had already thought about that and acknowledged the pressures on staff but ideas had already been discussed within the teams and representatives put forward.

Fiona Osborne suggested for Quality Priorities to be deferred until February given the workshop would be in January.

Sepsis appeared to be in the main a data collection issue rather than a patient care issue so Fiona Osborne asked if the Quality priorities were the correct place to look at that or should it be monitored in a different way noting it was not showing in the CLIP report.

Fiona Moore agreed it was about looking at it differently but did not believe it was entirely a data collection issue although it was a factor but we needed to assure ourselves that the sepsis screening took place on time and currently there was not any data to provide the reassurance to say that happened consistently throughout the Trust but that would be discussed at the workshops. The workshops would be used as an opportunity to drill down into the detail so perhaps we did not have to look at all the sepsis six and build on that each year so that maybe in the future there would be that assurance for all six but at the moment Fiona Moore would be nervous to give that evidence, although there was clinical reassurance we would not necessarily have the documented evidence.

332/22 Quality & Safety Committee Terms of Reference

Fiona Osborne referred to the Terms of Reference distributed which were taken as read. Amendments had been made but Fiona agreed it was best to wait for the revised workplan before final agreement. Kate Wood agreed, there were also comments about an overlap and duplication with ARG so there was a lot that probably needed tightening up and aligning with the Board Assurance.

Peter Reading thought that was an interesting comment from Kate about the ARGs as they record the information but it did not happen the other way and that was in the national guidance. Kate Wood noted that the ToR said that ARG should share their report with this Committee and thought what Peter said was more eminently appropriate. Once the core workplan for this Committee had been set this would be revisited.

Kate Wood asked for her title to be appropriately changed to Chief Medical Officer but otherwise accepted the amendments so far.

Ellie Monkhouse re-joined the meeting at 3.35pm

Highlight reports

333/22 Quality Governance Group (QGG)

Item deferred

334/22 Mortality Improvement Group (MIG)

Item deferred

335/22 Patient Safety Champions group (PSG)

The highlight report was distributed for infortion . Jennifer Granger escalated that we were overdue on a patient safety alert for insulin pumps but had now received assurance that was embedded and could be closed.

Items for information

336/22 Quality Governance Group (QGG) minutes

Item deferred

337/22 Mortality Improvement Group (MIG) minutes

Item deferred

338/22 Patient Safety Champions group (PSG) minutes

Attached for information

339/22 Any Other Business

None raised.

340/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

Fiona Osborne agreed to add the following points to the highlight report to the Trust Board.

- Manual recording of sepsis
- Referral to the workforce committee around timescales to recruit and asking for assurance.

341/22 Meeting review

Members were happy with the format of the meetings, it seemed to work well and Fiona Osborne thanked everybody for chasing up the papers.

342/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 24 January 2023
Time: 1.30pm – 4pm
Venue: Via MS Teams

Kate Wood raised the February meeting now clashed with the Joint Trust Board and would need to be re-arranged. The decision of when and how the February meeting would be held would be agreed outside of this meeting. Ellie Monkhouse suggested as an option B to have an Extra ordinary QSC for an hour as we did during the pandemic

Action: QSC members to let Laura Coo know their availability for w/c 20th, and 27th February

The meeting closed at 3.50pm

Annual Attendance Details:

Name	Dec 2021	Jan 2022	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
Michael Proctor	✓	✓	x	✓	✓	✓	✓	✓	✓					
Michael Whitworth														
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Maneesh Singh	✓	✓	✓	✓	✓	✓	✓	✓	x	✓				
Dr Kate Wood	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	
Ellie Monkhouse	x	✓	✓	✓	✓	✓	✓	x	✓	x	✓	x	✓	
Dr Peter Reading	✓	✓	✓	✓	x	✓	✓	✓	x	x	x	x	✓	
Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
Jennifer Granger										✓	✓	✓	✓	
Helen Harris	x	x	x	x	x	x	x	x	x	x	x	x	x	
Jan Haxby	x	x	✓	✓	✓	✓	x	x	✓	x	x	x	✓	
Shaun Stacey	✓	x	x	x	✓	x	x	x	x	✓	✓	x	x	
Susan Liburd											✓	✓	✓	
Kate Truscott											✓	✓	✓	

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 22 November 2022 from 1.30pm to 4pm
Via MS Teams

Present:

Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Kate Truscott	Non-Executive Director
Susan Liburd	Non-Executive Director

In attendance:

Dr Kate Wood	Medical Director
Melanie Sharp	Deputy Chief Nurse
Jennifer Granger	Interim Associate Director of Quality Governance
Ashy Shanker	Deputy Director of Planning & Performance
Diana Barnes	Governor (Observer)
Fiona Moore (Item 303/22)	Head of Quality Assurance
Jane Warner (item 289/22)	Associate Chief Nurse, Midwifery, Gynae & Breast Services
Donna Smith (item 290/22)	Associate Chief Nurse, Community & Therapies
Denise Gale (item 291/22)	Associate Director of Cancer
Simon Buckley (item 295/22)	Associate Chief Nurse, Medicine
Vicky Thersby (item 296/22)	Head of Safeguarding
Laura Coo	PA to the Medical Director **(minute taker)**

283/22 Welcome and Apologies for Absence

Apologies for absence were received from: Ellie Monkhouse (Mel Sharp to rep), Ian Reekie, Peter Reading, Shaun Stacey (Ashy Shanker to rep), Kelly Burcham

284/22 Opening remarks

Fiona Osborne welcomed members to the meeting and advised of a slight change to today's agenda. Matthew Thomas had stepped in to support the Cancer Transformation work and so it was decided it would be beneficial to defer the colorectal cancer paper until January until Mr Thomas had caught up with the service.

Fiona had listened to feedback from the last meeting and acknowledged the format did not fully work however there was no contingency for extra time today. Papers would still be taken as read but presenters would be asked if there were key points they wanted to highlight before going into questions.

285/22 Declaration of Interests

The Quality and Safety Committee would not be quorate until Dr Kate Wood was in attendance therefore any decisions would be made once Kate had joined the meeting.

There were no declarations of interest related to any agenda item.

286/22 To Approve the Minutes of the Previous Meeting held on 25 October 2022

The minutes were accepted as an accurate reflection of the previous meeting.

287/22 Matters Arising

The draft CQC report has been received and has been reviewed by the Executives for matters of accuracy. The final CQC report was due to be published in early December and at the next meetings we'll receive an update on next steps.

288/22 Review of action log

175/22 – DOLS - an update would be provided with the agenda item from Vicky Thersby.

197/22 – Pharmacy & 202/22 - Nursing Assurance – Both actions had been transferred to the Chair of the Workforce Committee however the next meeting had not been held yet.

258/22 - Risk stratification – This would be presented at the December meeting

259/22 - CNST update – no update received
Action: Laura Coo to send a reminder to Preeti Gandhi

262/22 – Nursing Assurance report, Press Ulcer Deep Dive – This would be included in the workplan review meeting with Fiona Osborne, Kate Wood and Ellie Monkhouse once Ellie was back from leave.

263/22 – Annual SI reports, Power BI reports – Fiona Osborne had spoken to Shauna McMahon who did think Ulysses had the ability to create the reports and would be in touch with Kelly Burcham to look at how they could be accessed.

269/22 – Register of External visits – Jennifer Granger would discuss the closure report later in the meeting.

274/22 - BAF discussion – Fiona Osborne discussed the concerns raised with Helen Harris and Linda Jackson and it would be reviewed in December.

Jane Warner joined the meeting at 1.35pm

Kate Wood joined the meeting at 1.40pm. (The meeting reached quoracy)

Regular Reports

289/22 Ockenden update

Jane Warner referred to the document distributed which was taken as read and highlighted the key points. This was still work in progress, some of the things outstanding i.e., the personal support plans would be going to the Divisional Governance Meeting on Friday week.

Jane invited any comments or questions.

Susan Liburd referred to IEA 4, Managing Complex Pregnancy and wondered what governance process needed to be completed and if they were Leeds or ours. Jane updated that there was lots of work ongoing, they had appointed a lead consultant and a consultant midwife so everything was coming together but was not yet functioning, we already refer into Leeds and Sheffield, but it would not change drastically to what we already have. Sue asked about Fetal Medicine and Jane informed that the Trust already had a Fetal Medicine Consultant, Lawrence Roberts who worked part time and did already refer to Leeds when required.

Fiona also asked about the Audit 1% notes comment which was mentioned under IEA %, Risk Assessment through Pregnancy. Jane explained that it was an expectation that audits were undertaken which was between 40 and 50 cases, time was the biggest challenge. They needed an SOP writing which had to be embedded and they were now at the audit stage.

Kate Truscott joined the meeting at 1.43pm

Fiona Osborne asked about the East Kent report and what the next steps were as it was not clear, but knew it was all about communication with staff members as to what went wrong. Jane informed that we were still waiting to hear about how this was going to play out but did know we were challenged with cultural issues and were already doing lots of work to address that, it had been discussed and shared widely with staff and posters were displayed. A few years the Trust took part in a score survey which was being repeated and Jane was keen to do that again and would be more than happy to be that person.

Jane advised the Trust has a pastoral support Midwife in post who supported the younger Midwives. Looking for staff themselves to have a behavioural charter so they can set that bar of what would be acceptable behaviours also linking in with the Royal College of Midwives. The Team had also met with the LMS to see if there were any massive flags that needed highlighting now, but they did not have any initial concerns. Jane was aware it was going to be extremely challenging perhaps more so than Ockenden as that was more black and white. Work was continuing with the Maternity Voices Partnership which they were keen to ensure was maintained as the woman's voice was important

Kate Truscott mentioned that the Maternal Medicine Centre in Leeds was such a long way away and wondered how that was working out, was there anything that could be done in partnership with Hull. Jane advised that Hull was already a unit we referred into as it is a tertiary centre, as well to Sheffield and Hull depending on the patient needs.

Question 48 a gap analysis Kate Truscott wondered what it showed. Jane advised that NLaG were lucky to have a Consultant Midwife when many Trusts did not and were committed to leadership development. It was recommended that we should have a Director of Midwifery, but Jane was the Associate Chief Nurse and did not think that the title stopped her having a voice with the Board.

Fiona felt confident this was being well managed and did not think there was anything to highlight to the Board. Fiona asked if the next report could show what had changed since the last report.

The committee thanked Jane for the update and were assured.

Donna Smith joined the meeting at 1.50pm

Jane Warner left the meeting at 1.51pm

290/22 End of Life update

Donna Smith referred to the document distributed which was taken as read and highlighted the key points. In terms of the report Donna felt as a Project Group they had reached a natural hiatus and were waiting for advice from the CQC report on what to move forward on.

Recognising when people were dying was a real focus as well as looking at the documentation for EoL patients. They had a problem with how to collate the data to get the best from that. Also, recognising that our consultants needed to be skilled in communication in terms of people who were dying was a focus.
The four key areas of priority were:

- Recognition
- Communication
- Feedback
- Documentation

Fiona Osborne commented that on the project plan there were a lot of actions that were out of date and asked if they had the support admin wise from the project team and if that would be re-baselined shortly. Donna agreed that the project plan needed re-baselining, and this would be looked at shortly. Donna expressed that she felt current project support was sufficient.

Sue Liburd commented about the recognition for EoL and asked if there was a particular stakeholder group, they wanted to focus on in terms of advance care planning. Donna felt it needed to be a joint process and responsibility for medical and nursing.

Ashy Shanker asked if there was a single EoL implementation group that took things like this forward. Donna explained that internally there was an operational group that feed into the governance groups, but they had limited ability to access the Wards, there was also a joint EoL group which included CCG's. A workshop was going to be held early next year to bring everybody together.

Kate Truscott asked about the training, the training package and the assessment tool. Donna informed that in relation to training and education there was a package tool available through ESR but as part of the refresh Donna felt they needed to look at what

was mandatory training in terms of EoL, and they needed some time to consider what needed to be updated.

The Pain assessment (item 3.4) on the implementation had a date of 2021. Donna apologised that was completely out of date and would be updated as part of the refresh of the EoL.

Kate Truscott asked about the matron post and whether anybody had been appointed. Donna informed that somebody had been appointed but only as a secondment, so it was only temporary.

Kate Truscott asked if the EoL newsletter was a one off. In response Donna advised that was a big publication that went out earlier in the year and was a one off however Donna had not been with the organisation that long so could not be certain.

Denise Gale joined the meeting at 2pm

Referring to the operation EoL group, whilst it was well attended Kate Truscott thought that stakeholders needed to make sure they heard the voice of the patients and families so absolutely needed to get that tied in. Donna added they do work well with the hospices at North and North East Lincs sides.

Fiona Osborne added that as part of the refresh one of the recommendations would be that stakeholders would be included.

Kate Wood informed that community partners, hospices, GPs and that piece of work was on going and the integration of pathways was looked at in detail and developed. Kate Wood was aware that Kate Truscott, Sue and Donna were not aware of what had gone before as they were all new to the organisation, but Kate Wood did provide an update on EoL through the IPR to the board regularly. However, Kate Wood agreed this was an opportunity to do a refresh and Donna had done the right thing to look at this and look at the patient focus. Donna was reviewing everything to consider ways to improve and identification of EoL was one of those things that could be done better. Although documentation needs to be improved, we are good once we have people on the pathway.

Action: Laura Coo to set up a meeting with Kate Wood and Sue Liburd to update Sue on the history of the EoL work and to include some of the EoL team.

Kate Wood thought we needed to support the EoL team with their priorities and there was going to be a need for some additional support for that as this was a small team and this was a real focus for NLaG as an organisation. Kate Wood thanked Donna for leading on this.

Fiona asked what the timeframe was for this piece of work. To be able to do it properly Donna thought it needed three months and they needed to see what the CQC report said to be able to make sustainable change they needed that time. Fiona would include in the highlight report to the Board that there was being a refresh for EoL and would be the potential for further monies being required.

Donna Smith left the meeting at 2.09pm

291/22 Cancer & Learning

Fiona Osborne explained the responsibility for the tumour site pathways falls to the clinicians presenting the pathway papers however the transformation work helps inform us to better understand those presentations . This paper assists the Committee to get a better understanding of how the action plans contribute to improved patient quality of care both psychological (e.g., reduction in waiting times) and physical and to receive information on bottlenecks or risks in the Transformation Programme that we may be able to assist with by either highlighting to Board and/or questioning the cancer site pathways.

Denise Gale referred to the report distributed which was taken as read and highlighted the key points.

There were a lot of challenges across all cancer pathways, in all tumour sites and it became very complicated. There was a hold up with diagnostics and the biggest bottle necks were turnaround times. The NLaG target for turnaround was fourteen days but needed to be seven days from request to test to be in line with the National standard Best Practice Timed Pathway (BPTP). A lot of the cancers ended up with two or three diagnostic tests, so they tended to do them sequential rather than at once so that added on another fourteen days each time to the patient diagnostic pathway. This increased the possibility of psychological harm to the patient.

To meet the best practice time pathways Mick Chomyn advised they needed to go to seven day working for pathology. This proposal had been presented in the 2022/23 Operational planning process but had not been successful. At that time cancer pathways were performing better but had been impacted this year. The paper would be represented in the 2023/24 operational planning process. Denise had flagged that lung had made some significant changes to their pathway and had increased by approx. 20%.

Kate Truscott commented that it seemed so stark that we needed seven day working it would seem there was a solution and was just about affordability. Denise had discussed with Mick Chomyn and thought part of the problem was that although Pathology sat with NLaG it was under East Midlands and as part of East Midlands they did not get the same consideration for funding which needed to be addressed.

Ashy Shanker added that this was one of the highly prioritised business cases that was submitted, there was a five-day service in place and this was about going to seven days and they had prioritised this and hoped this time round it should improve. In terms of funding, it was looking at what could be done at ICS level and through the Cancer Alliance, there were some quick wins but at a fundamental level there would be some priorities. Mick Chomyn had already put forward some bids for funding to East Midlands and the Cancer Alliance but was not successful. Denise would feedback today's conversation to Mick Chomyn.

Upper GI and Head and Neck were both pathways where there was a significant amount of staging which would all impact on our patients, but the capacity issues at Hull did not allow us to transfer the patients which hindered our performance in getting the patients within the 62 days.

Fiona Osborne felt there were two items to highlight to board.

- Recommendation to adopt the National standard Best Practice Timed Pathway of seven days rather than fourteen
- Commend the proposal for 7-day pathology in the 2023/24 operational planning process.

Denise had provided a copy of the highlight report and the slides (appendices) that went to the Cancer Board and asked if there was anything else that would be helpful.

Ashy Shanker added that they were also supporting cancer PTL for patients waiting longer than 62 days so once they had done that initial analysis, they could provide that report for assurance too.

Fiona thanked Denise Gale for the update.

Denise Gale left the meeting at 2.26pm

292/22 Colorectal Cancer

This paper was deferred.

293/22 External Visits Closure Paper

Jennifer Granger referred to the External Agency Visits Closure Form distributed as an item for AOB which was taken as read and highlighted the changes/updates.

Jennifer explained this was the interim external screening for the antennal programme which happened earlier in the year and was more of a data collection process before the visit and there were no formal action plans following it. This just related to the interim data collection. Kate Wood was happy to support closure and Fiona Osborne supported that.

294/22 New-born Audiology Issue - update

Kate Wood advised at the last meeting that she had received a letter about some concerns raised with regards to the Trusts low reporting rates for issues relating to neonatal audiology. Kate had concerns on new-born screening putting context to that there was an incident in East Lothian for screening. Our Trust was designated as a low reporter, there was some work done earlier this year by the national team and we were gaining some assurance from them that we were ok however after further work they were concerned we were a low reporting, Trust. A Deep Dive was being done with our support and with the full knowledge of our Commissioners and Kate had informed the CQC of this too. One SI had been declared regarding new-born screening and there was a potentially another. Right now, we do not fully understand or know the scope of the issue but this could be a national media concern. Kate had specifically asked the question on two separate occasions to Public Health and the Commissioners if there was anything we needed to change now however they had assured the trust there is no immediate risk to patient safety and services can continue during the investigation process.

The first part of the investigation would be the 90-case public review which they were already doing. Although there was no expectation or recommendation for any actions by NLaG at this stage Kate Wood had done more. Kate had encouraged the Regional Audiology Lead to visit who made some suggestions Kate had already delivered about

technical equipment. She had also networked one of our Audiologists with another organisation and they were going to visit.

Kate was happy to take any questions.

Sue Liburd asked what Kate's main worry was. Kate Wood was worried that some children could have been missed due to the NLaG referral rate being below the national average however it could be that there was not a problem. Kate could not do anything about the referral rate but could look at preparing the service for the future providing support for the team which was very fragile. The team only has four people so Kate thought we needed to be very careful that we did not make them feel vulnerable in this. Kate's worry was about the staff as there were a lot of unknowns at this stage.

Fiona Osborne asked when this committee should be looking at this next in terms of gaining assurance. Kate thought two/three months would be right and could provide a written paper. Jennifer Granger agreed that three months was realistic.

Action: New-born Audiology update to be added to the QSC workplan for February 2023.

This would be monitored through QGG, and Fiona suggested for it to be included in the QGG highlight reports.

Action: Jennifer Granger to advise QGG on the requirement to monitor and highlight the New-born Audiology work.

Simon Buckley joined the meeting at 2.35pm

295/22 Diabetes Management

Simon Buckley referred to the report distributed which was taken as read and highlighted the key points.

Simon informed that this audit was initiated after an incident in DPoW ED in September 2018 with a tragic outcome. At a previous QSC it was agreed to move the adult monitoring away from monthly monitoring and into Divisional quarterly audits as monthly monitoring had reached the targets consistently. This paper recommended moving paediatric monitoring in the same way. There was some maintained improvement at DPoW and in the last three months at SGH too, but Simon acknowledged it had not stayed within the 95% target.

They continued to report any cases of DKI incidences for sharing.

Fiona Osborne mentioned that when it was agreed that adult monitoring would come out of the monthly monitoring, there was a very high achievement and that was the standard they had based that decision on. She felt paediatric monitoring had not reached that consistent target.

Sue Liburd asked given the current achievement was at 86% why were we not waiting until we had three months at 95% why was the decision being made now rather than waiting until we had a higher percentage. Simon thought that was a good question and if the consensus of the committee was for the audit to continue to reach that higher

standard, they were happy to do that. Simon had some reflections on recent conversations and wondered whether we were continuing with the right standards and whether 95% was the right target. The departments had moved on with regards to more robust training and in relation to Paediatrics, the Manchester training an internationally recognised tool for triaging was not introduced then, had access to internal and external study days and have a closely monitored matrix, linked to the care of the Paediatric child. They had invested in clinical educators and Simon was confident there was a more robust governance process so his thoughts were are we doing the right thing continue to run the BM audit that we had run for so long. He recommended that the target was too high given the specific challenges with paediatric cases in the ED.

Kate Truscott asked why they would not want to hit the 95% target. Simon explained that recording a BM would not always be necessary but there had been a smaller number of cases where if we had recorded the BM there would potentially be a different outcome for those specific patients. Simon was happy to take Kate Wood and Mel Sharp's thoughts.

Fiona Osborne mentioned a conversation with Simon about the patient journey and recalled that the BM might be tested after the child had left the ED in another environment. The important thing was that that test happened and maybe it was about widening it to include the paediatric wards in addition to ED rather than reducing the target from 95%.

Kate Wood thought Simon had made a good point about where we were and where we are now. At that time there was a knee jerk reaction as our staff were not doing the BM's but now there had been a huge amount of education. For Kate the question was what was happening to those children where the BMs were not done, was there a clear rational that would give Kate the assurance to say we did not need to do that anymore. Kate's worry was that gap where we had not hit 100% was there a narrative that explained why the measure had not met that assurance. Simon's thought was how did we know the impact for those patients where it had not been done so had similar thoughts about whether the audits were looking at the right thing.

Ashy Shanker asked if the exception reporting was recorded anywhere else or would that be manual which would be difficult. Simon confirmed that recording the data was a manual process

Fiona commented that ultimately, we needed to ensure the tragic outcome in 2018 did not happen again.

Kate Wood proposed that we needed to make sure the audit was valued and valuable. Her view was that the audit continued for another three months and for those not achieved, there needed to be a narrative for those, and it would become business as usual and if not then we need to address that. Mel Sharpe agreed with Kate Wood but questioned what Fiona had said about the right time to test and did it need to be in ED but would consider a shorter audit. Another three months was agreed and would pick up a narrative for those children who were not tested.

Action: Laura Coo to update the workplan for this to come back in February 2023.

Simon Buckley left the meeting at 2.55pm

296/22 Safeguarding / Vulnerabilities Annual Report

Vicky Thersby joined the meeting at 2.50pm

Vicky Thersby referred to the report distributed which was taken as read and highlighted the key points.

Safeguarding needed to be more and more aware of what was coming through the front door and had a number of challenges over recent years with domestic violence, domestic homicide reviews due to the pandemic.

Late notifications of looked after children continued to be a pressure.

Some of the key achievements.

- Developing new ways of working
- All WebV referrals go directly to the local authorities
- Collaborating the safeguarding and vulnerabilities was one of the biggest achievements
- Four business cases were being put forward: Transition business case and pilot case
- There was a real focus on domestic abuse
- Focus on sharing and embedding learning and on our strategy as well

Vicky invited any comments or questions.

Kate Truscott thought it was an excellent report and asked about the passport for people with a learning disability and if there had been any progress with that. Vicky would get back to Kate with an update.

Sue Liburd thanked Vicky for the report and noted one of the points was around depravation of liberty and asked what the impact of that was. Vicky thought it was important that we had that assurance and the team would be focussing on a back-to-basics approach to ensure delivery.

Fiona Osborne asked about the Paediatric liaison role and asked if the risk rating associated with it would change given the extensive mitigations that had been put in place. Vicky had looked at a number of controls and mitigations and reviewed it with Ellie Monkhouse and the score was to be reduced. Fiona asked if that business case would be raised again for the 2023/24 operational planning process. Vicky would like to put another business case in.

Fiona noted that in the slide presentation Vicky talked about a domestic abuse post and about a main lead and asked if that was something that had come about since the annual report had been written. In response Vicky advised that they were looking at what services were needed and that needed to be a separate post for the collaborative side although they covered domestic abuse within their roles Vicky thought it needed to be a more focused role.

In terms of timings and the business case Ashy Shanker asked what timeframe Vicky was thinking of. Vicky expected it would be January. Ashy asked if Vicky could send it through to her and she would try to get t it through quicker

Mel Sharpe added the numbers for domestic abuse had increased as they now included our staff too.

Kate Truscott noted the looked after children initial health assessment figures were low and asked if that was our responsibility. Vicky confirmed it did fall within our responsibility and had already been added to the risk register, the local authority should notify us within 48 hours of a child going into care which was not always happening which impacted on us but that was not say we had not got oversight of the children and Vicky was assured that our named nurses had the mitigations in place.

The report was now going to board and Fiona, Sue and Kate Truscott felt assured.

Fiona requested for next year's report for the achievements to be aligned to the key priorities for that year so it was clear where/what was not able to be delivered and what this Committee could do to support that.

Vicky Thersby left the meeting at 2.11pm

297/22 Nursing Assurance Report

Mel Sharp referred to the report distributed which was taken as read and invited any comments or questions. Her key points to note were:

- Recruitment was positive, had 130 successful offers for Health Care Assistants (HCAs) so now needed to look at retaining staff.
- Falls, pressure ulcers and MRSA had reduced
- Complaints – featured in the report as they were challenging from an assurance point of view mainly because of the complexity of them. Had found a lot of the complaints were from bereaved relatives. Our complaints manager was back in post after being on long term sick and they were already seeing an improvement.
- From an infection prevention control perspective had the challenge of *C. Diff* targets and had exceeded our Pseudomonas target.

Kate Truscott thought it was great news about the HCAs and asked when they would be on the Wards. Mel advised they were still going through the recruitment process so were not on the Wards yet. They attend a care camp and were currently going through that process but 130 would make a big difference. Kate Wood suggested for Kate Truscott to take this through workforce about the length of time taken from recruitment to getting people in post.

Kate Truscott thought it was great to see the 15 steps and that there did not appear to be any hotspots highlighted in this report.

The quality improvement plan for safe secure medications were picking up the odd lapse but they were being addressed at the time.

Sue Liburd confirmed that all Workforce items would be addressed at the Workforce Committee next week. Issues around the risk with recruitment sat with this Committee but the detail sat with the Workforce Committee.

Fiona Osborne commented that the sickness rates on Amethyst and Ward 17 continued to be high and knew there was a lot of intensive support work that had gone on and wondered if there was any more that could be done to address it.

In terms of Amethyst Mel informed that they now had two very experienced leaders in post for support which they hoped would make a difference.

298/22 IPR

Kate Wood referred to the report distributed which was taken as read.

Kate was most concerned about the weighing of patients. Now with the opening of the new ED they had scales for when patients came in on the trolleys but not everybody wants their weight documenting for various reasons, and we do not have the right equipment to be able to do it. Different approaches are being looked into to address this differently and needed to consider how the teams were supported to do this, but we needed to do something different.

Sepsis – A lot of notes were still being checked looking at undiagnosed sepsis but now needed to look at how this could be done electronically as currently it was recorded manually so the escalation for this was to be able to provide more support to Debbie Bagley who heads up the sepsis group to be able to provide some sort of delivery on this.

Kate invited any comments or questions.

Ashy Shanker asked if it was worth having a conversation with WebV etc to make this a priority.

Regarding weighing patients Mel Sharp had just completed a screening audit and was happy to share the findings from that, they did have their Nutrition Support Nurse too but agreed we need to do something differently.

What concerned Fiona Osborne was the actual rates recorded compared to the estimated and asked why it had deteriorated so much. Mel agreed it was a challenge to record the actual and estimated weights. Fiona commented that weighing patients should be considered under the Quality Priorities for 2023/24. This would be discussed later in the agenda

Kate Truscott wanted to understand the Pseudomonas comment that it had exceeded as she was not sighted on that, but Mel would pick that up with Kate outside of this meeting.

299/22 Key SI Update including Maternity

Jennifer Granger referred to the report distributed which was taken as read summarised the key points.

There were no new Maternity SI's or new key SI's reported however since the last meeting a Never Event had been declared about retained swabs, but this was in the very early stages. The incident happened a year ago but had only just been found. Kate Wood noted that the foreign object had been removed, the patient affected was fine and duty of candour was applied. Fiona Osborne asked about the ergonomist report which gave a lot of recommendations and asked how we ensured that was being followed. Kate Wood pointed out that this happened prior to the ergonomist report and all the recommendations from that report would support it not happening again.

Sue Liburd asked how the Trust was assured on the SI process. Jennifer informed that there were weekly SI meetings chaired by the Deputy Medical Director which were always well attended and everything was kept on the radar, although Jennifer acknowledged there could be more depth in the report to give more assurance of the processes that were in place and the target dates.

300/22 Annual CLIP Report

Jennifer Granger referred to the paper distributed which was taken as read.

Key themes across all areas were.

- Documentation
- Treatment and Management of Care
- Communication
- Discharge

Medication and Fluid management was no longer a theme.

24 new SI's had been reported on STEIS, 16 of which were pressure ulcers, there were no Never Events at the time of writing the report although as Jennifer had just mentioned there had been a retained swab Never Event reported.

Jennifer invited any comments or questions.

Fiona Osborne noted that the TPN audit had low assurance and asked if it was possible to understand what had happened there. If something shows low assurance, it would be helpful to have an explanation as to why that was the case.

Mel Sharp added that the TPN audit would be undertaken next year, they had changed the way the audits were being undertaken and it was a more detailed approach, that audit would be in February.

Fiona Moore joined the meeting at 3.35pm

Fiona Osborne comments that it would be useful to have reports on the efficacy of changes in areas that had been removed from the report after previously being reported wondered if that kind of review would be possible. Jennifer said she would look into this.

Action: Fiona Moore to look into the suggestion from Fiona Osborne

301/22 Potential Deviations from National Documentation

There were none to discuss

302/22 CQC Framework

Jennifer Granger referred to the paper distributed which was taken as read and highlighted the key points.

There had been a number of changes within the report, and it now included the updates that had happened within the report. Had taken out all the historical detail and focused

on what had changed in the last month and included updates within the actions that were rated as green to give a very transparent message.

Actions

- One action had progressed from amber to green due to an increase in compliance for Mandatory Training.
- Two position papers were submitted to the CQC however that had not resulted in a change to the rating, and they remained green; EoL Governance and out of hours medical staffing

Had received the draft report for CQC in October which had been returned for factual accuracy and we were now waiting for that to come back through.

Fiona Osborne thanked Jennifer for the more focused report it was a lot easier to see what had moved forward.

Kate Truscott noted there were several mentions of the assurance reports that was being reviewed by the Execs and asked if Jennifer could expand on that. Jennifer explained that the process was once the Divisions Felt they were ready they completed the assurance paper which then went to Jennifer, then Governance level and then to Execs. There was a process of gathering the evidence before going back to the Execs and finally to the CQC if appropriate, sometimes that was not a quick process. It very much varied on the level of the issue for example if there needed to be an audit it could take up to a few months.

Ashy Shanker added that one of the risks was about identifying recurring cost and thought perhaps they could look at whether that aligned with the operational planning process for this year-round. Jennifer thought that linked in with the financially strategy and was the most appropriate statement to add.

Kate Wood added that the process for collating evidence was very clear, and everybody was aware of the process. Since Kate had taken over assurance for CQC, Kate ensured we had the evidence which took hours of everybody's time but was the right thing to do and was an ongoing piece of work. The other thing to consider was that if everything was implemented that was recommended by the CQC we would need £8 million, so we then prioritised what we needed and presented that to the Commissioners to confirm and highlight what they did not want to fund, and that same strategy would be undertaken again this year.

Fiona Osborne wanted to raise 25 - EoL, lack of matron assurance and effectiveness of analgesia as compliance in the IPR is worsening. Jennifer agreed and thought that needed to be downgraded from green to amber.

303/22 Quality Priorities

Fiona Moore referred to the paper distributed which was taken as read.

The paper outlined the top five priorities that were chosen, there was quite a lot of opportunity to prompt people, but engagement was low compared to the previous year. Interestingly weighing and prescribing did not come in the top five however the top priority to the public is what is perceived to be a risk so may be an opportunity.

In terms of next steps meetings had been set up with various groups.

Fiona invited any comments or questions.

Kate Truscott asked Fiona Moore to recap who the stakeholders were and given there were only 85 responses was there anything that could be done differently. Fiona Moore advised the stakeholders were all staff, public Facebook, Health Watch and ICB colleagues as well as Governors. Fiona Moore though perhaps because the previous time was during the pandemic and people were at home more engagement was better and on reflection thought maybe Twitter could be used to improve engagement.

Highlight reports

304/22 Quality Governance Group (QGG)

The highlight report distributed was taken as read.

Jennifer Granger did not think there was anything that needed to be discussed here by exception from QGG.

305/22 Mortality Improvement Group (MIG)

The highlight report distributed was taken as read.

Items for information

306/22 Quality Governance Group (QGG) minutes

Distributed for information

307/22 Mortality Improvement Group (MIG) minutes

Distributed for information

308/22 Any Other Business

Nothing raised

309/22 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

Fiona Osborne agreed to add the following points to the highlight report to the Trust Board.

- Diagnostic time for Cancer referrals
- Business case for seven day working

310/22 Meeting review

The revised format seemed to work better and would be followed for the next meeting.

311/22 Date and Time of the Next Meeting:

The next meeting will take place as follows:

Date: 20 December 2022
Time: 1.30pm – 4pm
Venue: Via MS Teams

The meeting closed at 4pm

Annual Attendance Details:

Name	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	March 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022
Michael Proctor	x	✓	✓	✓	x	✓	✓	✓	✓	✓	✓			
Michael Whitworth	✓	✓												
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maneesh Singh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓		
Dr Kate Wood	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓
Ellie Monkhouse	✓	✓	x	✓	✓	✓	✓	✓	✓	x	✓	x	✓	x
Dr Peter Reading	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	x	x	x	x
Angie Legge	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Jennifer Granger												✓	✓	✓
Helen Harris	x	✓	x	x	x	x	x	x	x	x	x	x	x	x
Jan Haxby	✓	x	x	x	✓	✓	✓	✓	x	x	✓	x	x	x
Shaun Stacey	x	x	✓	x	x	x	✓	x	x	x	x	✓	✓	x
Susan Liburd													✓	✓
Kate Truscott													✓	✓

NLG(23)030

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 7 February 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 Assurance Report**
Purpose of the Report and Executive Summary (to include recommendations)	The Board is asked to note the content of the report. The overall CHPPD was 8.5 in November. Safer Nursing Care Tool data shows increases in patient dependency on all 3 sites over the last 3 years. The Midwife to Birth ratio data for DPOW is 23.3 and SGH for 22.4 which is below the acceptable ratio of 1:28. Findings from the establishment review using the Birthrate Plus workforce planning tool was presented to TMB in November and shows the Trust is complaint with Birthrate Plus calculations. Vacancies on the inpatient wards in November for Registered Nurses and Healthcare Assistants show a decrease. There is a total of 236.41 WTE (12.76%) Registered and 128.10WTE (13.29%) Unregistered vacancies across the Trust. Recruitment and retain work remain a priority. The Trust is on track to recruit 90 international nurses by December 2022 and international midwife recruitment has commenced. A total of 41 nurse staffing red flags were reported in our hospitals compared to 82 in October. Some fluctuation is seen month by month. For Community 9 were reported which is the same as the previous month. The total number of falls reported in November 2022 has decreased across all 3 sites to 102 from 122 in October. In acute the number of pressure ulcer incidents reported has increased slightly for the second consecutive month however, there has been a sustained improvement in the number of pressure ulcers reported over the last eight months. In Community the incidence of pressure ulcers has seen a slight decrease in November 2022 from 39 to 31, however this is a notable reduction from June, July and August 2022. New formal complaint numbers continued to reduce, with 21 received during November. At the end of November there were 61 open complaints compared to 96 in Oct, a reduction of 36% and 39 complaints closed. The ongoing work to address complaints over 60 working day timescale has resulted in a further reduction of over 50% in November. Trust wide the number of new PALs concerns received was 167, a further decrease compared to October.

	November saw the overall organisational FFT response rate increase to the highest total of the whole year. The Patient Experience Manager is now actively meeting areas with identified actions for each area to increase their responses and staff engagement In November the Trust had eight mix sex breaches which involved 2 patients Twelve acute 15 Steps Challenge visits were completed during November 2022. Ten in the acute and two in Community and Therapies The Trust is performing within the expected parameters for mandatory organisms. It is unlikely that the case threshold of 21 for C. difficile will be met as the Trust has reported number of 19 cases so far. The QI Showcase, a hub portal to capture QI projects from across the trust, successfully launched in November 2022 with a total as of December 2022 of 127 project logged (back dated) in the past 12 months. 32% have shown measurable signs of improvement with a further 21% actively testing ideas with the other 47% in the early stages of staff and patient engagement and ideas generation.	
Background Information and/or Supporting Document(s) (if applicable)	NA	
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

Assurance Report January 2023 (November data)

1.0 Introduction

This is a routine report in accordance with the requirements of the updated National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance (July 2016), the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014 and Developing Workforce Safeguards (2018).

Trusts must ensure the three components are used in their safe staffing processes:

- evidence-based tools (where they exist)
- professional judgement
- outcomes

The Trust is committed to providing safe, effective, caring, responsive and well led care that meets the needs of our patients. It is recognised that decisions in relation to safe clinical staffing require a triangulated approach which consider Care Hours per Patient Day (CHPPD) together with staffing data, acuity, patient outcomes and clinical oversight. This report provides evidence that processes are in place to record and manage nursing and midwifery staffing levels on a shift by shift basis across both hospital and community settings, and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care, thus enabling the Trust to demonstrate compliance with safer staffing guidance. It also seeks to provide information on vacancy rates and nursing metrics across all ward areas.

Oversight continues to be provided to the Quality and Safety Committee on nursing and safe staffing. The changes to ward configurations and zoning throughout the pandemic has made it challenging to make comparisons and benchmark. It is worth noting that this will affect any Model Hospital metric comparisons.

As we continue to reset ward configurations and utilise escalation beds across the Trust, any data should be viewed with caution and for this reason we continue to review individual metrics and apply professional judgement. In line with the document published in February 2021, Deployment and Assurance of Clinical Nursing Workforce during Covid 19 emergency, Quality impact assessments are undertaken with final sing-off by the Chief Nurse prior to additional wards being opened.

The Nursing Metrics Review Panel is chaired by the Chief Nurse, meets monthly and is attended by the senior nursing team for the organisation. The panel review the information provided by the nursing dashboard and commission any work required to investigate and support any areas of concern.

2.0 Safe Staffing

2.1 Shift Fill Rates and Care Hours per Patient Day (CHPPD)

The information presented shows data on inpatient wards only.

Shift Fill Rates Summary Nov 2022

Overall

95.9% ▲ 5.4%

Registered Nurses and ...

98.7% ▲ 5.9%

Care Staff

91.5% ▲ 4.7%

Overall Fill Rate

Fill Rate by Staff Group

Overall Fill Rate by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Nov 2022	DPoW	94.7%	5.0%	89.7%	
Nov 2022	GDH	93.0%	-8.1%	101.0%	
Nov 2022	SGH	97.7%	7.5%	90.3%	

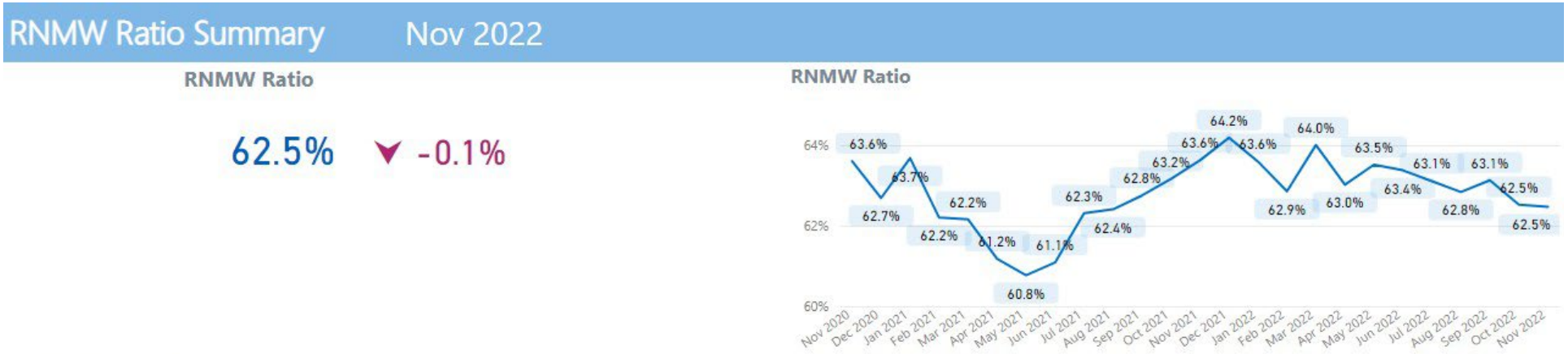
Overall Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Nov 2022	Medicine	98.1%	3.7%	94.4%	
Nov 2022	Surgery & Critical Care	93.8%	4.4%	89.4%	
Nov 2022	Women & Children's	92.8%	11.1%	81.7%	

Shift fill rates are reported against ward establishments. Staffing reviews take place at intervals throughout the day, including a trust wide review of SafeCare Live information at 10am.

The Chief Nurse establishment review is planned for Q3/4 of 2022/23. The Safer Nursing Care Tool (SNCT) data was collected during May/June 2022 following the increase in establishments and collected again 20 days during October/ November to account for seasonal variation. Meetings will be held with ward and department managers to review the SNCT data and nurse sensitive indicators.

The graphs above show the fill rate trends from the Nursing Assurance Dashboard. The combined fill rate shows some variance from month to month, in November being 95.9% just above the target of 95%.



RNMW Ratio by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Nov 2022	DPoW	59.7%	-0.4%	60.1%	
Nov 2022	GDH	58.0%	-1.2%	59.2%	
Nov 2022	SGH	66.2%	0.2%	65.9%	

RNMW Ratio by Division

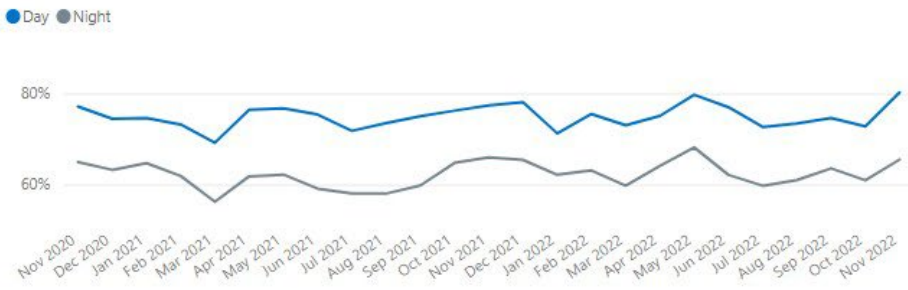
Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Nov 2022	Medicine	56.6%	-0.1%	56.8%	
Nov 2022	Surgery & Critical Care	70.3%	-1.8%	72.2%	
Nov 2022	Women & Children's	68.8%	1.7%	67.1%	

A mix split of 60:40 is aimed for, with a higher skill mix for midwifery. Registered Nurse and Midwife to HCSW ratio for the Trust has been above 60% for the last year. Medicine remains the lowest RN ratio in November at 56.6%. Surgery & Critical Care has the highest RN ratio and is reflective of the number of level 2 and 3 beds within the division.

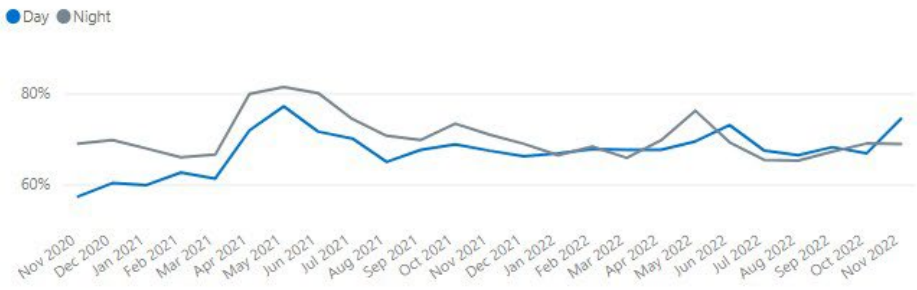
Substantive Fill Rates Summary Nov 2022

RNMW - Day		RNMW - Night		Care Staff - Day		Care Staff - Night	
80.2%	▲ 7.5%	65.5%	▲ 4.6%	74.4%	▲ 7.6%	68.9%	▼ -0.1%

Registered Nurses and Midwives Substantive Fill Rate %



Care Staff Substantive Fill Rate %



RNMW - Day Substantive Fill Rate by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Nov 2022	DPoW	80.8%	6.8%	74.0%	
Nov 2022	GDH	70.0%	-21.9%	91.9%	
Nov 2022	SGH	80.6%	11.3%	69.3%	

RNMW - Day Substantive Fill Rate by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Nov 2022	Medicine	80.3%	7.1%	73.2%	
Nov 2022	Surgery & Critical Care	81.3%	0.3%	81.1%	
Nov 2022	Women & Children's	78.8%	16.7%	62.1%	

Wards with Substantive Fill Rate Below 50% **Nov 2022**

Staff	
Day or Night	
Ward name	

Staff	Registered Nurses and Midwives	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
Ward C3	50.0%	▼ -7.9%
Clinical Decisions Unit	48.3%	▲ 7.1%
Ward A1	48.3%	▼ -0.1%
WARD C5 DPoW	36.7%	▲ 7.7%
Gynae Assessment Unit	33.3%	▼ -31.6%
WARD 17 SGH	26.1%	▼ -4.3%
WARD 3 GDH	16.6%	▼ -22.1%

Staff	Care Staff	
Day or Night	Day	
Ward name	Substantive Fill Rate %	Change
Stroke Unit SGH	47.7%	▼ -0.5%
LAUREL WARD DPoW	42.0%	▲ 5.4%

Staff	Care Staff	
Day or Night	Night	
Ward name	Substantive Fill Rate %	Change
ITU DPoW	43.3%	
WARD 16 SGH	43.3%	▲ 0.8%
WARD 25 SGH	40.0%	
WARD 23 SGH	15.6%	▲ 4.8%
Ward 27 SGH	13.3%	

Substantive versus temporary staff fill rate is monitored and an increase in substantive staff fill rate is seen for both days (7.5%) and nights (4.6%) for Registered Nurses. A 7.6% increase is seen on days for HCAs.

No wards had a RN substantive fill rate less than 50 % on days.

On night shifts there were 7 wards with a fill rate less than 50% for RNs, this is an improvement to 13 wards in October.

Of the 7 wards that had RN substantive fill rate less 50%, only 3 of these featured in last month's report and are contained in the table below to triangulate with sickness and vacancy. None are raising concerns when triangulated with quality and safety data.

The information below demonstrates the level of sickness and vacancy in the areas with the lowest substantive fill rate.

Ward	Sickness	RN vacancy wte	HCA vacancy wte
C5	9.84%	3.08	2.27
Ward 17	6.93%	6.33	4.33
Ward 3	10.44%	2.46	0.25

CHPPD Summary Nov 2022

Overall

8.5 ▲ 0.56

Registered Nurse...

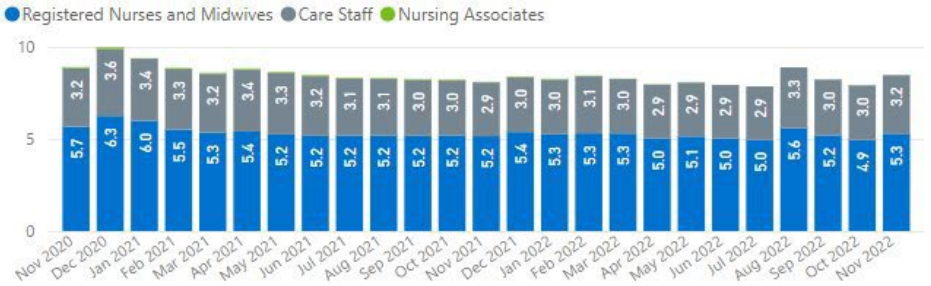
5.3 ▲ 0.34

Care Staff

3.2 ▲ 0.21

Overall CHPPD

CHPPD by Staff Group



CHPPD by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Nov 2022	DPoW	8.5	0.6	7.9	
Nov 2022	GDH	6.8	-0.3	7.0	
Nov 2022	SGH	8.6	0.6	8.0	

CHPPD by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Nov 2022	Medicine	7.2	0.4	6.8	
Nov 2022	Surgery & Critical Care	9.5	0.8	8.8	
Nov 2022	Women & Children's	12.8	0.9	11.9	

Wards with CHPPD Below 6.0 **Nov 2022**

Staff	Registered Nurses and Midwives		Care Staff		Nursing Associates		**Total**	
Ward name	CHPPD	Change	CHPPD	Change	CHPPD	Change	**CHPPD**	**Change**
WARD C2	3.0	▲ 0.07	3.0	▼ -0.14	0.0		**5.9**	**▼ -0.07**
NRC Nursing Team GDH	2.9	▼ -0.32	2.8	▼ -0.25	0.0		**5.7**	**▼ -0.58**
WARD 18 SGH	0.0	▼ -4.13	0.0	▼ -2.91	0.0		**0.0**	**▼ -7.04**

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.

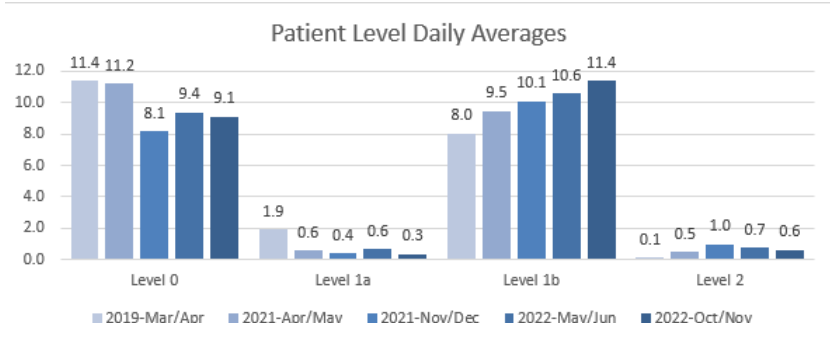
The overall Trust CHPPD was 8.5 in November. The latest model hospital data for October 2022 indicates a provider value of 7.9 (quartile 2 mid-low 25%) against a peer median of 8.1 and provider median of 7.9.

2.2 Acuity and dependency

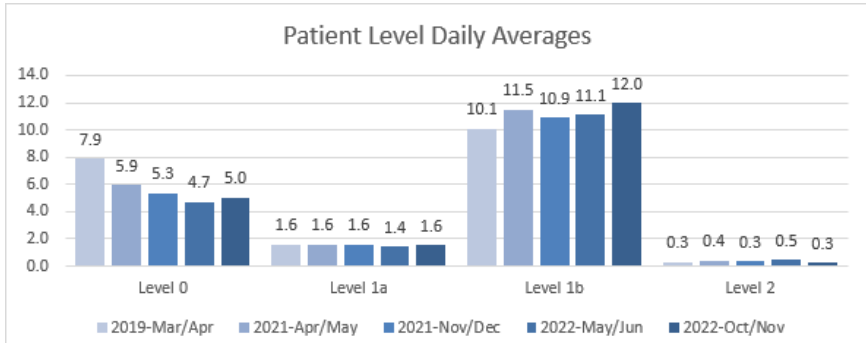
The Safer Nursing Care tool is an evidenced-based tool that supports Chief Nurses to determine optimal nurse staffing levels by measuring patient acuity and/or dependency.

The data below evidences the increase in patient dependency, by site over the last 3 years.

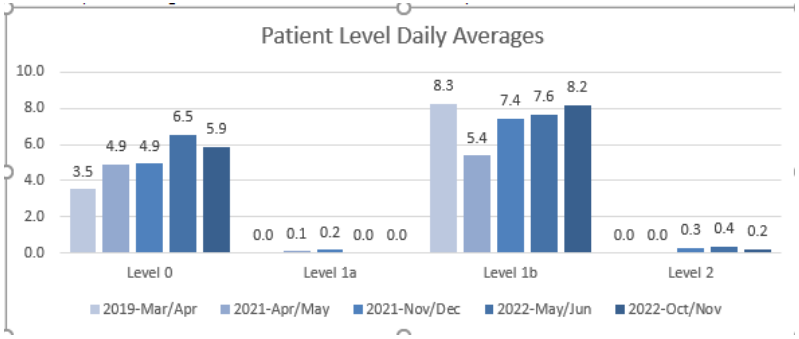
DPOW



SGH

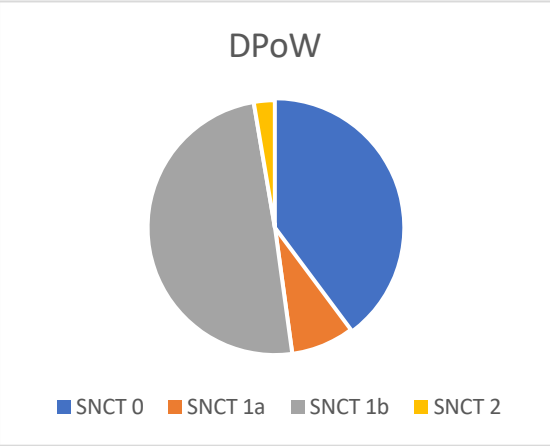


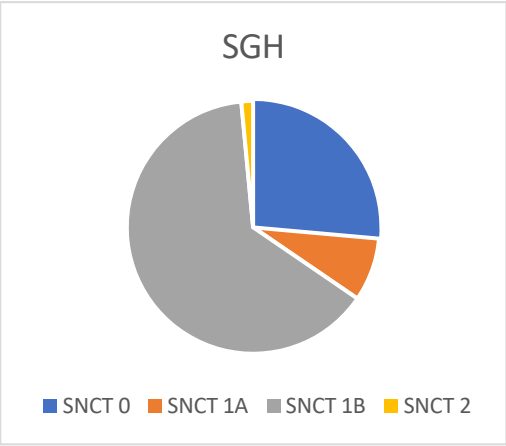
Goole

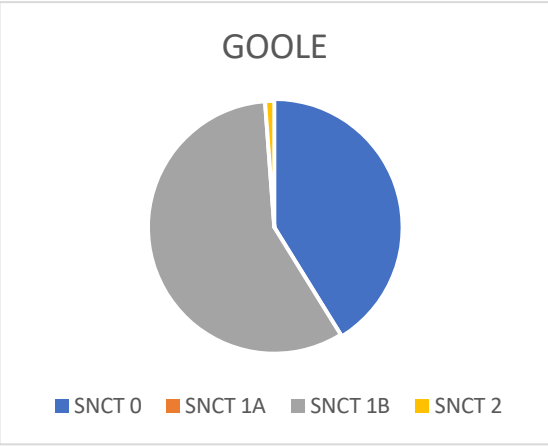


The charts below display the patient acuity level split across the site, with level 0 being the lowest acuity and level 2 the highest acuity.

A higher proportion of patients within our wards are level 1b who are dependent on nursing care to meet most or all the activities of daily living. This is particularly apparent at both Scunthorpe and Goole Hospitals.







Safer Nursing Care Tool levels of care:

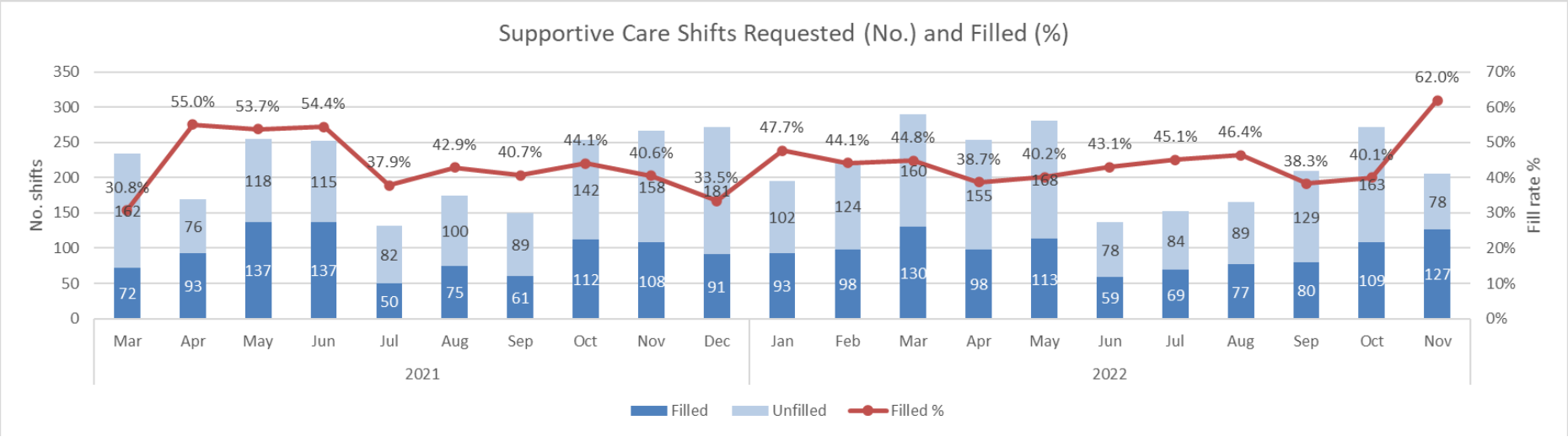
Level 0 - patient requires hospitalisation. Needs met by provision of normal ward care

Level 1a - Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate

Level 1b - Patients who are in a stable condition but are dependent on nursing care to meet most or all of the activities of daily living

Level 2 - may be managed within clearly identified, designated beds, resources with the required expertise and staffing level or may require transfer to a dedicated level 2 faculty/unit

2.3 Supportive Care



The wards are seeing an increase in the number dependent patients, several which require 1:1 supportive care. These shifts are not part of the ward establishment. Shifts are sent to the temporary staffing team to source unregistered cover via the Bank. Additional processes have been put in place for risk assessing our patients with tools such as AFLOAT to support prioritisation and decision-making regarding options available. All areas where 1:1 care need is identified have permission to access additional duties to try and cover this need. Additional allocate on arrival shifts are also booked centrally to help with providing a staff resource outside of the ward establishments to support 1:1 supportive care need. Matrons have a daily presence on the wards and can review patients and risk assessments and provide support and oversight of high-risk patients. This low fill rate impacts on the ward with core ward staff supporting. SafeCare Live supports deployment decisions which are based on the acuity and dependency of patients and available staff.

The above chart shows a substantial increase in the percentage of filled shifts (62%). This is the highest fill rate in the last 18 months and is thought to reflect the active recruitment to substantive and bank healthcare assistants. Recruitment onto the Bank continues, and it is hoped that improvements seen can be sustained.

2.4 Escalation Beds

It is still not possible to obtain accurate escalation bed data against established beds from WebV or the Sitrep reports. In November escalation beds which are not established are open on C3 (n4), B2 (n5), ward 24 (n6), IAAU (n12), SGH gynae (n2 D2A– total 29 beds). This has an impact on staffing across all areas.

2.5 Staffing Indicators

2.5.1 Vacancies

The information presented below shows data on **inpatient wards** only.

Vacancies Summary Nov 2022

Vacancies - Total

185.3 ▼ -34.5

Vacancies - Qualified

106.3 ▼ -30.7

Vacancies - Unqualified

79.0 ▼ -3.7

Vacancies

Vacancies by Staff Group

Vacancies - Qualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Nov 2022	DPOW	58.6	-18.9	77.5	
Nov 2022	GDH	12.0	-1.5	13.5	
Nov 2022	SGH	35.6	-10.3	46.0	

Vacancies - Qualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Nov 2022	Community & Therapies	12.0	-1.5	13.5	
Nov 2022	Family Services	29.3	-8.9	38.2	
Nov 2022	Medicine	36.3	-17.4	53.6	
Nov 2022	Surgery	28.7	-3.0	31.7	

Vacancies - Unqualified by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Nov 2022	DPOW	41.7	2.5	39.1	
Nov 2022	GDH	3.6	-1.4	5.0	
Nov 2022	SGH	33.8	-4.9	38.7	

Vacancies - Unqualified by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Nov 2022	Community & Therapies	3.6	-1.4	5.0	
Nov 2022	Family Services	3.9	6.6	-2.8	
Nov 2022	Medicine	51.7	-9.8	61.4	
Nov 2022	Surgery	19.8	0.7	19.1	

Vacancies on the inpatient wards in November for Registered Nurses and Healthcare Assistants have decreased although the significant decrease is in RNs.

The Registered Nurse vacancy rate decrease is due to the newly qualified nurses obtaining their NMC registration and moving into registered nurse Band 5 roles alongside the international recruitment. It is anticipated that further reductions will be seen in HCA vacancies as the staff recruited through the rapid recruitment events come into post.

There is a total of 236.41 WTE (12.76%) Registered and 128.10WTE (13.29%) Unregistered vacancies across the Trust. A total of 87 newly qualified nurses and midwives are due to commence in post over the autumn/winter, with a further 20 to start in January and February. 44 international nurses (INs) are commencing in post over Q3/4.

The overseas Pre-registration nurses who have joined the Trust continue to progress through their OSCE preparation and induction programme.

2022/23 Cohort	Start date	Number of Pre-registration nurses	OSCE 1st attempt pass rate	OCSE 1st Resit pass rate	OCSE 2nd resit pass rate
13	Jun - 22	10	2	7	1
14	Aug - 22	10	1	8	1
15	Sep - 22	7	4	3	N/A
16	Oct - 22	16	2 (4 awaiting results)	7 awaiting results + 3 yet to take 2nd attempt	N/A
17	Nov - 22	19	6	13 yet to take 2nd attempt	

The national pass rate for the new NMC test of competence (*including resits*) is 61% for Q1 as published on the NMC website.

The Trust is on track to recruit 90 international nurses by December 2022 in line with the MOU for funding support agreed with NHSE/I. The final cohort have been delayed until January 2023 with agreement from NHSE/I due to Border Strike Action. An additional bid has been successful to support the appointment of 10 international nurses in Q4.

A risk associated with the ability to continue to support international nurse recruitment includes Practice Development team capacity to support OSCE prep and induction as temporary funding ends March 2023 (3 x Band 6 posts to support OSCE prep and induction). An additional risk is the availability of training rooms for OSCE prep which is resulting in additional costs associated with transporting IENs across sites. Rooms have been sourced at UCNL; also negotiating with GIFHE with respect to utilising their rooms however there is a cost associated with this.

Recruitment continues for the nursing apprenticeship programmes which have proved to be popular:

- Five starting on the RNA – RN Top-up programme at the University of Hull in January 2023
- Nine starting on the TNA programme at the University of Lincoln in January 2023

- RNDA programme to commence September at the University of Hull

A workforce plan and RN forecast has been developed with finance and workforce colleagues to support recruitment initiatives going forward.

2.5.2 Staffing Incidents

The information presented below shows data on inpatient wards only.

Wards with Incidents

Indicator	Staffing Incidents		Red Flags	
Site - Ward	Value	Change	Value	Change
DPOW - Rainforest	3	▲ 2	9	▼ -11
SGH - Ward 26	6	▼ -4	2	▼ -5
DPOW - C2	2	▲ 2	4	▼ -13
DPOW - Maternity	5	▼ -6	1	0
DPOW - A1	0	▼ -2	4	▼ -1
DPOW - C3 Short Stay	0	▼ -2	4	▼ -4
DPOW - NICU DPW	4	▼ -2	0	0
SGH - CDU	1	▲ 1	2	▲ 2
SGH - Ward 22	2	▲ 1	1	▲ 1
DPOW - B2 Assessment Unit	0	0	2	▲ 2
DPOW - Stroke DPW	0	0	2	▼ -3
GDH - Ward 6	1	▲ 1	1	▲ 1
SGH - Disney	1	0	1	▲ 1
SGH - Ward 23 Short Stay	1	0	1	0
SGH - Ward 27	0	0	2	▼ -2
DPOW - B7	0	0	1	0
DPOW - C5	0	0	1	0
SGH - ICU	0	0	1	0
SGH - NICU SGH	1	▲ 1	0	0
SGH - Stroke SGH	0	0	1	0
SGH - Ward 16	0	▼ -1	1	▼ -1
SGH - Ward 24 Assessment Unit	1	▼ -1	0	▼ -3

28 nurse staffing incidents were reported in November on the Ulysses system compared to 43 in October.

2.5.3 Red Flags

A total of 41 staffing red flags were reported in November (34 on Safecare Live and 7 on Ulysses). This was a decrease compared to 82 in October. Some fluctuation is seen month by month.

Red Flags on SafeCare Live

Red Flag type, Ward	No.
Below Safe Staffing Levels	26
Rainforest	7
A1	4
C3 Short Stay	3
B2 Assessment Unit	2
Ward 27	2
C2	2
Stroke DPW	2
B7	1
Ward 22	1
Stroke SGH	1
Ward 16	1
Less than 50% substantive staff on shift	4
CDU	1
C5	1
C2	1
C3 Short Stay	1
Less than two trained nurses on a Clinical Area	3
Rainforest	2
Ward 6	1
Co-ordinators Non Supernumerary	1
ICU	1

Red Flags on Ulysses

Red Flag type, Ward	No.
Below safe staffing levels following escalation	2
Ward 26	2
Less than 50% substantive staff on a shift	2
Ward 23 Short Stay	1
C2	1
Less than 2 trained nurses on a clinical area	1
Disney	1
Community staff have been called into work on the	1
Maternity	1
Delay in medicines rounds by 1 hour	1
CDU	1

Rainforest/PAU, A1 and C3 short stay are the highest reporters of red flags for November and is reflective of a good reporting culture in these areas.

3.0 Community Nursing

Activity data not currently available.

Community Nursing Assurance Dashboard Nov 2022

Northern Lincolnshire and Goole NHS Foundation Trust

Indicator Category	Activity			Safety & Quality							Staffing	Infection Control	Friends & Family	End of Life Care
Team	Contacts Actual	Contacts Planned	Contacts Telephone	Red Flags	Falls - Total	Community Acquired PU - Total	Complaints	Weekly Assurance Tools	Caseload Reviews	Caseload	Vacancies - Total	Hand Hygiene %	FFT Recommended Rate %	Deaths with Care in Last Days of Life %
West Network				1.0	0.0	11.0 ↘		0.0	0.0		5.5 ↗			
East Network				1.0	0.0	11.0 ↗		0.0	0.0		11.6 ↗			
South Network				1.0	0.0	3.0 ↘		0.0	0.0		4.2 ↘			
Unscheduled Care Team (UCT) (incl rapid response)				1.0	0.0	0.0		0.0			2.6 ↘			
Macmillan Health Care Team				0.0	0.0	0.0		0.0 ↘			0.7			
Specialist Palliative Care Nurses (SPC)				0.0	0.0	0.0		0.0			6.0			
Palliative Care				0.0	0.0	0.0		0.0			0.0			
Single Point of Access (SPA)				3.0	0.0	0.0		0.0			1.7 ↘			
Continence Team				0.0	0.0	0.0		0.0			0.5 ↘			
Tissue Viability Team				0.0	0.0	4.0 ↗		0.0			0.6			
Long Term Conditions / Complex Care Matrons (Comm Matrons)				0.0	0.0	0.0		0.0			-0.6 ↘			
Intermediate Care Services (ICS) + Core Therapy				0.0	0.0	2.0 ↘		0.0			0.7			
Discharge Liaison Team				0.0	0.0	0.0		0.0			-1.0			
Locality Co-ordinators				0.0	0.0	0.0		0.0			0.4 ↗			
Evening / Night Service				0.0	0.0	0.0		0.0			0.0 ↗			
Chronic Wound Team				0.0	0.0	0.0 ↘		0.0			-0.8	100.0		
DN Students				0.0	0.0	0.0					0.0			
Community Nursing													64.0 ↘	34.3

3.1 Community Nursing Workforce

3.1.1 Safe Staffing

Team	Vacancies - Qualified	Vacancies - Unqualified	Total
East Network	11.9	-0.3	**11.6**
Specialist Palliative Care Nurses (SPC)	3.0	3.0	**6.0**
West Network	4.7	0.8	**5.5**
South Network	3.2	1.0	**4.2**
Unscheduled Care Team (UCT) (incl rapid response)	2.5	0.2	**2.6**
Single Point of Access (SPA)	1.5	0.1	**1.7**
Intermediate Care Services (ICS) + Core Therapy	1.5	-0.8	**0.7**
Macmillan Health Care Team		0.7	**0.7**
Tissue Viability Team	0.0	0.6	**0.6**
Continence Team	0.0	0.5	**0.5**
Locality Co-ordinators	0.4	0.0	**0.4**
Evening / Night Service	-0.9	0.9	**0.0**
Palliative Care	0.0		**0.0**
DN Students	0.0		**0.0**
Long Term Conditions / Complex Care Matrons (Comm Matrons)	-0.6		**-0.6**
Chronic Wound Team	-0.3	-0.5	**-0.8**
Discharge Liaison Team		-1.0	**-1.0**
Total	**27.0**	**5.2**	**32.1**

3.2 Vacancies

Staffing capacity is an ongoing issue with work being undertaken to recruit to vacancies and retain existing staff and new starters, particularly in community nursing where the largest number of unfilled posts remain. The vacancy position within the community networks links to risk 2921 on the risk register, this remains at a moderate risk. A slight increase overall in vacancies has been seen for November 2022, although there has been a decrease of 5.9wte in the number of Registered Nurse vacancies.

For community nursing, East Network have the highest number of Registered Nurse vacancies, however, 3.0wte RNs have been appointed to and are in the recruitment pipeline with an anticipated start date of February 2023.

What have we done?

- Recruitment Webinar held
- Minimum and optimum staffing levels agreed for each network, work now underway to ensure that rosters and establishments reflect safe staffing principles.
- Weekly safe staffing meetings to be held to review staffing levels in community nursing
- SoP for safe staffing agreed and has gone through the ratification processes and implemented
- Establishment review of all 3 networks to ensure appropriate number of staff allocated to each network
- CNSST training underway ahead of consensus week to take place this year which will underpin next establishment reviews
- QI project to combine DN Hub & SPA into a True SPA with dedicated resource underway
- QI team supporting process mapping completed and identified communication as common theme across all areas – change ideas to be progressed

So what?

- Red flags remain static
- Staff feel that workload is being more appropriately allocated
- 0 PALs & Complaints associated with missed visits and communication in last 8 weeks
- Reduction in unallocated visits continues with less frequent OPEL 3 escalations

What next?

- Roster approval processes / confirm and challenge to be held monthly to ensure appropriate action is taken to mitigate risk in the event of unsafe staffing levels

The vacancies in the Intermediate Care Service, Unscheduled Care Team, Single Point of Access, Continence team, MacMillan Nursing team and Macmillan Health Care team have all been appointed to and are in the recruitment pipeline.

3.3 Activity

There is limited activity information for November due to the BlueFish reporting contract ending.

Activity not delivered - Community Nursing Networks
Despite daily problems with capacity and demand, information from the electronic allocation tool shows an ongoing slightly improved position of visits deferred from the planned date.

Visits Allocated Oct 22	Visits Completed Oct 22	Visits Deferred Oct 22
11894	10825	1069
	91.0%	8.98%
Visits Allocated Nov 22	**Visits Completed Nov 22**	**Visits Deferred Nov 22**
12250	11284	966
	92.0%	7.88%

So What?

- ✓ Housekeeping to ensure all tasks are accurately assigned to staff
- ✓ E- Allocation coordinator overseeing the system and making “on the day” changes with a second role being recruited to
- ✓ Cancelled visits - visits are prioritised throughout each day.
- ✓ E-allocation tool now optimised and delivering more streamlined allocation of work to available staff on duty with improved data quality
- ✓ Minimum staffing levels and optimum staffing levels available for each network with weekly safe staffing meeting planned to review staffing levels in community nursing
- ✓ SoP for safe staffing agreed and has gone through ratification process
- ✓ Reduction in PALS/complaints associated with missed visits and communication

3.4 Community Nursing Red Flag incidents

The total nursing red flag incidents for November 2022 is 9, 3 of these relate to a shortfall in nurse staffing although this is not reflective of the workforce challenges particularly in Community Nursing.

4.0 Maternity Dashboard and Red Flag Incidents

4.1 Maternity Staffing

The Chief Nurse undertook a desktop maternity staffing establishment review in early March 2021 and the increases in establishments identified were included in the Trust's Ockenden Immediate and Essential Actions submission. A desktop review with ward managers took place at the end of May 2022 and an establishment review using the Birthrate Plus workforce planning tool has been undertaken and the final report presented to TMB in November. The Trust is compliant with Birthrate Plus calculations with a positive variance of 2.55wte.

4.2 Maternity Fill Rates and CHPPD

Maternity Wards Fill Rates and CHPPD — Nov 2022

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**101.4%**	▲ **10.4%**	**96.9%**	▲ **15.4%**	**14.0**	▲ **2.34**
Registered Nurses and Midwives	100.4%	▲ 9.9%	96.0%	▲ 15.8%	8.8	▲ 1.45
Care Staff	103.0%	▲ 11.1%	98.4%	▲ 14.7%	5.2	▲ 0.89
Central Delivery Suite	**115.1%**	▲ **40.2%**	**84.8%**	▲ **37.7%**	**41.4**	▲ **7.89**
Registered Nurses and Midwives	121.8%	▲ 46.9%	85.2%	▲ 42.5%	35.3	▲ 8.31
Care Staff	87.2%	▲ 12.7%	83.0%	▲ 18.0%	6.1	▼ -0.42
Jasmine & Honeysuckle	**91.7%**	▲ **5.8%**	**69.1%**	▼ **-1.3%**	**10.7**	▼ **-0.84**
Registered Nurses and Midwives	89.8%	▲ 5.8%	69.4%	▼ -3.1%	7.0	▼ -0.54
Care Staff	95.4%	▲ 5.6%	68.6%	▲ 2.4%	3.6	▼ -0.30
Ward 26 SGH	**97.8%**	▲ **18.9%**	**73.4%**	▲ **18.6%**	**8.6**	▲ **1.56**
Registered Nurses and Midwives	102.4%	▲ 25.9%	74.7%	▲ 24.5%	6.6	▲ 1.59
Care Staff	85.4%	▼ 0.0%	69.8%	▲ 2.6%	2.0	▼ -0.03
Total	**101.1%**	▲ **17.7%**	**81.5%**	▲ **16.6%**	**13.5**	▲ **1.90**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	63.1%	▼ -0.2%
Central Delivery Suite	85.2%	▲ 4.7%
Jasmine & Honeysuckle	66.0%	▲ 0.2%
Ward 26 SGH	76.5%	▲ 5.6%
Total	**72.3%**	▲ **3.3%**

The fill rate in all maternity area is above 95 %.

Recruitment is ongoing and vacancies are reviewed regularly and taken to the weekly establishment review meeting. There is a rolling advert for rotational midwifery posts and international recruitment of midwives has commenced with the support of the regional NHS England workforce team.

4.3 Midwife: Birth ratio

Assurance that safety was maintained within the maternity units is supported by the Midwife to Birth ratio data. In November 2022 the data for both units is DPOW 23.3 and SGH 22.4 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 November 2022. There is a robust escalation policy that is utilised in times of high acuity and there are close links to the Operations team throughout both sites. Maternity services have commenced using the maternity OPEL status to provide an oversight of their current position. This is provided to the Trust Operational meetings and reported regionally.

4.4 Maternity Dashboards

DPOW Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022
Midwife to Birth Ratio	24.8 ↗	24.6 ↘	24.9 ↗	24.0 ↘	23.9 ↘	24.9 ↗	24.8 ↘	26.5 ↗	26.5	25.6 ↘	25.5 ↘	23.3 ↘
Red Flags	17.0 ↗	10.0 ↘	12.0 ↗	6.0 ↘	11.0 ↗	2.0 ↘	2.0	7.0 ↗	9.0 ↗	9.0	3.0 ↘	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)	4.0 ↗	1.0 ↘	3.0 ↗	2.0 ↘	0.0 ↘	1.0 ↗	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)	1.0	0.0 ↘	0.0	1.0 ↗	0.0 ↘	0.0	1.0 ↗	2.0 ↗	0.0 ↘	1.0 ↗	1.0	0.0 ↘
(c) Missed medication during an admission to hospital	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	1.0 ↗
(d) Delay of more than 30 minutes in providing pain relief	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0	0.0	2.0 ↗	2.0	4.0 ↗	0.0 ↘	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	1.0	1.0	0.0 ↘	0.0	0.0	0.0	0.0	0.0	1.0 ↗	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	3.0 ↗	2.0 ↘	4.0 ↗	2.0 ↘	2.0	0.0 ↘	1.0 ↗	2.0 ↗	4.0 ↗	2.0 ↘	0.0 ↘	1.0 ↗
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	1.0 ↗	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	2.0 ↗	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 ↗	2.0 ↘	5.0 ↗	1.0 ↘	9.0 ↗	1.0 ↘	0.0 ↘	0.0	2.0 ↗	2.0	2.0	1.0 ↘
Continuity of Carer %	20.0	17.0 ↘	24.0 ↗	19.0 ↘	20.0 ↗	21.0 ↗	21.0	23.0 ↗	24.0 ↗	24.0	25.0 ↗	
In Receipt of %	9.0 ↘	10.0 ↗	23.0 ↗	9.0 ↘	14.0 ↗	10.0 ↘	15.0 ↗	13.0 ↘	14.0 ↗	15.0 ↗	15.0	
CoC In Receipt of %	52.0 ↘	21.0 ↘	83.0 ↗	56.0 ↘	82.0 ↗	79.0 ↘	72.0 ↘	89.0 ↗	72.0 ↘	68.0 ↘	66.0 ↘	
Continuity Team Caseload	326.0 ↘	342.0 ↗	334.0 ↘	319.0 ↘	347.0 ↗	314.0 ↘	314.0	305.0 ↘	305.0	295.0 ↘	311.0 ↗	
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Actual v Planned Staffing %	90.1 ↘	92.8 ↗	91.5 ↘	95.1 ↗	94.0 ↘	91.5 ↘	92.2 ↗	86.0 ↘	86.0	89.0 ↗	89.5 ↗	97.9 ↗
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies	10.8 ↘	12.1 ↗	11.8 ↘	11.2 ↘	19.3 ↗	19.4 ↗	19.1 ↘	20.2 ↗	20.3 ↗	26.3 ↗	20.7 ↘	20.5 ↘
Vacancies - Registered	8.8 ↘	10.3 ↗	10.9 ↗	10.2 ↘	16.4 ↗	17.4 ↗	17.5 ↗	17.7 ↗	17.8 ↗	19.5 ↗	19.1 ↘	16.1 ↘
Vacancies - Unregistered	2.1 ↗	1.9 ↘	0.9 ↘	0.9	2.9 ↗	2.1 ↘	1.5 ↘	2.5 ↗	2.5	6.8 ↗	1.5 ↘	4.4 ↗
Serious Incidents	1.0	1.0	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0	0.0	1.0 ↗	1.0	0.0 ↘	0.0
Complaints	1.0 ↘	0.0 ↘	0.0	1.0 ↗	2.0 ↗	1.0 ↘	1.0	2.0 ↗	1.0 ↘	0.0 ↘	0.0	1.0 ↗
PALS	7.0 ↘	5.0 ↘	1.0 ↘	2.0 ↗	3.0 ↗	4.0 ↗	3.0 ↘	1.0 ↘	5.0 ↗	2.0 ↘	2.0	3.0 ↗

SGH Maternity Dashboard

Indicator	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022
Midwife to Birth Ratio	24.9	24.2	23.9	23.9	26.4	25.3	25.5	25.8	25.8	26.0	23.8	22.4
Red Flags	43.0	23.0	24.0	17.0	19.0	22.0	15.0	27.0	6.0	4.0	14.0	6.0
(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)	9.0	1.0	3.0	0.0	2.0	0.0	1.0	5.0	0.0	1.0	0.0	0.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	3.0	1.0	2.0	0.0	1.0	2.0	2.0	0.0	1.0	0.0	0.0	0.0
(c) Missed medication during an admission to hospital	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	2.0
(d) Delay of more than 30 minutes in providing pain relief	1.0	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	11.0	1.0	2.0	3.0	1.0	11.0	5.0	11.0	1.0	2.0	5.0	2.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	1.0	0.0	1.0	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.	19.0	19.0	16.0	13.0	15.0	9.0	7.0	10.0	4.0	1.0	9.0	2.0
Continuity of Carer %	22.0	14.0	16.0	21.0	18.0	20.0	13.0					
In Receipt of %	6.0	8.0	7.0	5.0	6.0	6.0	5.0	3.0				
CoC In Receipt of %	64.0	38.0	38.0	47.0	44.0	50.0	30.0	33.0				
Continuity Team Caseload	161.0	155.0	151.0	171.0	177.0	174.0	174.0	0.0	0.0	0.0	0.0	
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0		
Actual v Planned Staffing %	85.1	87.4	88.8	88.1	80.2	83.3	82.7	81.4	81.4	80.9	88.3	94.0
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies	18.3	19.3	18.3	20.5	27.9	28.5	25.1	24.9	25.5	26.1	21.5	21.2
Vacancies - Registered	15.7	16.7	15.7	17.3	22.3	23.5	21.9	22.7	23.4	23.2	21.3	18.9
Vacancies - Unregistered	2.6	2.6	2.6	3.2	5.6	5.0	3.2	2.2	2.0	2.8	0.3	2.3
Serious Incidents	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0
Complaints	0.0	1.0	0.0	1.0	0.0	0.0	2.0	0.0	2.0	1.0	3.0	1.0
PALS	1.0	2.0	3.0	2.0	2.0	2.0	1.0	0.0	1.0	3.0	3.0	1.0

Trustwide Maternity Dashboard

Indicator	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022
Midwife to Birth Ratio	24.8 ↗	24.4 ↘	24.5 ↗	24.0 ↘	24.9 ↗	25.1 ↗	25.0 ↘	26.2 ↗	26.2	25.8 ↘	24.8 ↘	22.9 ↘
Red Flags	60.0 ↗	33.0 ↘	37.0 ↗	23.0 ↘	30.0 ↗	24.0 ↘	18.0 ↘	34.0 ↗	16.0 ↘	13.0 ↘	17.0 ↗	9.0 ↘
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	13.0 ↗	2.0 ↘	6.0 ↗	2.0 ↘	2.0	1.0 ↘	1.0	5.0 ↗	0.0 ↘	1.0 ↗	0.0 ↘	0.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	4.0 ↗	1.0 ↘	2.0 ↗	1.0 ↘	1.0	2.0 ↗	3.0 ↗	2.0 ↘	2.0	1.0 ↘	1.0	0.0 ↘
(c) Missed medication during an admission to hospital	0.0	0.0	1.0 ↗	0.0 ↘	0.0	0.0	0.0	2.0 ↗	0.0 ↘	0.0	0.0	3.0 ↗
(d) Delay of more than 30 minutes in providing pain relief	1.0 ↗	1.0	0.0 ↘	0.0	0.0	0.0	0.0	2.0 ↗	2.0	4.0 ↗	0.0 ↘	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	1.0	1.0	0.0 ↘	0.0	0.0	0.0	0.0	0.0	1.0 ↗	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	14.0 ↗	3.0 ↘	6.0 ↗	5.0 ↘	3.0 ↘	11.0 ↗	6.0 ↘	13.0 ↗	5.0 ↘	4.0 ↘	5.0 ↗	3.0 ↘
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	1.0 ↗	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	3.0 ↗	0.0 ↘	1.0 ↗	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.	27.0 ↗	21.0 ↘	22.0 ↗	14.0 ↘	24.0 ↗	10.0 ↘	8.0 ↘	10.0 ↗	6.0 ↘	3.0 ↘	11.0 ↗	3.0 ↘
Continuity of Carer %	21.0 ↗	16.0 ↘	20.0 ↗	20.0	19.0 ↘	20.0 ↗	18.0 ↘	12.0 ↘	12.0	12.0	14.0 ↗	
In Receipt of %	8.0 ↘	9.0 ↗	16.0 ↗	7.0 ↘	11.0 ↗	8.0 ↘	11.0 ↗	9.0 ↘	8.0 ↘	9.0 ↗	8.0 ↘	
CoC In Receipt of %	56.0 ↘	47.0 ↘	67.0 ↗	49.0 ↘	69.0 ↗	68.0 ↘	58.0 ↘	70.0 ↗	72.0 ↗	68.0 ↘	66.0 ↘	
Continuity Team Caseload	487.0 ↘	497.0 ↗	485.0 ↘	490.0 ↗	524.0 ↗	488.0 ↘	488.0	305.0 ↘	305.0	295.0 ↘	311.0 ↗	
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0 ↗	0.0 ↘	0.0		
Actual v Planned Staffing %	88.0 ↘	90.5 ↗	90.3 ↘	92.1 ↗	88.1 ↘	88.0 ↘	88.1 ↗	84.1 ↘	84.1	85.5 ↗	89.0 ↗	96.2 ↗
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
1:1 Care in Labour %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Vacancies	29.7 ↗	32.0 ↗	30.7 ↘	32.2 ↗	46.6 ↗	47.3 ↗	43.5 ↘	44.5 ↗	45.2 ↗	51.7 ↗	41.6 ↘	41.1 ↘
Vacancies - Registered	25.1 ↗	27.6 ↗	27.2 ↘	28.2 ↗	38.1 ↗	40.3 ↗	38.8 ↘	39.8 ↗	40.6 ↗	42.2 ↗	39.8 ↘	34.4 ↘
Vacancies - Unregistered	4.7 ↗	4.5 ↘	3.5 ↘	4.1 ↗	8.5 ↗	7.0 ↘	4.7 ↘	4.7	4.6 ↘	9.6 ↗	1.8 ↘	6.7 ↗
Serious Incidents	1.0	2.0 ↗	0.0 ↘	1.0 ↗	0.0 ↘	0.0	0.0	0.0	2.0 ↗	1.0 ↘	0.0 ↘	0.0
Complaints	1.0 ↘	1.0	0.0 ↘	2.0 ↗	2.0	1.0 ↘	3.0 ↗	2.0 ↘	3.0 ↗	1.0 ↘	3.0 ↗	2.0 ↘
PALS	8.0 ↘	7.0 ↘	4.0 ↘	4.0	5.0 ↗	6.0 ↗	5.0 ↘	1.0 ↘	6.0 ↗	5.0 ↘	6.0 ↗	4.0 ↘
Sickness Absence (Division) %	7.2 ↗	8.4 ↗	7.2 ↘	8.0 ↗	8.8 ↗	5.9 ↘	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.

The total number of falls reported in November 2022 has decreased. The 102 falls reported involved 79 patients. A total of 13 patients had more than one in-patient fall.

There has been a decrease in the number of reported falls at all three sites with the largest decreases at the Grimsby and Goole sites.

There were two falls reported with moderate harm in November 2022. Both falls were reported at the Scunthorpe site. One fall occurred on Ward 28. This resulted in the patient sustaining a bleed on the brain, no surgical intervention was required. The patient had full mental capacity and no lapses in care were identified at the huddle. The huddle was completed within two working days of the incident.

The second fall with moderate harm occurred on Ward 16. This resulted in the patient sustaining a fracture to the skull and a bleed on the brain, neither of which required any surgical intervention. The huddle was held within four working days of the incident. No lapses in care were identified and it was noted that the ward had implemented and embedded learning from a previous incident.

There were no delays with discharge to assess for either of the incidents reported with moderate harm.

5.2 Falls per 1,000 Bed Days

The falls per 1000 bed days across the Trust has decreased in November 2022. Caution should be used when interpreting the data as not all escalation beds are captured within the occupied bed days.

Falls per 1,000 Bed Days Summary Nov 2022

Falls per 1,000 bed days

5.2 ▼ -0.8

Falls per 1,000 Bed Days

Falls per 1,000 Bed Days by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Nov 2022	DPOW	5.6	-0.8	6.4	
Nov 2022	GDH	5.2	-5.2	10.4	
Nov 2022	SGH	4.7	-0.1	4.8	

Falls per 1,000 Bed Days by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Nov 2022	Community & Therapies	5.2	-5.2	10.4	
Nov 2022	Family Services	0.4	0.0	0.4	
Nov 2022	Medicine	6.5	-0.7	7.2	
Nov 2022	Surgery	4.3	0.0	4.3	

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5.3 Wards with Highest Incidence of Falls

Highest Reporting Wards with Falls Incidents Nov 2022

Indicator	Falls - No Harm		Falls - Minor Harm		Falls - Moderate Harm		Falls - Major or Catastrophic Harm		Falls - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
DPOW - Stroke DPW	10	▲ 3	0	0	0	0	0	0	10	▲ 3
SGH - Ward 16	6	▲ 6	2	▲ 1	1	▲ 1	0	0	9	▲ 8
SGH - Ward 22	6	▲ 3	2	▲ 1	0	0	0	0	8	▲ 4
DPOW - B2 Assessment Unit	5	▼ -3	2	0	0	0	0	0	7	▼ -3
DPOW - C2	2	▼ -1	5	▲ 2	0	0	0	0	7	▲ 1

Highest Reporting Wards - Falls per 1,000 Bed Days

Site - Ward	Falls per 1000 Bed Days	Change
DPOW - Stroke DPW	13.5	▲ 4.1
SGH - Ward 16	13.3	▲ 11.9
SGH - Ward 22	10.0	▲ 5.1
SGH - Stroke SGH	9.9	▼ -1.5
DPOW - B7	9.2	▲ 5.0

Ward C3 (Short Stay) Grimsby has not triggered as a higher reporting ward for the first time in five months. This will be monitored through the Nursing Metrics Panel to establish if this is an improving trend.

Ward B2 (IAAU) at Grimsby has triggered as a higher reporting ward for the second consecutive month. The number of falls reported in November 2022 has fallen.

None of the other higher reporting wards are demonstrating any trends at present.

The areas detailed above will be reviewed alongside other metrics at the Nursing Metrics Panel.

6.0 Pressure Ulcers

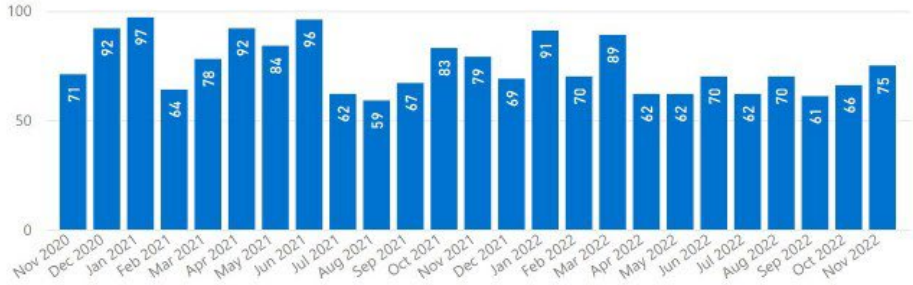
6.1 Hospital Acquired Pressure Ulcer Incidents

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.

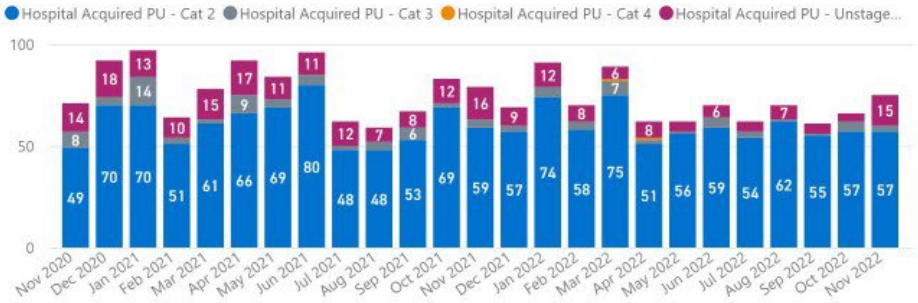
Hospital Acquired PU Incidents Summary Nov 2022

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
75 ▲ 9	57 0	3 ▼ -2	0	15 ▲ 11

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
Nov 2022	DPOW	45	▲ 3	42	
Nov 2022	GDH	3	▲ 2	1	
Nov 2022	SGH	27	▲ 4	23	

Hospital Acquired PU - Total by Division

Latest Month	Divison	Result	Variance to Previous	Previous Month	Trend
Nov 2022	Community & Therapies	3	▲ 2	1	
Nov 2022	Family Services	0	◆ 0		
Nov 2022	Medicine	47	▲ 8	39	
Nov 2022	Surgery	25	▼ -1	26	

There number of pressure ulcer incidents reported in November 2022 has increased slightly for the second consecutive month. There has been a sustained improvement in the number of pressure ulcers reported over the last seven months.

Both the Grimsby site (DPOW) and the Medicine division continue to report higher numbers of pressure ulcers.

6.2 Hospital Acquired Pressure Ulcers per 1,000 Bed Days

The incidence of reported pressure ulcers per 1000 occupied bed days has increased slightly in November 2022 and remains higher at the Grimsby site.

Hospital Acquired PU per 1,000 Bed Days Summary — Nov 2022

PU per 1,000 bed days

3.8 ▲ 0.6

PU per 1,000 Bed Days

PU per 1,000 Bed Days by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Nov 2022	DPOW	4.5	▲ 0.5	4.0	
Nov 2022	GDH	2.6	▲ 1.8	0.8	
Nov 2022	SGH	3.2	▲ 0.6	2.6	

PU per 1,000 Bed Days by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Nov 2022	Community & Therapies	2.6	▲ 1.8	0.8	
Nov 2022	Family Services	0.0	◆ 0.0		
Nov 2022	Medicine	4.0	▲ 0.8	3.2	
Nov 2022	Surgery	6.0	▲ 0.4	5.6	

6.3 Wards with the Highest Incidence

Highest Reporting Wards with PU Incidents **Nov 2022**

Indicator	Hospital Acquired PU - Cat 2		Hospital Acquired PU - Cat 3		Hospital Acquired PU - Cat 4		Hospital Acquired PU - Unstageable		Hospital Acquired PU - Total	
Site - Ward	No.	Change	No.	Change	No.	Change	No.	Change	No.	Change
DPOW - B3	8	▲ 5	1	0	0	0	0	0	9	▲ 5
SGH - Ward 29	8	▲ 5	0	0	0	0	1	▲ 1	9	▲ 6
DPOW - B2 Assessment Unit	4	▲ 3	1	▲ 1	0	0	3	▲ 3	8	▲ 7
DPOW - C2	4	▼ -2	0	0	0	0	3	▲ 1	7	▼ -1
DPOW - Stroke DPW	3	▲ 1	0	▼ -1	0	0	2	▲ 1	5	▲ 1

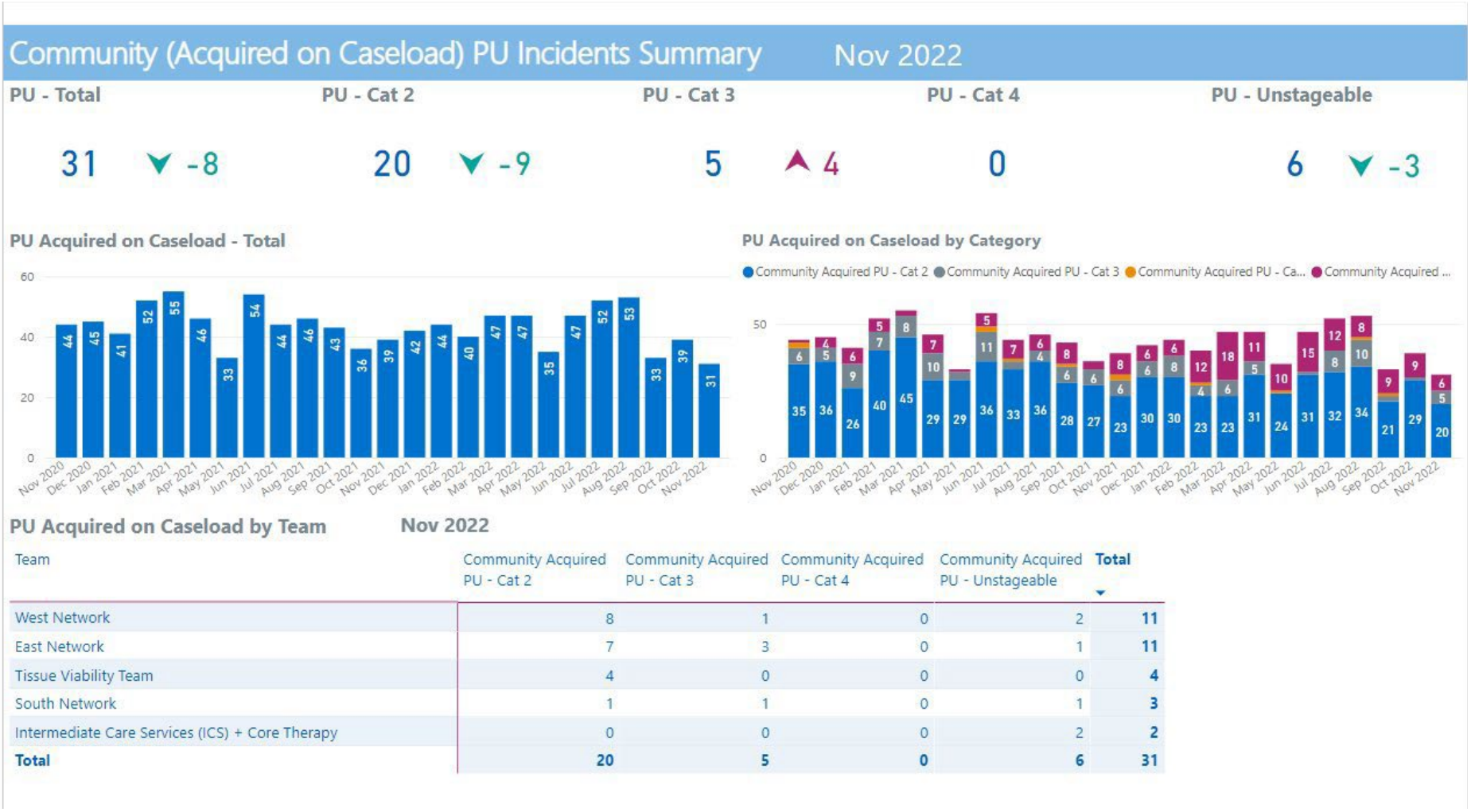
Highest Reporting Wards - PU per 1,000 Bed Days

Site - Ward	Hospital Acquired PU per 1000 Bed Days	Change
SGH - Ward 18	20.6	▲ 13.6
DPOW - ITU	14.1	▲ 0.9
SGH - Ward 29	12.6	▲ 8.6
DPOW - B3	11.8	▲ 6.6
DPOW - B2 Assessment Unit	10.2	▲ 9.1

None of the higher reporting wards are currently demonstrating any concerning trends. The areas identified above will be discussed in more detail at the Nursing Metrics Panel alongside other indicators.

6.4 Community (Acquired on Caseload) Pressure Ulcer Incidents

The information presented shows data on pressure ulcers acquired on community caseload. Please note this does not include category 1, suspected deep tissue injuries or moisture lesions. Data changes from month to month due to ongoing validation and these figures may contain un-validated pressure ulcers.



PU Acquired on Caseload by Team Nov 2022

Team	Community Acquired PU - Cat 2	Community Acquired PU - Cat 3	Community Acquired PU - Cat 4	Community Acquired PU - Unstageable	Total
West Network	8	1	0	2	11
East Network	7	3	0	1	11
Tissue Viability Team	4	0	0	0	4
South Network	1	1	0	1	3
Intermediate Care Services (ICS) + Core Therapy	0	0	0	2	2
Total	**20**	**5**	**0**	**6**	**31**

The incidence of pressure ulcers has seen a slight decrease in November 2022 from 39 to 31, however this is a notable reduction from June, July and August 2022.

The most reported pressure ulcers overall are category 2 which is a consistent theme each month. This is suggestive that preventative interventions put in place by network teams have impacted on further deterioration of category 2 pressure ulcers. We have seen a reduction in the incidence of unstageable pressure ulcers; a slight increase in category 3 pressure ulcers, and we have had no category 4 pressure ulcers in November 2022.

All moderate harm pressure ulcers for November have been reviewed with no lapses in care and no new themes for learning.

A review of the network and place of residence for patients who developed a moderate harm pressure ulcer for November is as below with no notable themes.

Pressure Ulcer	**Developed in patients own home/network**	**Developed in residential/care home setting (name if known)**
Category 3	1 **West Network** 1 **South Network** 1 **East network**	2 **East Network** Abbey Village Care Home (same patient)
Category 4	0	0
Unstageable	1 **South Network** 1 **West Network** 1 **East Network**	1 **West Network** at Greenacres Residential Home 2 **Intermediate Care** at Sir John Mason House

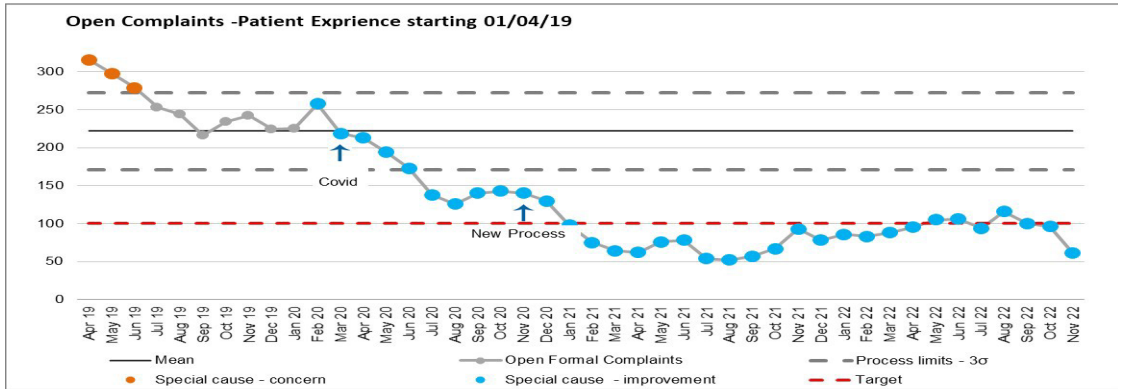
Over the past 24 months the division has reported a stagnant position in relation to pressure ulcers acquired on caseload, with increases in moderate harm incidents. Current systems and process for managing pressure ulcer incidents, investigations and learning are not achieving any improvements in pressure ulcer prevalence.

What have we done?

- Thematic review of PU incidents undertaken & identified recurrent themes & no new learning.
- Tabletop exercise with ICB quality lead which reviewed all outstanding moderate harm PU incidents identified no new learning
- Proposal to transform the process by which moderate harm community pressure ulcers are reviewed in collaboration with ICB Quality lead in line with PSIRF approved and on track to deliver by end Q3.
- Improvement opportunity identified in relation to risk assessment for pressure damage and BRADEN to be implemented by end of Q4.
- Ongoing work to review the education and training with dates to be scheduled for 2023 to ensure staff have received an update on pressure area management.

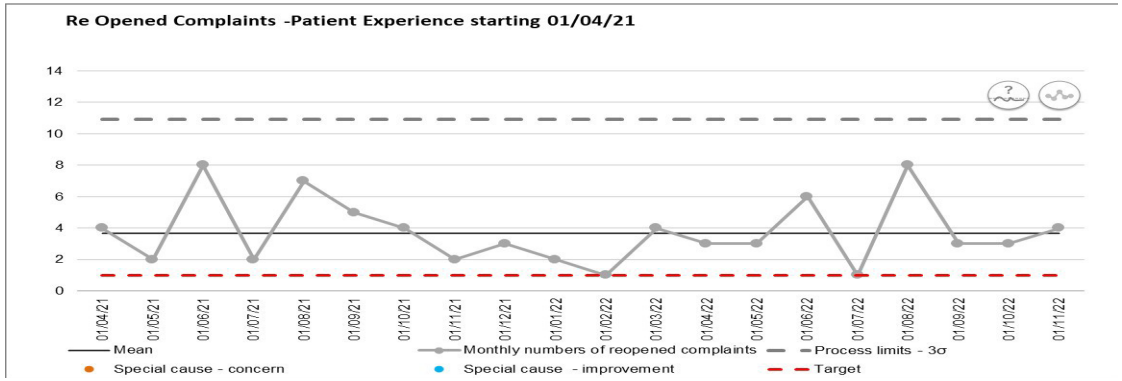
7.0 Patient Experience

New formal complaint numbers continued to reduce, with 21 received during November. At the end of November there were 61 open complaints, a reduction of 36%. This data in seen in graph A below:



Graph A

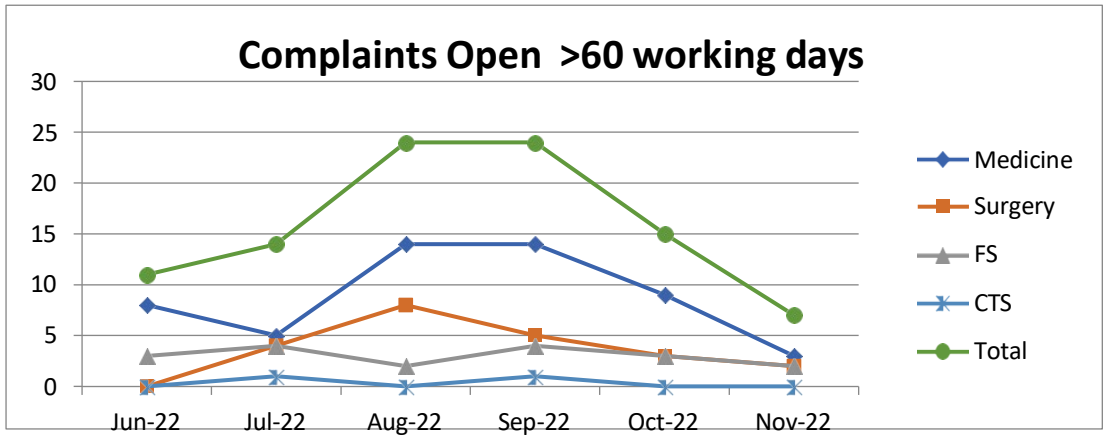
There were 4 reopened complaints in November, as seen in graph B.



Graph B

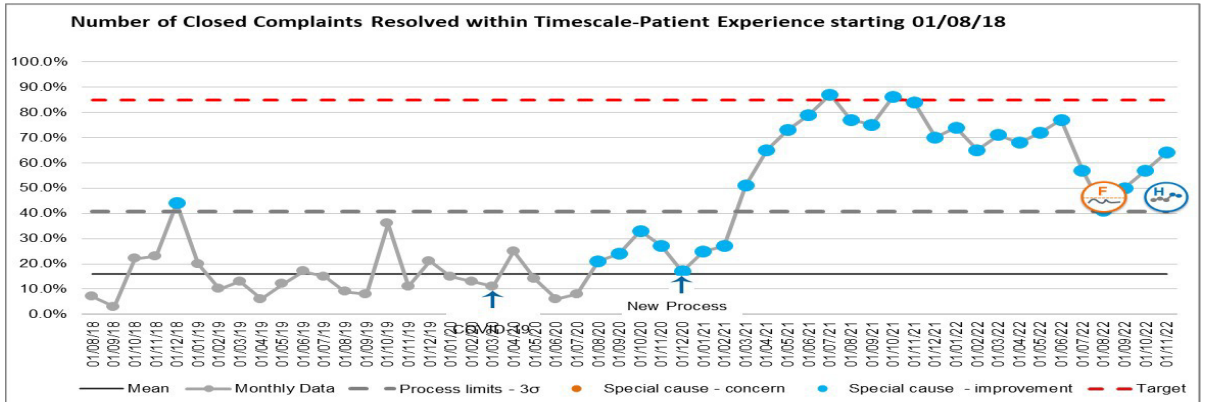
These may not necessarily be progressed depending on what information was provided in the first response. A process is in place to manage this which is divisionally led with Complaint Manager oversight.

It is reassuring to note that the work to address complaints over 60 working day timescale has resulted in a further reduction of over 50% in November, with 7 being over timescale at the time of reporting, as seen in graph C:



Graph C

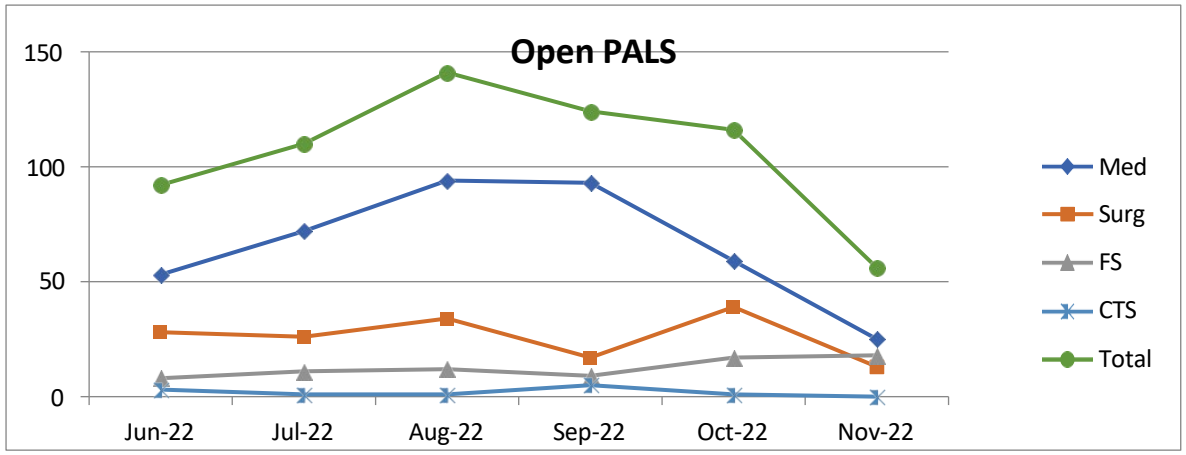
In November 39 complaints were closed, 64% were in timescale as seen in graph D:



Graph D

Of those that were out of timescale, 3 were over 100 days due to complexity and delays, 9 were over 70 days and 3 were 61-69 days.

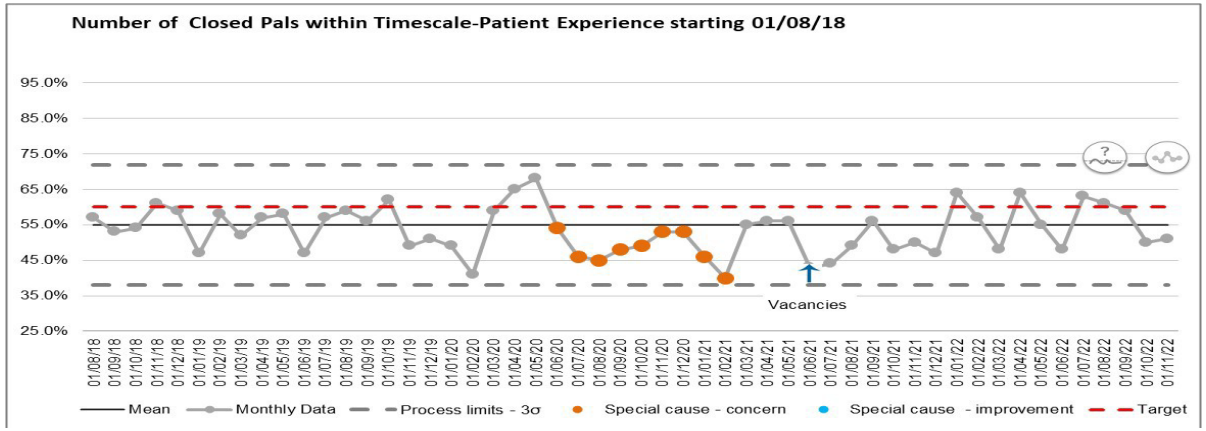
Trust wide the number of new PALs concerns received was 167, a further decrease compared to October. Open concerns decreased by over 50% to 56, as seen below in Graph E:



Graph E

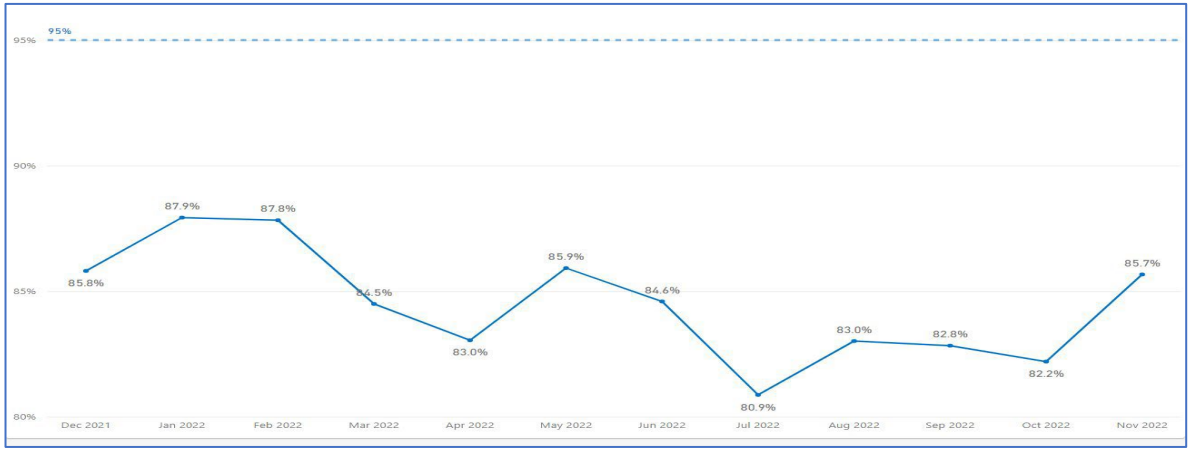
This impact directly correlates to the commencement of an additional band 7 PALs and Complaint Manager who is supporting key elements of the complaint agenda, PALs being the initial priority.

A total of 224 PALs concerns were closed. The KPI of 60% of PALs closed in timescale was recorded at 51% for November, it is hoped this will now begin to increase as concern numbers are more manageable. This can be seen in graph F below:



Graph F

November saw the overall organisational FFT response rate increase to the highest total of the whole year from the previous month, as seen in the image below. 87.5% of those respondents rated they would recommend the Trust.



The Patient Experience Manager is now actively meeting areas with identified actions for each area to increase their responses and staff engagement being increased, as part of this.

The Volunteering Manager and Patient Experience Lead have identified areas for improvement in the recruitment process, which has been a concern due to the length of time. Through a simple change to occupational health forms up to 3 weeks can be removed from the process. The next phase of the plan is to move the recruitment of volunteering onto TRAC, which will release valuable volunteer administration staff time, has been progressed. The system will be built in the coming months with a provisional go live date of February 2023.

8.0 Mixed Sex Breaches

In November the Trust declared 8 mix sex breach at DPOW which involved 2 patients and one action plan was commenced which contained all the actions for all patients affected. The theme for these was that the Trust had declared OPEL 4 on all occasions and there was a lack of capacity in step down beds.

Site	Speciality	Date	Sex	No. that occurred	Reason
DPOW	ITU	08/11/22	M	4	OPEL 4 on site, patient flow- unable to support step down- escalated at the time
DPOW	ITU	08/11/22	F	4	OPEL 4 on site, patient flow- unable to support step down- escalated at the time
DPOW	ITU	08/11/22	M	4	OPEL 4 on site, patient flow- unable to support step down- escalated at the time
DPOW	ITU	08/11/22	M	4	OPEL 4 on site, patient flow- unable to support step down- escalated at the time
DPOW	ITU	18.11.22	M	4	OPEL 4 on site, capacity at DPOW and patient flow- unable to support step down- escalated at the time
DPOW	ITU	18.11.22	M	4	OPEL 4 on site, capacity at DPOW and patient flow- unable to support step down- escalated at the time
DPOW	ITU	18.11.22	F	4	OPEL 4 on site, capacity at DPOW and patient flow- unable to support step down- escalated at the time
DPOW	ITU	18.11.22	M	4	OPEL 4 on site, capacity at DPOW and patient flow- unable to support step down- escalated at the time

9.0 15 Steps Challenge

Twelve acute 15 Steps Challenge visits were completed during November 2022. Ten in the acute and Two in Community and Therapies. Ward 29 improved from intensive support to requires improvement. A&E DPOW remained at Intensive support.

Acute 15 Steps Challenge Visits			
Date of visit	Ward/ Department	Rating 22-23	Previous Rating
02/11/2022	**Ward 28 Revisit**		
03/11/2022	Ward 29 Revisit		
08/11/2022	Rainforest		
08/11/2022	Ward B4		
09/11/2022	**B2 IAAU Revisit**		
15/11/2022	Ward 3		
16/11/2022	**A&E DPOW Revisit**		
17/11/2022	Ward 19		
22/11/2022	GAU (on CCU)		
29/11/2022	Theatres SGH		

Community and Therapies 15 Steps Rating October 2022			
Date of visit	Community Team/ Clinic	Rating 22-23	Previous rating
10/11/22	Community Dental, Ashby		N/A
30/11/22	Community Therapies, Cromwell PCC		N/A

Themes for areas of consideration/ action within the acute schedule

	Themes	Actions
Standard 1: Observations	• Medications left out throughout ward/ department	• Quality Improvement to support the areas • Shift lead to have oversight of safe and secure storage day to day • WAT to be consistently completed and then fed back to staff for learning
	• Dirty commodes/ sluice	• Commode checklists added to safe to care checks • Dirty utility checklists introduced
	• Flammables cupboard unlocked	• New keys ordered • Staff aware cupboard to be secure at all times
	• Clean utility room door open throughout visit	• Locks reported as broken • Staff made aware to keep door closed and not to prop open
	• Out date stock found within storage areas including clinical equipment and supplements	• Stock rotation process introduced • Staff members assigned to monitor storage areas weekly • Communication sent out to staff c/o findings
	• Poor meal service preparation • Staff taking breaks over mealtimes • Interrupting meals to preform clinical tasks	• Protected meal services to be enforced in clinical areas and staff given time to prepare patients and patient areas for eating
Standard 2: Documentation	• MUST outstanding • No accurate weight for vulnerable patients	• Daily review of MUST required by shift lead • Weighing PAT slide purchased • Accurate weight to be recorded wherever possible – source weighing hoist if required
	• Food & Fluid charts with significant gaps	• Stop & Check introduced to make F&F a focus • WAT to be consistently completed by Ward Managers and themes fed back to the staff
Standard 3: Patient Feedback	• Patients not aware of plans for discharge or estimated discharge, EDD and R2R not completed on WebV	• PCN to update EDD or R2R daily and staff to discuss daily and update patients looking at being discharge in next few days or MFFD about delays
Standard 4: Staff Feedback	• Lack of feedback relating to FFT, complaints and PALS	• Ward Manager to feedback in staff communications • Highlight learning lessons at S&C

Themes for areas of consideration/ action within the community and therapy schedule

	Themes	Actions
Standard 1: Observations	• To ensure fire extinguishers are checked	• Business manager to contact NL College to ask for a check
	• For the team to display and up to date future 5 – nursing, and have a working knowledge of the strategy	• Poster in situ and communicated to staff
	• Uniform identification posters to be visible to patients	• Posters in situ
	• Posters on walls need to be up to date and evidence based	• Posters Reviewed
Standard 2: Documentation	• Reminder to record NEWS2 scores for all patients on initial review or if patient deteriorates	• Email cascaded by Q&D nurse
Standard 3: Patient Feedback	• To collect FFT/IWGC evidence to measure service satisfaction.	• To carry out interview's via phone; this action does now sit with the Malinko and Phlebotomy coordinator who make phone contact with patients on the community nursing caseloads
Standard 4: Staff Feedback	• Continue to encourage staff to share positives 'what we are proud of' in supervision and at staff meetings	• Ongoing in supervision
	• All staff to know the process for making a Safeguarding referral at a weekend	• Comms will be circulated to the networks to explain the usual process at weekends for any safeguarding concern. Discussion has happened with community safeguarding nurse to agree action.
Staff Feedback: continued	• To identify key support strategies to increase staff morale and shared understanding of roles and responsibilities	• Clarity on roles and future of the service. One to one held with all team. Joint restorative supervision held within the team. QI process mapping with each team. Larger scale engagement session with all team, social care and acute
	• To increase team awareness of Professional Nurse Advocate roll	• Attendance at caseload manager/team meeting- added to agenda

10.0 Infection, Prevention & Control

ALERT mandatory organisms

The Trust is performing within the expected parameters for mandatory organisms.
It is unlikely that the case threshold for C. difficile will be met. Due to success of considerable reduction of cases in previous years, the trajectory for this year of 21 cases is extremely challenging, with a reported number of 19 cases so far. Through the PIR process, cases so far have been deemed unpreventable. Despite this, the Trust is performing well in comparison to peer Trusts. C.difficile infection is one of the lowest in the country.

Hospital onset positive blood culture cases (gram-negatives, MSSA and MRSA) are in line with predicted numbers, and the Trust is performing well in comparison to peer trusts. However, the case threshold has been exceeded for Pseudomonas aeruginosa. Again, due to success of considerable reduction of cases in previous years, a case threshold of 7 is challenging, with a reported number of 12 cases so far. There have been no cases of hospital onset MRSA bacteraemia for 24 months.

Respiratory Viruses

Winter was predicted and is proving to be very challenging regarding isolation/cohorting hospital inpatients with expected high cases of Influenza A & B, Bronchiolitis – RSV, and a surge of COVID-19. Currently we have patients across the sites with these illnesses, numbers are rising (especially on the SGH site) and we are seeing patients, young and old with dual viruses. Children's services have seen very high numbers of RSV cases for several months, and although the national picture shows it has reached peak, high numbers are still being seen in our hospitals.

Mitigation actions and controls remain in place to safeguard patients and staff safety. HEPA filtration units are in use on the wards. Isolation facilities are being increased using redirooms. C02 monitoring is being carried out regular in waiting areas and actions taken as appropriate.

Group A Streptococcus

There are currently high rates of Group A Strep and Scarlet Fever and sadly, 30 children have recently died of Invasive group A streptococcus (iGAS) infections in the UK. Understandably we are seeing a significant increase of children presenting at our ED's, as per current national guidance we have lowered the threshold of the criteria for taking throat swabs and consequently the lab is processing a 1000% increase. Parents anxiety levels are high, and those discharged home are given NHS Healthier Together Safety Net advice.

Positive results received post discharged are communicated by the IPC Team to Children Community Nurses who provide follow up support.

Mandatory alert organism

Overview 2022/23 YTD
Healthcare-associated cases

	April – December 2022					2021/22	
	PHE Trust-level Targets	Trust	DPOW	SGH	GDH	2021/22 Targets	2021/22 Actuals
C. difficile	21	19	13	6	0	33	20
MRSA	0	0	0	0	0	0	0
MSSA	No Target	11	7	3	1	No Target	21
E. coli	65	38	20	14	4	110	56
Klebsiella spp.	25	17	5	12	0	21	26
P. aeruginosa	7	12	6	6	0	16	12

Targets 2022/23

Healthcare-associated cases (HOHA and COHA)
Baseline dataset 12 months ending November 2021
C. difficile – Trusts with greater than 10 cases – target 1 less than count
Gram-negative bloodstream infections - Trusts with greater than 10 cases – target 5% less than count
https://www.england.nhs.uk/publication/minimising-clostridioides-difficile-and-gram-negative-bloodstream-infections/

MRSA/MSSA hospital onset bacteraemia cases

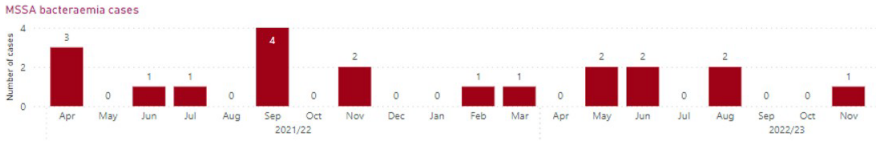
MRSA

YTD: 0 **Target: Zero cases**

Last Hospital MRSA bacteraemia case December 2020.
Community case detected Nov 2021

MSSA

YTD: 11 **Target: No target set**



MSSA remain stable

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

C. difficile Regional comparison

https://publicview.health/Auth/Performance/RJL/1

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

E. coli Regional comparison

https://publicview.health/Auth/Performance/RJL/1

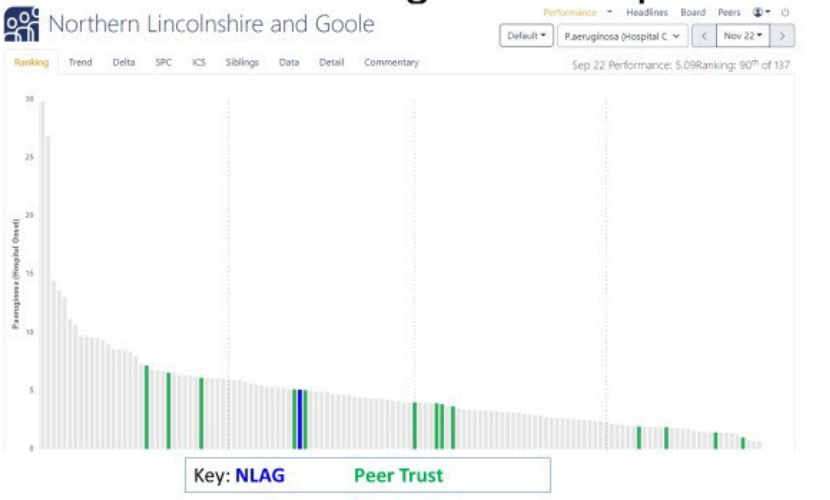
Northern Lincolnshire and Goole NHS
NHS Foundation Trust

Klebsiella Regional comparison

https://publicview.health/Auth/Performance/RJL/1

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

Pseudomonas Regional comparison



https://publicview.health/Auth/Performance/RJL/1

11.0 Quality Improvement

There are various QI initiatives active across the Trust. In focus this month is to improve the timely assessment / reassessment and documentation of pain management by using an electronic WebV tool by March 2023. A QI collaborative involving 5 wards at DPOW commenced July 2022 to engage frontline teams in idea generation to address the problems surround effective pain management. Wards tested and developed a WebV tool using PDSA cycles during which saw an improvement in electronic recording of pain assessments from 10 in Aug 2022 to 2032 in Nov 2022. Further developments of the WebV tool are currently underway to include an electronic prompt to staff for reassessment of pain, this is currently waiting for approval at the January 2023 Digital Solutions Delivery Group. Subject to approval and implementation of this Web development, further testing will commence in February 2023 prior to scaling up and spreading across all wards from March 2023 onwards.

The QI Showcase, a hub portal to capture QI projects from across the trust, successfully launched in November 2022 with a total as of December 2022 of 127 project logged (back dated) in the past 12 months. 32% have shown measurable signs of improvement with a further 21% actively testing ideas with the other 47% in the early stages of staff and patient engagement and ideas generation.

December 2022 saw the QI Academy continue with the 2022/23 QI training across the ICS for Foundation Doctors (both Years 1 & 2). During the month 37 FY1's (9 from NLaG) and 21 FY2's (4 from NLaG) received QI training from the team. This will continue into 2023 with the intention of Foundation Doctors (at both Years 1 & 2) gaining an understanding of a common language and approach towards a QI methodology as well as the tools and resources to enable them to develop their own Quality Improvement Projects (QIP's). For those Foundation Doctors in rotation at NLaG, specific coaching/mentoring is given from the team to support this.

A number of QIP's, across the Trust as a whole, commenced during December. These QIP's are still in the infancy stages of development but below are some examples of the areas that the QIP's will focus on:

- Improving compliance with Oxygen Prescribing in A&E
- Improve number of adults in Emergency Department receiving an appropriate severity assessment as per the British thoracic society guidelines over a three month period
- Reduce number of patients admitted with IPC (Indwelling Pleural Catheter) issues at both SGH and DPOW

12.0 Conclusion

Vacancy rates remain high and recruitment and retention work remain a priority. The Trust is on track to recruit 90 international nurses by December 2022. The final cohort have been delayed until January 2023 with agreement from NHSE/I due to Border strike action. An additional bid has been successful to support the appointment of 10 international nurses in Q4.A risk associated with the ability to continue to support international nurse recruitment includes Practice Development team capacity to support OSCE prep and induction as temporary funding ends March 2023. A business case is being prepared to support the permanent funding.

The overall Trust CHPPD was 8.5 in November. The latest model hospital data for October 2022 indicates a provider value of 7.9 (quartile 2 mid-low 25%) against a peer median of 8.1 and provider median of 7.9. A number of escalation beds remain open and a higher proportion of patients within our wards are now level SNCT level 1b and are dependent on nursing care to meet most or all the activities of daily living. This is particularly apparent at both Scunthorpe and Goole Hospitals.

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 November 2022 and there is a robust escalation policy.

Whilst there has been a decrease in the number of reported falls at all three sites, there were two falls reported with moderate harm at the Scunthorpe site. The two huddles were completed within good time frames with no lapses in care identified. There were no delays with discharge to assess for either of the incidents reported with moderate harm. Ward C3 (Short Stay) Grimsby has not triggered as a higher reporting ward for the first time in five months. None of the other higher reporting wards are demonstrating any trends at present.

Whilst the number of pressure ulcer reported has increased slightly for the second consecutive month there has been a sustained improvement in the number of pressure ulcers reported over the last seven months. None of the higher reporting wards are currently demonstrating any concerning trends.

In community the incidence of pressure ulcers has seen a slight decrease with the most reported consistently are category 2 which suggests that preventative interventions put in place by network teams have impacted on further deterioration of category 2 pressure ulcers. All moderate harm pressure ulcers for November have been reviewed with no lapses in care and no new themes for learning.

New formal complaint numbers continued to reduce along with 4 reopened complaints. The recent work to address complaints over 60 working day timescale has resulted in a further reduction of over 50%, with only 7 being over timescale at the time of reporting. 39 complaints were closed during the month, 64% were in timescale, however 3 were over 100 days due to complexity and delays, 9 were over 70 days and 3 were 61-69 days. Trust wide the number of new PALs concerns received was 167, a further decrease from the previous month. A total of 224 PALs concerns were closed in the month.

Twelve acute hospital and ten in Community and Therapies 15 steps challenge visits were completed. Ward 29 improved from intensive support to requires improvement. A&E DPOW remained at intensive support with close working and support offered to and accepted by the Division.

The QI Showcase, a hub portal to capture QI projects from across the trust, successfully launched in November 2022 with a total as of December 2022 of 127 project logged (back dated) in the past 12 months. 32% have shown measurable signs of improvement with a further 21% actively testing ideas with the other 47% in the early stages of staff and patient engagement and ideas generation.

Winter was predicted and is proving to be very challenging regarding isolation/cohorting hospital inpatients with expected high cases of Influenza A & B, Bronchiolitis – RSV, and a surge of COVID-19. We have patients across the sites with these illnesses, numbers are rising, and we are seeing patients, young and old with dual viruses.

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 7 February 2023
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jane Warner, Associate Chief Nurse – Midwifery, Gynaecology & Breast Services Jenny Hinchliffe, Deputy Chief Nurse
Title of the Report	**Midwifery Safe Staffing Review**
Purpose of the Report and Executive Summary (to include recommendations)	The Clinical Negligence Scheme (CNST) for Trusts outlines a requirement for Trust Boards to demonstrate effective workforce planning and provide evidence of funded establishment being compliant with outcomes of BirthRate Plus calculations. The paper presents a review of workforce, activity and patient safety data which was undertaken by the Chief Nurse in May 2022 for the maternity wards, delivery suites and community services, along with the final Birthrate Plus report. The Trust is compliant with Birthrate Plus calculations with a positive variance of 2.55 WTE. Although the targets set out in the Maternity Incentive Scheme (CNST) for women to be cared for in continuity teams has been removed until such time that the midwifery workforce nationally has improved, assessment of staffing levels using the NHSE/I Continuity of Carer (CoC) Workforce planning tool in January 2022 highlighted that an increase in our current establishment of 15.95 WTE would be required to fully implement CoC and to meet the national requirement to have all eligible women on a CoC pathway. It is therefore recommended that the establishments are not altered at this time. The Board are asked to note the content of the report.
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 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:**

	☐ 1 - 1.6 **To be a good employer:** ☐ 2	☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	There will likely be some financial requirements relating to service developments and/or reconfigurations via usual business planning routes	
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

1.0 Introduction

NHS providers are responsible for delivering the right staff, with the right skills, in the right place at the right time in line with the requirements of the updated National Quality Board 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

In addition, within Safety Action 5 of the Clinical Negligence Scheme for Trusts (Maternity incentive scheme – year four, NHS Resolution 2022) there is a requirement for Trust Boards to demonstrate effective workforce planning and provide evidence of funded establishment being compliant with outcomes of BirthRate Plus calculations. Where not compliant, Trust Board minutes must show the agreed plan with timescales for achieving the appropriate uplift in funded establishments.

A review of workforce, activity and patient safety data was undertaken by the Chief Nurse in May 2022 for the maternity wards, delivery suites and community services whilst awaiting the outcome of the full establishment review using Birthrate Plus methodology (July 2022).

This paper will provide the Board with the safe staffing review of maternity staffing in line with the above guidance and requirements.

2.0 Context

The Trust has a duty to ensure that midwifery staffing levels are adequate and that women are cared for safely by appropriately qualified and experienced staff. This is incorporated within the NHS Constitution (2013) and the Health and Social Care Act (2012). NICE (2015) states of the Trust Board that it should ensure that the budget for maternity services covers the required midwifery staffing establishment for all settings**.**

The evidence suggests that appropriate staffing levels and skill mix influences patient outcomes, for example:

- Reducing mortality & morbidity
- Reducing 30-day readmissions for both mothers and babies
- Reducing adverse incidents, particularly related to medication errors
- Improving the patient experience – continuity of carer throughout the pregnancy

Safe midwifery staffing for maternity settings (NICE 2015) has recommended the use of red flags. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will determine whether midwifery staffing is the cause, and the action that is needed. Red flags are reported monthly as part of the midwifery dashboard.

It is essential that the trust can demonstrate an effective system of midwifery workforce planning to the required standard. It should be underpinned by a systematic workforce strategy and use of a recognised workforce planning tool for determining the total number of Midwifery and Midwifery Support Worker (MSW) staff required per maternity service. Staffing

levels and skill mix within maternity services have been the focus of much debate in recent years. Maternity services nationally are constantly under pressure to utilise their manpower resources effectively and efficiently. A number of other factors have emerged, which include population demographics, national reports and guidelines, along with an increase in public awareness and expectations especially in light of Morecambe Bay and, more recently, the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust (2020 and 2022) and the Kirkup review into maternity and neonatal services at East Kent Hospitals University NHS (2022).

In addition, diversity and complexity of patient needs continue to increase and range from promoting health and well-being through the wider public health agenda, to the high dependency care of sick women and babies. More women are now having babies in their 40s than in the under 20s for the first time since 1949. This increase in age profile comes with a recognised increase in complexities as it does with the increased surveillance for those that are at higher risk (women who smoke, those with gestational diabetes, and those with a higher BMI). The additional work associated with increased antenatal screening and the national Saving Babies Lives Care Bundle v2, which includes the GAP/GROW programme of assessing foetal growth, has been an additional pressure to the service.

Safe midwifery staffing for maternity settings (NICE 2015) also recommends that when calculating the midwifery staffing levels, the number of whole-time equivalents should be based on registered midwives and should not include the following in the calculations:-

- Registered midwives with supernumerary status (this may include newly qualified midwives, or midwives returning to practice)
- Student midwives
- The proportion of time specialist and consultant midwives who are part of the establishment spend delivering contracted specialist work (for example, specialist midwives in bereavement roles)
- The proportion of time midwives who are part of the establishment spend coordinating a service, for example the labour ward

The Clinical Negligence Scheme for Trusts (CNST) has introduced an incentive scheme for trusts and maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend. Trusts that improve their maternity safety will be saving the NHS money, allowing more money to be made available for frontline care. One of the ten required standards for the Trust regards demonstrating an effective system of midwifery workforce planning:

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

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 four reporting period.
Minimum evidential requirement for Trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio -The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not

	included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

The Trust publishes its midwifery staffing hours, both Registered and unregistered, planned versus actual in line with the National Quality Board (NQB) guidance. This is published externally on NHS Choices with a link to the Trust's own website.

3.0 Background

Maternity care is delivered across the three hospital sites, with an obstetric unit at Grimsby and Scunthorpe and a Home from Home midwifery led facility at Goole. Community midwifery, which includes antenatal, intrapartum (home delivery) and postnatal care, covers a wider area in Lincolnshire including Louth, Mablethorpe and Alford.

The number of births has continued to reduce over recent years, although births have increased in complexity with more interventions required.

		SGH	DPOW
Year	Total births	MW: Birth ratio/WTE midwives	MW: Birth ratio/WTE midwives
2016-17	4468	1:32/ 60.23wte	1:32/ 73.59wte
2017-18	4322	1:22/ 58.91wte	1:27/ 75.53wte
2018-19	4033	1:22/ 58.61wte	1:27/ 74.4wte
2019-20	4041	1:24/ 68.22wte	1:28/ 87.34wte
2020-21	3747	1:21/73.62wte	1:25/ 94.45wte
2021-22	3742	1:24/ 73.55wte	1:25/ 98.67

Midwifery Continuity of Carer has been proven to deliver safer and more personalised maternity care. Building on the recommendations of the Better Births report and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services, and available to all

pregnant women in England. Where safe staffing allows, and the building blocks are in place this was to be achieved by March 2023, with rollout prioritised to those most likely to experience poorer outcomes first.

Three continuity of carer (CofC) teams were established; 2 at Grimsby, 1 at Scunthorpe. The 2 teams at Grimsby deploy a shift-based model of CofC whilst the team at Scunthorpe deployed a birth availability model of CofC. The recommendation from the national team is that the birth availability model should be adopted to offer the most flexibility and provide better relational CofC for women thus delivering better outcomes for women and their babies. These teams have been developed within midwifery staffing from the existing establishment supported by non-recurrent funds from transformational monies. The non-recurrent funds supported purchase of equipment, lease car costs and the Better Births Lead Midwife post. In 2020/21 the Trust performed well regionally, despite the additional challenge of a pandemic, and has been able to offer assurance to both the LMNS and regional bodies.

Assessment of staffing levels using the NHSE/I Continuity of Carer Workforce planning tool in January 2022 highlighted that, without an increase in current establishment (15.95wte) the service would only be able to achieve partial implementation and would not be able to meet the national requirement to have all eligible women on a CoC pathway.

The targets set out in the Maternity Incentive Scheme (CNST) for women to be cared for in continuity teams has been removed from 21 September 2022 until such time that the midwifery workforce nationally has improved. Current data highlights that 15% of women in our care at Grimsby received continuity throughout their pregnancy, labour, delivery and in the postnatal period. A decision was made in June 2022 to pause the CoC team at Scunthorpe due to vacancies and staffing pressures.

The maternity service staffing establishments are required to be reviewed at yearly intervals as per CNST/NICE/Better Births. The recommended methodology by the Royal College of Midwives/CNST and CQC is Birthrate Plus (which focuses on acuity), although NICE also have published an alternative methodology (NG4 2015).

A full establishment review using Birthrate Plus data was conducted in November 2019 following concerns being raised about a gap between establishments and Birthrate Plus calculations, particularly in the community. CoC teams were not included within this establishment review. Staffing shortfalls were identified and the recommendations made have been fully funded.

Due to the Covid-19 pandemic the planned 6 monthly establishment reviews were not undertaken in 2020 however the maternity dashboard and workforce data has been reviewed monthly by the Chief Nurse and Associate Chief Nurse – Midwifery and in the Nursing Metric Panel meeting and reported monthly to the Quality and Safety Committee during this period.

4.0 Chief Nurse establishment reviews

In March 2021 a review of workforce, activity and patient safety data was undertaken by the Chief Nurse for the maternity wards, delivery suites and community services.

The review groups consisted of the ward/department/service manager, Chief Nurse, Deputy Chief Nurse, Head of Nurse Staffing, Head of Midwifery, Matron and Finance Business Partner. It is essential to include the manager in the review process as they are the accountable leader and meetings were arranged to accommodate their attendance.

The review considered a triangulation of elements for each ward/department/service, which also included a financial review. It is an important factor to incorporate the professional

judgment of the midwifery managers. Their views were then supported objectively by use of the following information:

- Review of registered to unregistered midwives' ratios
- Booking & delivery statistics
- Review of the maternity dashboard
- Clinical/ Professional judgement
- A review of ward budgets and establishments, with a clear breakdown of staffing budgets at each band and non-pay
- Agency and bank use
- Roster management
- HR benchmarks including vacancy and sickness
- NICE Guidance (2015) Safe midwifery staffing for maternity settings
- Review of staffing red flags and staffing incidents
- Mandatory Training, appraisals, and professional development
- Recruitment and retention
- Temporary staffing and fill rates

Identifying how many midwives and MSWs are needed will vary from service to service and will depend on a number of variables, such as models of care, configuration of services, case mix, length of stay in the acute setting and the competency levels of MSWs. Each of these will have implications for how staff are deployed.

The review included a celebration of what was going well on the ward areas, which highlighted good practice and exceptional leadership. A consistent theme from the managers included ability to cover rosters due to the impact of Covid-19, impact of CoC team still being realised, and the difference filling the vacant posts will make (recruitment ongoing). Lone working was no longer an issue due to the increases in establishments. There had been a sustained increase in statutory and mandatory training and appraisal rates, with most areas advising that they are near completion.

At the end of each review a discussion was held, and decision agreed on what recommendations would be put forward.

The review identified that recruitment was underway to fill the vacancies and staff in most areas felt that staffing levels would be appropriate when vacancies were filled. A shortfall in midwifery staffing was identified in two areas where it was found that staffing reduced at weekends however this was not reflected in reduced activity, and for increased diabetic specialist midwife capacity to support high numbers of diabetic pregnant women. The following recommendations were made:

Ward	Recommendations
Acorn Antenatal Unit	No change (See Antenatal SGH re 1wte Band 7 Diabetic Specialist Midwife – cross-site post)
Labour Co-ordinators	No change
Blueberry/Holly	Increase RM x 1 weekend Saturday and Sunday – 0.79 WTE Cost 41.1k (requested via Ockenden funding)
Jasmine/Honeysuckle	No change
Community- DPOW	No change
Ward 26 SGH	No change
Central Delivery Suite	No change
Antenatal SGH	Increase 1 WTE band 7 Diabetic Specialist Midwife – cross-site post

	Cost £51.1k (Ockenden funding)
Community SGH	Increase MSW x 1 at a weekend 09.00-17.00 hours – 0.48 WTE Cost £13.2k

Recommendations were funded except for the 1wte Band 7 Diabetic Specialist Midwife post. The Trust does not have a Diabetic Specialist Midwife.

This methodology was used to undertake another establishment review by the Chief Nurse in May 2022.

4.1 May 2022 findings

Quality and Safety

There is a robust assurance process including Birthrate Plus Intrapartum Acuity Tool that is a live data collection tool as well as Midwifery Red Flag data collection via the Datix system. This clearly demonstrates that safety is maintained. This is achieved utilising a bank of midwives, agency midwives and re-deployment from the community setting including those that cover an on-call service for home deliveries and the management team currently work on an 80% clinical rota.

To gain assurance of safe staffing levels daily, there are 4 times a day sit rep reviews in the acute clinical areas (LDRP and CDS), highlighting those areas most acute to enable deployment of staff. Maternity OPEL levels have recently been developed and are used to inform the Trust nursing/ midwifery staffing level.

There is a robust Maternity Escalation Tool that is enacted when necessary as well as the BirthRate+ Intrapartum Tool that is undertaken 4 hourly.

Labour Co-ordinators maintain their role consistently without requiring undertaking care of a woman in labour, and there is a 1:1 provision of care in labour to 100% of labouring women.

Staffing is discussed as part of the shift leader hand over. This meeting takes place twice a day and ward dependency, women on protocol (high risk needing midwifery high dependency 1:1 care) and overall staffing ratios/ gaps are discussed. The following actions are agreed to support a reduction of risk:

- Moving from outpatient areas
- Moving staff from one ward to another
- Moving from or to Community midwifery
- Sanctioning additional staff if required due to a patient safety risk
- Closing the Maternity Unit

To support the management of any identifiable risks, the midwives in charge of wards/departments are engaged with staff at a safety brief. A Trust Midwifery Staffing Policy is in place to support the decision-making process. The risks discussed, for example, are high acuity women and babies requiring additional monitoring to that of a low risk new-born. Staff also receive feedback regarding complaints or leaning from incidents that have taken place in or that affect the Trust.

Midwife: Birth ratio

The midwife: birth ratio for the Trust has been maintained below 1:28 and in line with national guidance. This calculation is derived from the Birthrate Plus tool and is based upon an understanding of the total midwifery time required to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour. 100% of women receive one-to-one care in labour.

Midwifery Unit closure

There have been 2 incidents of unit closure in the last year which were due to midwifery staffing issues and the escalation policy was enacted. On both occasions the unit was closed overnight and reopened the following morning once staffing had improved. There have been occasions when one unit has diverted to the other and whereby the Maternity Escalation Tool has been enacted, likewise the maternity unit has accepted women from other units when they have been closed due to acuity.

Challenges & Risks

The age profile of the Midwifery staff and recruitment into Midwifery vacancies is both a local and national challenge. Recruitment campaigns continue and the service has plans to recruit 16 internationally educated midwives in 2023. The team continue to explore recruitment to the Midwifery bank, staff work additional hours to cover gaps in off duty where possible, and agency staff are used where available. Vacancies and increased absence rates during the Covid pandemic have resulted in below minimum staffing on occasions and remains a potential risk to the organisation.

Changes in acuity in workload due to an increase in complexities women present with is not reflected at present in current staffing levels. Safecare Live was implemented in 2021 and supports deployment of staff to maintain patient safety.

The Trust has identified a programme of improvements linked to the recommendations made in the Ockenden Review and is making good progress in meeting the recommendations.

Covid-19 pandemic

The Covid-19 pandemic had, and to a lesser extent continues to have, an impact on staffing levels. The Trust was able to continue with all services including home birth, labour, and anaesthetic care. Preparation for sudden staff shortages was monitored daily with a review of e-roster, co-ordinator daily tool, intrapartum acuity tool and daily operations meetings.

Recommendations

The review identified that recruitment was continuing to fill the vacancies and ward and department managers felt that staffing levels would be appropriate when vacancies were filled.

Although Labour Co-ordinators maintained their supernumerary status 100% of the time, there was limited time to deliver training and additional capacity would support training and succession planning and should be considered. The ATAIN (avoiding term admissions into neonatal units) role was created to support babies that require additional care to ensure deterioration and admission to a neonatal unit is avoided. This is currently a 12-hour Band 3 post and has overwhelmingly been successful with evidence that avoidance of transfer to the neonatal unit has been achieved. There was an additional clinic running in the Pregnancy assessment centre which has been commenced without resources to support it. This should be explored with the ACOO.

There were no immediate/ high risk actions and the following recommendations were made:-

Ward	Recommendations
Acorn Antenatal unit	Look to flex MW hours from Friday to Mon or Thurs. Recommend that business team review clinic activity/ capacity.
Labour Co-ordinators	1wte to support all specialist/ lead roles and to support succession planning (5 retirees in next 2 years) – potential from Ockenden funding.
Blueberry/Holly	Twilight shift for MSW ATAIN role - 1 post will support all wards – to support patient safety. Surgery to be asked to support theatre HCA role in theatre - business case may be required.
Jasmine/Honeysuckle	Twilight shift for ATAIN role - 1 post will support all wards as above.
Community- DPOW	No change. Consider development of metrics & triggers for community workload.
Pregnancy assessment centre	Need additional clinic on Tuesday resourced – to review with business team.
Ward 26	No change Review of administrative support for the ward required as MWs admitting patients on ECAMIS. Ward attender data would be beneficial. Staff to ensure staff are redeployed on Safecare Live
Central Delivery Suite	No change Review of administrative support required. Explore ATAIN role
Community SGH	No change Consider development of metrics & triggers for community workload.

Additionally, consideration should be given to funding the 1wte Band 7 Diabetic Specialist Midwife post which was a recommendation from the review undertaken in March 2021.

5.0 Birthrate Plus Review (2022)

The Royal College of Midwives and CNST recommend using the Birthrate Plus tool to undertake a systematic review of workforce requirements. Birthrate Plus is the only approved and most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care. The final report (July 2022) can be found in Appendix 1.

Annual activity was based on 2020/21 with toral births of 3747 as below:-

	DPOW	SGH
D/S	2149	1508
Home Births	55	35
Total Births	**2204**	**1543**

The Maternity Day Units in DPOW and SGH are staffed daily with a midwife who provides some cover for triage activity and all the planned day unit work. DPOW has 12,574 annual episodes and SGH has 1312. The differences in activity are a result of differences in recording of the data and the challenges faced by lack of ultrasound appointments. These are being addressed.

For both units there has been a noticeable rise in the acuity of women in the 2 higher categories (IV and V): 17% for DPoW and 23% for SGH. For DPOW the case mix of women in the 2 higher categories (IV and V) is 60.6% and for SGH 68.8%. The average for England is 60% based on 70 maternity units from a wide range of size and location, with the range being 54% to 77%. The increases seen are a result of the increase in inductions and women with obstetric or medical problems which is in line with the national picture and because of additional surveillance for those higher risk women.

DPOW	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
2021 %Case mix	2.9	11.5	25.0	33.9	26.7
	39.4%			60.6%	
2017 Case mix	*56.9%*			*43.1%*	

SGH	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
2021 %Case mix	1.5	9.7	20.0	32.5	36.3
	31.2%			*68.8%*	
2017 Case mix	*54.2%*			*45.8%*	

Summary of results

Based on 2020/21 activity and a 24.52% headroom uplift, the total recommended by Birthrate Plus is 185.39wte against the current funded 187.94wte – positive variance of 2.55wte if providing care in a mainly 'traditional' model with limited caseload teams.

The clinical wte includes a contribution from the specialist midwives who have both a clinical and non-clinical role.

	Current Funded wte (Bands 5 to 8)	Birthrate Plus Clinical wte	**Variance wte**
DPOW	99.14	93.72	5.42
SGH	73.00	73.30	-0.30
Additional Specialist and Management wte (across both services)	15.80	18.37	-2.57
TOTAL CLINICAL, SPECIALIST & MANAGEMENT WTE	**187.94**	**185.39**	**2.55**

Birthrate Plus advise that "in smaller maternity services of 2200 or less births, it is not always appropriate in the postnatal ward to replace midwifery roles with MSWs, as this impacts on the ability to provide intrapartum care in response to the significant 'peaks and troughs' experienced in the service. The ward midwives are used for escalation to delivery suite so advisable to retain the staffing as midwives. Adjusting the midwifery staffing for postnatal support staff is a local management decision. In community services, some of the postnatal care related to support with feeding can be undertaken by suitably qualified and competent Band 3 MSWs but this is a small % of the total clinical wte required. As with the postnatal ward, it is not advisable to replace midwifery hours with a Band 3 in the community as this will likely have a negative impact on the required midwifery wte to implement Continuity of Carer teams".

As outlined in the report, there is also a need to have support staff usually at Band 2 working on delivery suites, maternity wards and in outpatients and it is recommended that professional judgement is used to determine this requirement.

It is noted in the report that implementing caseload teams as recommended in Better Births (2017) is likely to require an increase from the baseline thus utilising the current midwifery establishment.

6.0 Conclusion

The Birthrate Plus review has calculated that establishments are compliant with Birthrate Plus recommendations to safely deliver the maternity services. However, current vacancies (September 2022 - 42.2wte RM, 9.6wte MSW) and the limited ability to source bank and agency midwives remain a potential risk to the Trust. Sixteen newly qualified midwives are joining the teams in Q3 and recruitment of 16 internationally educated midwives is underway.

Although the targets set out in the Maternity Incentive Scheme (CNST) for women to be cared for in continuity teams has been removed until such time that the midwifery workforce nationally has improved, assessment of staffing levels using the NHSE/I Continuity of Carer Workforce planning tool in January 2022 highlighted that an increase in our current establishment of 15.95wte would be required to fully implement CoC and to meet the national requirement to have all eligible women on a CoC pathway. It is therefore recommended that the establishments are not altered despite the positive variance of 2.55wte from the Birthrate Plus review.

Appendix 1

NORTH LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST

MIDWIFERY WORKFORCE REPORT

JULY 2022

Table of Contents

Birthrate Plus ®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have more than 8000 births. In addition, it caters for the various models of providing care, such as traditional, community-based teams and continuity caseload teams. It is responsive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

An individual service will produce a case mix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to

deviations from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery.

Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery.

Together with the case mix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and competent & qualified support staff is included.

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community**.**

Factors affecting Maternity Services for inclusion within the Birthrate Plus® Study

The Governance agenda, which includes evidence-based guidelines, on-going monitoring, audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; plus, other key health policies. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities.

Increasingly, with having alongside midwife units where women remain for a short postnatal stay before being transferred home, the maternity wards provide care to postnatal women and/or babies who are more complex cases. Transitional care is often given on the ward

rather than in neonatal units, safeguarding needs require significant input which put higher demand on the workload.

Shorter postnatal stays before transfer home requires sufficient midwifery input to ensure that the mothers are prepared for coping at home. It is well known that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

Community based care is expanding with the emphasis being placed on ‘normal/low risk/need care being provided in community by midwives and midwifery support roles. Women and babies are often being seen more in a clinic environment with less contacts at home. However, reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Cross border activity can have an impact on community resources in two ways. Some women may receive antenatal and/or postnatal care from community staff in the local area but give birth in another Trust. This activity counts as extra to the workload as not in the birth numbers. They have been termed as "imported" cross border cases. Equally, there ae women who birth in a particular hospital but from out of area so are ‘exported’ to their local community service. Adjustments are made to midwifery establishments to accommodate the community flows. Should more local women choose to birth at the local hospital in the future adjustments will need to be made to workforce to provide the ante natal and intrapartum care.

The NICE guideline on Antenatal Care recommends that all women be ‘booked’ by 10 weeks’ gestation, consequently more women are meeting their midwife earlier than previously happened. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal.

Discussion of Data

1. Maternity Services in North Lincolnshire and Goole (NLaG) are delivered across 2 hospital sites – Diana Princess of Wales, Grimsby (DPOW) and Scunthorpe General Hospital (SGH).

2. Allowances of 24.52% uplift for annual, sick and study leave, and 12.5% community travel are included in the staffing figures.

3. Annual Activity is based on (FY) 2020/2021 with total births of 3747 and allocated as below:

	DPOW	**SGH**
D/S	2149	1508
Home Births	55	35
Total Births	**2204**	**1543**

Annual Births Table 1

4. The Birthrate Plus® staffing is based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care.

5. Time is included for Band 7 Coordinators, Ward and Department Managers and Team Leaders to cover the day-to-day management and coordination in all areas.

6. The case mix from 2017 was checked with a sample of births in 2021 and comparing to the maternity dashboard. There will be a correlation between the case mix, and maternity stats recorded on the dashboard especially in relation to Induction rates, delivery method, post-delivery problems, obstetric and medical conditions.

7. The case mix (Tables 2 and 3) indicates that for DPOW 60.6% of women and 68.8% for SGH are in the 2 higher categories IV and V. The average for England is 60% based on 70 maternity units from a wide range of size and location, with the range being 54% to 77%. The case mix is unique to each service as reflects the clinical and social needs of women, local demographics, clinical decision making and adherence to national guidelines. Appendix 1 provides a description of the 5 categories.

DPOW	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
2021 %Casemix	2.9	11.5	25.0	33.9	26.7
	39.4%			60.6%	
2017 Casemix	*56.9%*			*43.1%*	

DPOW Casemix Table 2

SGH	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
2021 %Casemix	1.5	9.7	20.0	32.5	36.3
	31.2%			*68.8%*	
2017 Casemix	*54.2%*			*45.8%*	

SGH Casemix Table 3

8. For both units, there has been a noticeable rise in the acuity of an overall 17% for DPOW and 23% for SGH. Increase in inductions and women with obstetric or medical problems are the main factors for the rise in acuity. Most maternity services completing an

assessment in the past 4 years have shown an increase in categories IV and V for similar reasons.

9. Table 4 shows the additional intrapartum activity.

	DPOW	**SGH**
Inductions of labour	1226	760
Antenatal cases (one to one care)	315	190
Non-viable pregnancies	20	20
Escorted transfers	8	10
Triage service		

Additional Intrapartum Activity Table 4

10. Table 5 shows the annual core activity on the maternity wards on the two sites. Note that the IOLs are part of the ward activity in SGH. For DPOW, the intrapartum and ward activity is provided via their LDRP model.

	DPOW	**SGH**
Antenatal admissions	1350	1400
Postnatal women	2149	1508
P/N readmissions	40	0
NIPEs	1610	1130
Extra care babies	300	250

Maternity Ward Activity Table 5

11. Often the antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or

preterm infants require more frequent hospital based care. The annual activity indicates there are high antenatal admission episodes to the wards in both units. This is consistent with previous assessments. Note that the totals exclude inductions and elective sections

12. The ‘extra care babies’ are those that have a postnatal stay longer than 72hrs. The increase in babies that require frequent monitoring is covered in the case mix as more hours are allocated to women in the higher categories IV and V.

13. Staffing is included for babies to have their NIPE carried out by a midwife. NIPE for home births is routinely included.

14. Births at home are based on a ‘package of care’ including ante and postnatal care and intrapartum care with 2 midwives at the delivery irrespective of where care is given, namely in the woman’s home or a community base.

15. The Maternity Day Units in DPOW and SGH are staffed daily with a midwife and provides some cover for triage activity and all the planned day unit work. DPOW has 12,574 annual episodes and SGH has 1312. It is significantly high activity in DPOW for maternity service with 2200 births.

16. There are weekly obstetric clinics and day unit activity in Goole and Louth staffed by the community midwives.

17. Outpatient Clinic services are based on services are based on session times and numbers of staff to cover these, rather than on a dependency classification and average hours. Professional judgement is used to assess the numbers of midwives and support staff required to ‘staff’ the clinics/sessions. The outpatients’ profile is unique to each maternity service.

18. Table 6 provides a summary of the community population receiving maternity care from NLAG midwives.

	GRIMSBY & LOUTH	SCUNTHORPE & GOOLE
Community Exports (Out of Area cases)	66	48
Community Imports	67	163
Community Cases (AN & PN care)	2150	1623
Total community population inc. home births	2205	1658
Attrition Cases (pregnancy loss/move out of area)	214	94
Total booked population	2419	1752

Community Activity Table 6

19. The community annual total for Grimsby includes 67 women and for Scunthorpe 163 women, who birth in neighbouring units and who receive ante and or postnatal care, from (community imports).

20. There are 66 women who birth in DPOW, and 48 women in SGH and as from 'out of area' receive their community care from their home Trust (community exports).

21. The total community populations for North Lincolnshire and Goole includes community homebirths and attrition cases.

22. Additional staffing for significant safeguarding cases is included in the community staffing.

23. Tables 7 and 8 summarise the Birthrate Plus staffing for the clinical areas.

Birthrate Plus® Staffing Baseline: DPOW and Grimsby Community

Clinical WTE required	
LDRP – 4 wards (ante, intra and postnatal)	59.65wte RMs
Maternity Day Unit	2.79wte RMs
Outpatients Services	3.57wte RMs
Community Services:	27.71 RMs & B3 MSWs
Total Clinical WTE	**93.72wte**

Recommended Staffing DPOW Table 7a

24. In smaller maternity services of 2200 or less births, it is not always appropriate in the postnatal ward to replace midwifery roles with MSWs, as this impacts on the ability to provide intrapartum care in response to the significant 'peaks and troughs' experienced in the service. The ward midwives are used for escalation to delivery suite so advisable to retain the staffing as midwives. Adjusting the midwifery staffing for postnatal support staff is a local management decision.

25. In community services, some of the postnatal care related to support with feeding can be undertaken by suitably qualified and competent Band 3 MSWs but this is a small % of the total clinical wte required. As with the postnatal ward, it is not advisable to replace midwifery hours with a Band 3 in the community as this will likely have a negative impact on the required midwifery wte to implement Continuity of Carer teams as per *Better Births: Improving outcomes of maternity services in England: A five year forward view for maternity care. (2017)*. To establish caseload teams requires a recommended number of midwives to provide a 24 hour services, 7 days a week and the MSWs are in addition to

the midwives. As 97% of women in NLAG are in area, they will all be eligible for being within a caseload team meaning the workforce required for out of area women is minimal.

DPOW: Comparison with Current Staffing of Baseline

	RMs WTE
Current Total Clinical	99.14
Birthrate Plus Clinical Total	93.72
Clinical wte Variance	**5.42wte**

Current Funded Establishment vs Birthrate Plus® recommendations Table 7b

26. Table 7b indicates there is a positive variance in the clinical staffing for DPOW and community accounting for caseload teams taking responsibility for a caseload of women, providing ante and postnatal community care and being the primary midwife for the intrapartum episode.

27. Implementing caseload teams as recommended in Better Births is likely to require an increase from the baseline thus utilising the current midwifery establishment. The NHSE Continuity of Carer Toolkit has been used to calculate for full caseload teams and confirmed there is an increase required, primarily to maintain safe staffing for core services. Whilst the caseload midwives will aim to provide care to women during their intrapartum episode, there will be occasions when the midwife is not available and/or requires the input from another midwife and likely this will be from the core. Professional judgement is used to estimate the number of midwives rostered to delivery suite and the

maternity ward to ensure there is always adequate staffing. There will be minimal, if any, impact of the caseload teams on day unit and outpatient clinics.

Birthrate Plus® Staffing Baseline: SGH and Scunthorpe Community

Clinical WTE required	
Delivery Suite	23.01wte RMs
Ward 26	24.22wte RMs
Maternity Day Unit	2.79wte RMs
Outpatients Services	2.68wte RMs
Community Services:	20.60RMs & B3 MSWs
Total Clinical WTE	**73.30wte**

Recommended Staffing SGH Table 8a

28. The same rationale regarding retaining the clinical wte as midwives applies to SGH as with DPOW (points 24 and 25).

29. Table 8b compares the current wte and skill mix with the Birthrate Plus wte.

SGH: Comparison with Current Staffing of Baseline

	RMs WTE
Current Total Clinical	73.00
Birthrate Plus Clinical Total	73.30
Clinical wte Variance	**-0.30**

Current Funded Establishment vs Birthrate Plus® recommendations Table 8b

30. Table 8b indicates the staffing is just 0.30wte short of the recommended wte.

31. Implementing caseload teams as recommended in Better Births is likely to require an increase from the baseline thus utilising the current midwifery establishment.

Clinical Specialist and Senior Management Roles

32. The above clinical wte will include a contribution from the specialist midwives who have both a clinical and non-clinical role. These roles will be shared across both maternity services. It is a local decision as to how much of the clinical midwife specialists contribute to clinical care.

33. The funded clinical midwifery total of 167.02wte as shown in Tables 7b and 8b excludes the non-clinical component of specialist midwives and senior management roles.

34. In addition to the clinical establishment, Birthrate Plus calculates the requirement for non-clinical midwifery roles needed to provide maternity services rather than midwifery care, as summarised below.

- Associate Chief Nurse - Midwifery, Deputy HoM, and Matrons with additional hours for Band 7s to participate in strategic planning & wider Trust business
- Additional time for specialist midwives to undertake audits, training of staff, etc.
    - Perinatal Mental Health
    - Bereavement
    - Fetal Monitoring
    - Infant Feeding Advisor
- Digital Midwife
- Risk and Governance Lead
- Consultant Midwife
- Better Birth lead
- Patient Safety and Skills Midwife

35. An additional 11% has been added to the total clinical wte of 167.02wte to cover the above roles. This equates to 18.37wte and indicates a small deficit to the current establishment of 15.80wte.

    Note: To apply a % to the clinical total ensures there is no duplication of midwifery roles. The % can be set locally, although the RCM Staffing Guidance support 9-11% and Birthrate Plus is NICE endorsed hence being generally applied in maternity services.

Summary of results

36. Based on 2020/21 activity, a 24.52% uplift the clinical total recommended for North Lincolnshire and Goole NHS FT is shown in Table 9.

	Current Funded wte (Bands 5 to 8)	Birthrate Plus Clinical wte	**Variance wte**
DPOW	99.14	93.72	5.42
SGH	73.00	73.30	-0.30
Additional Specialist and Management wte (across both services)	15.80	18.37	-2.57
TOTAL CLINICAL, SPECIALIST & MANAGEMENT WTE	**187.94**	**185.39**	**2.55**

Current Funded Establishment vs Birthrate Plus® recommendations Table 9

37. Table 9 shows that there is a positive variance of 2.55wte across both services if providing care in a mainly 'traditional' model, with limited caseload teams.

38. In addition, there is a need to have support staff usually at Band 2 working on delivery suite, maternity wards and in outpatient clinics. To calculate the requirement for these support staff, professional judgement of the numbers per shift is used rather than a clinical dependency method.

Appendix 1

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weigh more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Agenda Item: NLG(23)032

Name of the Meeting	**Trust Board of Directors - Public**	
Date of the Meeting	07 February 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 - November 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	The Workforce Committee Minutes from the meeting held on Tuesday 29 November 2022, and approved at its meeting on Tuesday 31 January 2023, are for information.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Workforce Committee
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

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

Minutes

WORKFORCE COMMITTEE

Meeting held on Tuesday, 29 November 2022 at 14:00 hours via Microsoft Teams

Present:

Susan Liburd	Non-Executive Director (Chair)
Christine Brereton	Director of People
Linda Jackson	Vice Chair and Non-Executive Director
Robert Pickersgill	Governor, Membership Office
Kate Truscott	Non-Executive Director

In Attendance:

Paul Bunyan	Associate Director for Workforce Operations
Mr Ajay Chawla	Consultant in Accident and Emergency Medicine (agenda item 5)
Kathryn Hallam	Undergraduate Education Manager, HYMS (agenda item 5)
Liz Houchin	Freedom to Speak Up (FTSU) Guardian (agenda items 7 and 8)
Jennifer Granger	Head of Compliance and Assurance (agenda item 9)
Annabelle Baron-Medlam	Inspection Compliance & Assurance Manager (agenda item 9 - shadowing Jennifer Granger)
Derek Conlon	Deputy Head of e-Rostering and bank Services (agenda item 11)
Helen Harris	Director of Corporate Governance (agenda item 16)
Wendy Stokes	Executive Personal Assistant to Director of People *(taking minutes)*

1 Welcome and apologies for absence

Apologies received from Nico Batinica, Jenny Hinchliffe, 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, 20 September 2022

The minutes from the previous meeting held on Tuesday, 20 September 2022 were accepted as a true and accurate record.

4 Matters arising from the previous minutes

There were no matters arising from the previous minutes.

4.1 Review of Action Log

Action 97 - NHS People Plan - share the plan on one page detailing the four areas of work
The NHS People Plan on one page is available on SharePoint with today's meeting papers. It was agreed to remove this item from the action log.

Action 100 - BAF SO5 - 'No investment specifically for staff training/courses to support leaders'
It was confirmed that this related to individual budgets and the BAF will be amended for Q3 to clarify that. It was agreed to remove this item from the action log.

Action 101 - Guardian of Safe Working Annual Report - Rise in exception reporting - amend report to explain peaks occur when new doctors rotate in August and February
The annual report was amended and submitted to Trust Board. It was agreed to remove this item from the action log.

5 Undergraduate Medical Education

Mr Ajay Chawla and Kathryn Hallam presented the Undergraduate Medical Education Report that is available on SharePoint. Kate Wood is responsible for both undergraduate and postgraduate medical education. Undergraduate medical education is subject to an annual monitoring visit form both Hull York Medical School (HYMS) and Sheffield Medical School.

NLaG is required to ensure Board level governance arrangements are in place. In June concerns were raised about NLaG Board level oversight, citing NLaG were an outlier compared with other NHS providers medical education governance structures.

Undergraduate medical education is now a six-monthly standing item on the Workforce Committee Annual Workplan to present an annual report and a six-monthly progress and exception report. This will ensure appropriate escalation and reporting mechanisms to Board, providing the necessary Board level oversight and governance. These actions will meet the assurance requirement of NLaG, the Medical School's and GMC.

6 People Strategy Annual Delivery Plan 2022-2023 - Quarter 2 Update

Christine Brereton reported the purpose of this report is to provide an update to the committee on the activities of the People Directorate for Q2 and set out proposed plans for Q3 against the Annual Delivery Plan.

Kate Truscott commented on the section on nursing recruitment and retention and felt that more detail was needed to show staff numbers after the recruitment pipeline which considered overall numbers, age profiles and retirement etc. Robert Pickersgill agreed, stating that Governors would be interested in a detailed report.

Christine Brereton highlighted that this particular report is to provide a progress report against the key actions contained with the annual delivery plan and not to provide a detailed analysis, that was the purpose of the deep dive/focus on section on the workplan/workforce committee agenda. Christine suggested that a deep dive or focus on the numbers could be presented at a future meeting re: Nursing profiles. This was agreed as an action for a future agenda.

Linda Jackson asked about the nurse degree apprenticeships and whether all posts had been taken up. Paul Bunyan reported that the only area to struggle was the band 4 nursing associate

role, but work was still ongoing. Linda went on to ask how the trust is managing people who are unsuccessful. Paul confirmed the Chief Nurse was providing some extra development and giving them some exposure, so not to lose them in the future and secure them for future apprenticeship programmes if possible.

Linda Jackson asked about the recommendations going to Exec Team from the Big Conversation that are going to be taken forward. Christine Brereton confirmed that is to be discussed at Exec Team tomorrow along with input from the Big Conversation. The report had already been shared with all staff.

The Chair asked whether Schwartz rounds were being taken up and were they successful. Christine Brereton reported that people are currently being trained to undertake the Schwartz rounds, no metrics are available yet.

Christine Brereton confirmed uptake of the Staff Survey was currently at 33.6% (final figures to be verified), slightly lower than last year and below the 46% national average.

Kate Truscott asked about the career framework for nursing, and whether she needed to have an offline conversation with Ellie. Christine Brereton replied that there are career pathways to get healthcare support workers to become associate nurses and nurses, and that is what the apprenticeship framework is about as discussed earlier.

7 Freedom to Speak Up (FTSU) Strategy 2020-2024 (DCM353) - Annual Progress Report

Liz Houchin presented an annual progress report against the FTSU strategy. The Committee noted progress against the actions and achievements to promote FTSU within the Trust.

8 Freedom to Speak Up (FTSU) Guardian - Quarter 2 Report

Liz Houchin gave highlights from the Q2 Report. A new indicator has been added about concerns closed the same day, with 27 being closed the same day at NLaG. This was an action following the board development session. There were more concerns in Q2 than Q1 and the national office was also reporting an increase in concerns.

Kate Truscott felt sad that someone used the FTSU route for an equipment issue. Liz Houchin stated this was not unique, there is a lack of understanding on how systems and processes work. FTSU should be the safety net when other systems and processes don't work, and lessons can be learnt from this.

9 CQC Update

Annabelle Baron-Medlam attended the meeting today with Jennifer Granger to observe. Annabelle will be covering Jennifer's role whilst she is on maternity leave. Jennifer Granger reported that the format of the report has changed and now includes updates on green actions to make sure they are at the correct rate. Jennifer Granger proceeded to give highlights from the report. Comms are going out regarding the new CQC report being published this Friday. Action plans will be will implemented and amalgamated with existing actions.

Kate Truscott highlighted concerns around mandatory training, and the actual physical facilities available in the trust to deliver training, particularly around end-of-life care and syringe driver training. Jennifer reported that syringe driver training has moved to amber from green due to a deterioration, there was an issue around which members of staff needed training. EOL staff are in

various areas, they have now been identified and the trust is focusing on that. Christine Brereton added that the Portfolio Governance Boards (PGBs) are determining who needs core skills, what is mandatory training and for which staff.

Linda Jackson asked about managing CQC actions moving forward, particularly old actions so not to lose sight of them. Jennifer agreed and reiterated new actions will be amalgamated with existing actions.

An update will be provided to the Chair once the statutory and mandatory review has been completed.

10 Health Education England - Annual Self-Assessment Review

Christine Brereton reported that the Self-Assessment had already been submitted. Christine signed it off with Chair's approval and it is now on the Workforce Committee Annual Workplan. Kate Truscott stated that HUTH have sophisticated training facilities and questioned if joint training may be considered going forward. Christine reported the trust is working more collaboratively with HUTH and there may be opportunities to share facilities/resources including resuscitation and manual handling. The trust does have a challenge around facilities for training and is pursuing several solutions. This has already been flagged as a risk.

11 Central Operations - Bank/Temporary Staffing

Derek Conlon presented highlights from the report available on SharePoint.

Regarding job planning Kate Truscott asked if there was a target of 70% for medical staff. Derek Conlon confirmed the target is 100%. The trust has reached 94% for consultants and he would check for SAS doctors. Derek added that other trusts are in a similar position to NLaG. Kate agreed to contact Derek for an update on SAS doctors.
Action: Kate Truscott

Derek reported a reduction in bank usage from the Thornbury agency. The trust is paying one of its other agencies a little more and focusing on A&E staff to optimize savings in a specialist area. The trust has reduced Thornbury usage from 50 to 30 shifts per week.

Linda Jackson asked about e-Rostering and Auto Roster usage. Derek Conlon advised that Auto Roster gives a level of flexibility to make sure shifts are fitting more flexibly around staff. Derek advised that usage was well over 40% and some managers/matrons were concerned about loss of autonomy.

Linda Jackson went on to ask if Derek and his team were on board to trial flexible working. Derek advised that he tried to do this two months ago remotely and it was a failure. Derek will support the process and introduce himself face-to-face.

Regarding bank incentives, Christine Brereton advised that the Executive team are currently considering Xmas incentives, and this will be communicated to relevant staff once a final decision had been made.

12 Workforce Integrated Performance Report - Trust and Directorate

Paul Bunyan presented the highlights and lowlights of the report available on SharePoint.

Linda Jackson asked about turnover, and what the Trust is doing to retain staff and stop them leaving the trust. Christine Brereton reported that the IPR around turnover/retention is not getting any worse, it is starting to balance off which is welcome news. In July, as part of a deep dive report, the trust wrote to leavers to ask why they had left the trust. The reasons given were no career development, particularly in nursing, and behaviours. This also mirrored the information available through leavers questionnaires. Through the culture work, the OD team is focusing its efforts in those areas. Details on these activities had been shared with the Board in early November.

Linda Jackson stated that people are saying they are physically exhausted and everything the trust is doing proactively will take time to put in place. Christine Brereton reported the trust is focusing on nurse recruitment, that is where the shortages are, and the trust has high cost spends on agency and bank staff. The trust can recruit nurses and healthcare support workers, but some leave the trust quickly, it is about doing more in their first few weeks to retain staff.

The Chair asked if the trust has any areas of concern around safe staffing levels. Paul Bunyan reported maternity is a concern but there are overseas midwives in the pipeline. Recruitment is working with the Chief Nurse team to find how best to onboard new staff. The establishment has increased, there has been a lot of interest with some staff in the pipeline.

The Chair went on to ask if the trust was confident about the levels of staff available through the winter period and cost of living crisis. Christine Brereton reported that the Chief Nurse is doing establishment reviews to assess against safe staffing levels, and her report will go to Board. The Operations team are also looking at winter plans in place both locally and across systems.

Kate Truscott stated that nursing workforce is highlighted in the nursing assurance report, and it was suggested that she brings any questions to the Workforce Committee. Kate asked going forward is there an opportunity for a deep dive into the top five risk areas. Kate highlighted that ward 19 had a 19% sickness rate, that wasn't discussed at Quality and Safety Committee. Kate felt that the IPR doesn't include enough detail, it is an assurance document, if she hadn't seen the nursing report, she wouldn't have had a clue about ward 19.

Christine Brereton highlighted the purpose of sub-committees is to look at data in the IPR and the report is then presented to Trust Board. The Workforce committee is responsible for looking at overall risks and to seek assurances that plans are in place to mitigate those risks, rather than getting into individual operational risks, which would be covered at operational PRIMS meetings.

Paul Bunyan concurred and felt that the level of assurance is probably there within the process that the trust follows when it identifies a hot spot. Operational data does get discussed at PRIMs meetings chaired by Shaun Stacey and the PRIMs report goes to Trust Management Board. Linda Jackson added that the IPR used to be over 50 pages long and it is now considered to be an exemplar within the NHS, and the trust shouldn't move away from that. Kate made a good point about triangulating information from one committee to another, and that is part of the NEDs role. Day to day management of risk is an executive role and there would be no problem if Kate and Susan in the Quality Committee asked for a deep dive to be presented at the Workforce Committee.

Robert Pickersgill reported that a deep dive of the BAF is being discussed at the Governor Assurance Group meting in January as Governors felt that more resources should be devoted to putting in contingencies. That might be an interesting issue for this committee to be able to dismantle the whole business of the BAF and relate it to the IPR and identification of risk. Robert felt that the IPR is there to quantify and identify risks and areas.

13 Recruitment KPIs/Dashboard

Paul Bunyan reported that recruitment activity remains high and completing checks is suffering because of the number of new starters. They are focusing on occupational health, particularly international recruitment, and the health clearance process for that staff group. The SOP has been revised and that goes live on 01 December, hopefully resulting in that staff group being able to start work with a risk assessment approach in place. There continues to be significant demand in occupational health, and a business case is being written to level up with the ICS.

14 Workforce Profile - Our Workforce - Annual Report

Christine Brereton reported that the annual report gives an overview of the workforce on 31 October. The Chair felt this was a helpful report, giving data, trends, and the comparison with last year, and it gives a good basis for future discussion.

15 Apprenticeship Levy - Annual Report

Christine Brereton highlighted the annual report shows how the apprenticeship levy is spent across the year within the Trust and how it assists other Trusts. The collaboration with HUTH will allow NLaG to spend the levy more effectively. Christine explained that in recent previous years (during Covid) the apprenticeship levy hadn't been fully utilised, and this work had been underdeveloped with no infrastructure to support apprenticeships. TMB had recently approved the career pathway for nursing staff which will help nursing staff have a defined career pathway. This would help support retention given that nursing staff are leaving due to lack of opportunities for career development.

Robert Pickersgill asked about the 100 apprentices, that didn't seem many. Christine Brereton replied that the Government take up 2.3% of the pay bill and invest that in apprenticeships for staff. Christine stated that 100 was a great start that would only continue to grow in the future now that the infrastructure is being developed, although further work was needed around mentors. This had been an area under resourced until more recently within the Trust. The people and nursing directorates have also been working closely with universities. Paul Bunyan added that before Covid NLaG had previously got ministerial accreditation for using all its funding for apprentices. Paul went on to highlight that if NLaG uses nurses off the ward to deliver training, their cover must be paid for from core budgets, not the apprenticeship levy.

16 Terms of Reference - Annual Review

Helen Harris reported the TOR had been reviewed by Christine Brereton and herself and amendments made as detailed on the front sheet of the report.

Regarding membership of the committee, Kate Truscott observed that most topics discussed fell under the Chief Nurse and Chief Operating Officer remit. It was noted that both Deputy Chief Nurse and Deputy Chief Operating Officer are frequent attenders at meetings. After discussion the following actions were agreed:

- Helen Harris and Christine Brereton to strengthen paragraphs 6.2 to include 'Chief Operating Officer/or Deputy' and 'Chief Nurse/or deputy'
- Once amended, the Committee asked Helen Harris to take the TOR to Trust Board for ratification.

Action: Helen Harris and Christine Brereton

17 Workforce Committee Annual Workplan

Minor amendments made to the workplan as follows:

- Undergraduate Medical Education - added an annual report and six-monthly review
- Health Education England - added Annual Self-Assessment Review

18 Trust Board Highlight Report

- Undergraduate Medical Education - added to workplan six-monthly for Board level assurance
- Workforce Profile Annual Report - committee welcomed this new report
- Apprenticeship Levy Annual Report - committee welcomed this new report
- Recruitment Strategy - acknowledgment of success
- The Committee agreed the Workforce Committee Terms of Reference for Board approval
- The Freedom to Speak Up (FTSU) Quarter 2 report approved by committee

19 Items for information

19.1 Culture Transformation Board - Terms of Reference

Nothing discussed.

19.2 Minutes of Health and Wellbeing Steering Group meeting held on 26 October 2022

Nothing discussed.

19.3 Minutes of Culture Transformation Board meeting held on Wednesday, 06 July 2022

Nothing discussed.

19.4 Workforce Systems Steering Group Action Log - September 2022

Nothing discussed.

19.5 Minutes of Portfolio Governance Board (PGB) - Core Skills meeting held on 16 September 2022

Nothing discussed.

19.6 Minutes of Portfolio Governance Board (PGB) - Clinical Skills meeting held on 16 September 2022

Nothing discussed.

20 Any Other Urgent Business

20.1 Industrial Action

Christine Brereton reported that several trade unions have notified NLaG that they have been balloting members on industrial action, including Chartered Society for Physiotherapists. NLaG is

awaiting the result of the UNISON ballot. The RCN has confirmed that they did not meet the threshold for strike action at NLaG.

Contingency planning is already being looked at as part of the winter planning process. EMAS and YAS are also balloting their members and the Government are talking about mobilization of army medical and logistics core to cover the ambulance service.

Linda Jackson thanked Christine Brereton on behalf of Trust Board for all her hard work and support over the past two years, resulting n the trust being in a better robust position. Linda wished Christine good luck for the future. The Chair also thanked Christine for all her help and support and stated that she is going to be missed.

21 Date, time, and venue of next meeting:

Tuesday, 31 January 2022 at 12:00 hours via Microsoft Teams

The meeting closed at 16.15 pm

NLG(22)033

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7/2/2022	
Director Lead	Adrian Beddow, Associate Director of Communications	
Contact Officer/Author	Charlie Grinhaff, Communications Manager	
Title of the Report	**Communications Round up – February 2023**	
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 November and December 2022 and includes an overview of team plans and progress. The Trust Board is recommended to note the report.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	✓ Pandemic Response ✓ Quality and Safety ✓ Estates, Equipment and Capital Investment ☐ Finance ☐ Partnership and System Working	✓ Workforce and Leadership ☐ Strategic Service Development and Improvement ☐ Digital ✓ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ✓ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ✓ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

February 2023

Kindness • Courage • Respect

Report period: November and December 2022

Contents

Headlines

TOP 20
Ranking on website accessibility amongst NHS Trusts

197
Ask Peter questions asked and dealt with

10,000+
Opens on our most popular Monday Message

112
Staff attended Senior Leadership Briefing

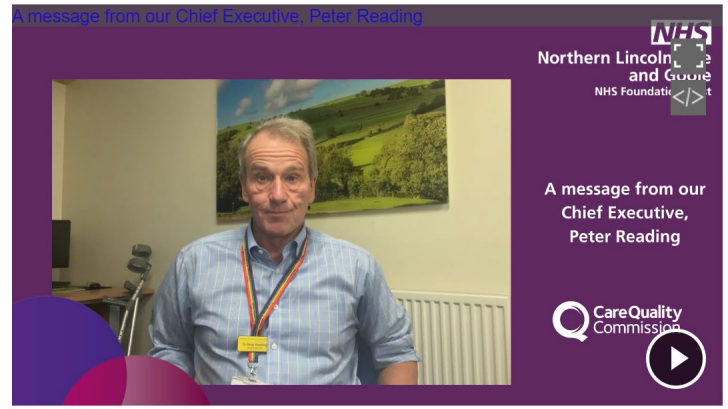
97%
Of media enquiries dealt with in requested timeframe

Progress and plans

Improve Trust reputation through external communications and patient experience	Improve staff morale and engagement
What we've already done • Launched a new website in line with accessibility requirements • Consistently achieved goals around responsiveness to media enquiries • Responded to 95%+ FOIs within statutory time limits. • Taken over the remit of 'Membership communications' and started a new quarterly newsletter • We have reviewed the content on our website and that on the NHS website for our Trust	**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
What we're working on • How we can work more closely with our local media, providing positive news stories • Introduce more video content where relevant • Reviewing our social media channels	**What we're working on** • Targeted line management communication • Working with senior leaders on their approach to engagement and communication • Supporting the People division with the Health and Wellbeing and Culture Transformation work. • Bringing back the annual staff awards ceremony, Our Stars 2023

Supporting the Trust's priorities

Trust Priority 1 – Our People
The **Staff Survey** continued to be promoted across all of our channels during November. In December, we worked with the OD team to publish the first Be The Change Monday Message, an update on our progress from staff feedback during the Big Conversation.
Disability History Month was in the spotlight at NLaG during Team Brief Live at which many attendees spoke involved. Flags were raised at each of our hospitals and our Monday Message from Simone opening up about her disability was extremely popular as it was opened more than 10,000 times.



Trust Priority 2 – Quality and Safety:
The latest **CQC report** was published in this period. Preparation included an all-staff email, messages to stakeholders, powerpoint slides, and prepping for media interviews which were undertaken by the Chief Executive with local TV and radio and the HSJ. A video sharing the good news with staff clocked up 539 views on Facebook (video figures are currently not available for the Hub) and more than 50 staff attended the CQC staff briefing sessions on 2 December. Kate Wood, Medical Director, led the sessions with support from other execs.

The latest theme from the **Trust Learning group** was on Healthy Handovers. The clinical blog had 548 views on our staff Facebook page, and the nursing blog had 511.

Supporting the Trust's priorities

Trust Priority 3 – Restoring Services
We used a Monday Message to encourage clinicians to use Patient initiated follow up to help reduce the number of unnecessarily follow-up appointments. It was opened 7,411 times.

Trust Priority 8 – Capital investment
As many of our external contractors and partners took time off for the festive break, we took the opportunity to look back at our achievements over the year – and to look ahead to what 2023 has in store. The total reach of the posts to our review of the year (internal and external) was 4,216 and the video showing the highlights of the year had more than 1,647 views and more than 70 positive interactions, including likes, comments and shares.

Trust Priority 10 – The NHS Green agenda
We continue to support and raise awareness of the Green agenda with regular campaigns and stories, including sharing sustainability videos from staff within the Trust. These videos introduced the green agenda and encouraged staff and patients to get involved. We produced three videos, which had a total reach of 5,079 on Facebook and 854 engagements.

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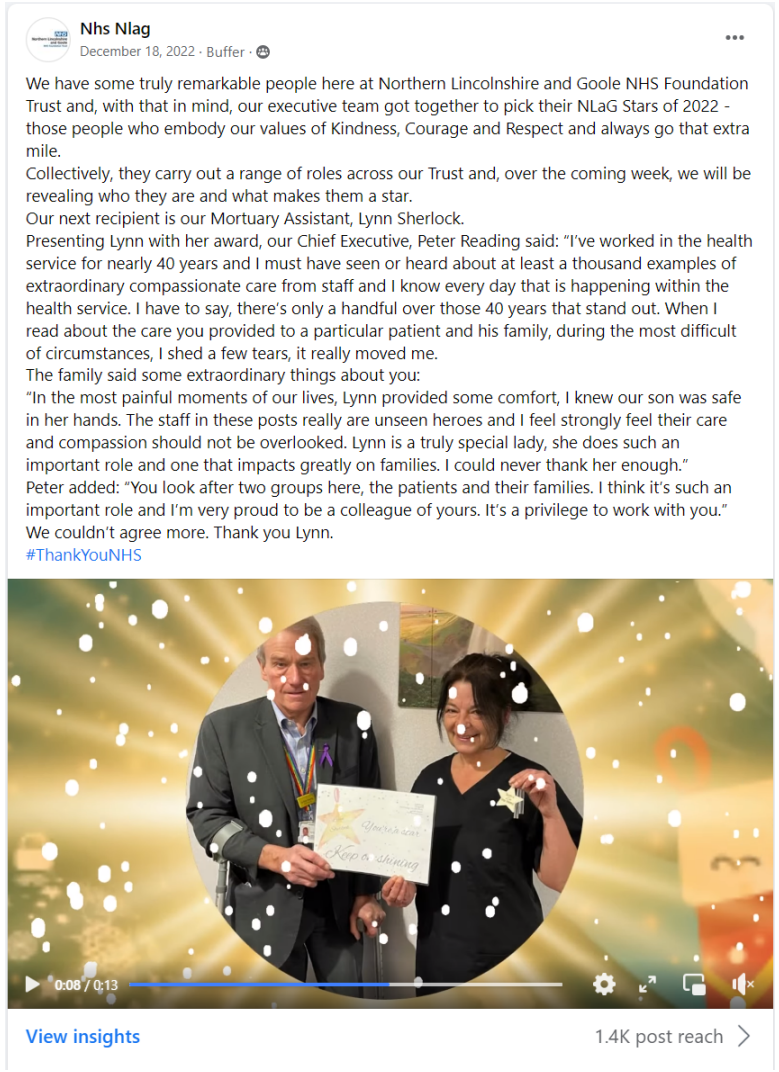
Campaigns and awareness weeks

We had a big push on ‘choose well’ messaging on our social media channels during December, to help with the pressures our hospitals were experiencing. We shared advice for parents about strep A on our social media channels and promoted the Relay UK service, for patients who are deaf or hard of hearing. We promoted our first Support Worker Appreciation Day, Advanced Practice Week and Fraud Awareness Month. We also supported with internal communications for the Perfect Fortnight which ran for two weeks in November

Celebrating staff
To end the year on a high and boost staff morale we celebrated NLaG Stars over the festive period. We sourced wooden stars as a keepsake with the words ‘You’re a star, keep shining’. These were awarded, with a certificate, by our Executive team to individuals and teams who had gone the extra mile. We shared photos and videos on our internal and external channels. The content generated:



Improving staff morale and engagement

Keeping staff informed

All staff emails

We have recently found a way to record total opens for any of the corporate emails we send out using Mailchimp – this is not unique opens e.g. if you open it three times it will register it as three opens.

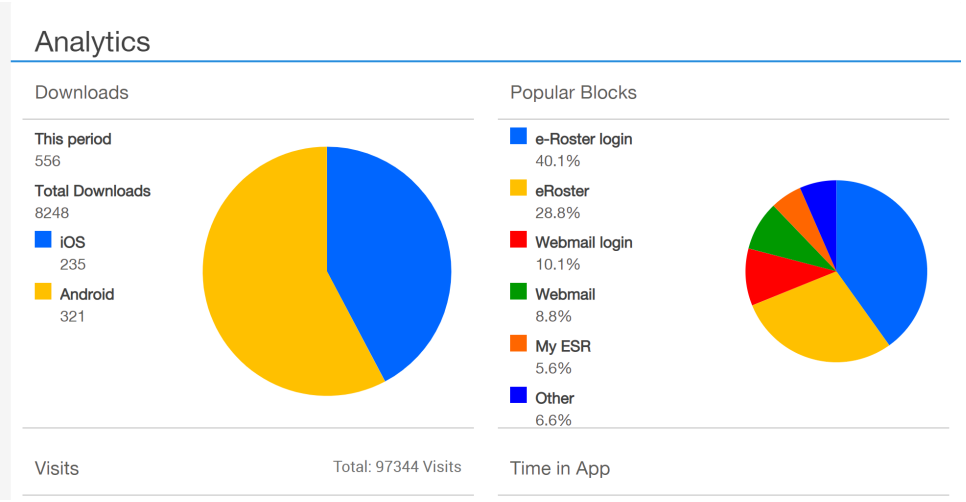
Each week we send to all staff the Monday Message (a blog from a senior leader on a key topic), Wednesday Weekly News (an e-news round-up of news and updated) and on Thursdays we have a dedicated 'Building Our Future' update covering updates on the capital programmes in both estates and digital.
The most read WWN in this period was the 7 December edition which had 7,163 total opens and the most read Monday Message was a staff story as part of Disability History Month which had more than 10,000 opens.

Monday Message topics have included:

- Update following the Trust Board meeting
- Round up of the year,
- Patient initiated follow up
- Update on HTF work
- Quality Improvement showcase
- Simone's personal story as part of Disability History Month

Staff app

We can now access stats for the staff app – there were more than 500 downloads during this period and the app was visited more than 900,000 times. Accessing e-roster is the main reason people use the app.



Improving staff morale and engagement

Team Brief Live

Team Brief Live is still a relatively new format held on Teams. For those who can't make it we share a recording of the session. Feedback has been positive so far.

November's session focused on Disability History Month and the Group Leadership Model – 73 staff attended

"I find these sessions valuable. I'm not bothered what time or day it is on as long as I have enough notice so that I can book time out of clinics.

I think these meetings should become a permanent feature."

Team Brief Live

NHS Northern Lincolnshire and Goole NHS Foundation Trust

We each have a voice that counts

Senior Leadership Briefing

112 senior leaders attended the SLC briefing in November which is the highest attendance this year.
88 joined in December where we asked managers to talk about what they were proud of from 2022.

112 Senior leaders attended the Nov SLC briefing

Improving staff morale and engagement

Giving staff a voice

197
Ask Peter questions

Ask Peter
An extremely popular forum for staff to raise concerns and ask questions about absolutely anything. We have received a total of 197 questions in the two-month period. Of these we had to remove one and redact seven. This compares to 279 questions received in November/December in 2012, of which we removed two and redacted three.

The hot topics included: smoking/vaping, annual leave, Christmas pay day/bank holidays, parking, park and ride, winter pay incentive, Christmas dinner, and face masks.

Staff Thank You
Since the 'Thank you' system launched in January staff have sent more than 980 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.

"You took being moved to a different area in your stride. You were really polite and brilliant to work with. I'm sure the patients appreciated the care you gave them. Thank you so much."

Improving reputation through external communications

Media coverage

There were 74 stories about the Trust in the media during this period. 82% of media coverage was positive or neutral in tone. 86% of coverage was in print or online media.

We categorise the media coverage into themes – in this period '**performance'** was the top theme, followed by 'fundraising'. Six stories related to care issues.

We issued 11 proactive news releases and the most covered was a story was on our CQC report which was covered by local TV, radio and print media, as well as in the HSJ. Staff have been interviewed on this and Sue Snelson talked to BBC Look North about her continued recovery from Covid-19.

National media coverage of note: our group model proposal was featured in the HSJ, our new governors were featured in Digital Health and our Finance Director was on the front cover of Heallthcare Finance.

Family Services was the division with the most positive media coverage.

00%
Of media coverage was positive or neutral

Media enquiries

61 media enquiries were handled in this time. In December 34 came in, the highest since April. 97% were dealt with within the requested timescale. The majority of requests came from radio outlets.

The main reason journalists got in touch was to put in an interview request. 12 reactive statements were produced in this period

97%
Of media enquiries dealt with on deadline

Improving reputation through external communications

General enquiries

The team receives general enquiries via a form on the Trust website. In this period 128 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 139 submitted in this period –of these 132 are closed, 5 are still in progress and 2 are awaiting a response from the requester. November 2022 saw the highest number of FOI requests in a single month in the past five years (ever).

External website – www.nlg.nhs.uk

We are now ranked in the top 20 Trust's on the Silktide Accessibility rating, with a score of 88 'great'. This is a jump up of more than ten places in the rankings. The way Trust's are ranked is set to change in January and it's anticipated scorings will change dramatically.

Key stats:

- 190,699 users, 77,470 visits and 156,317 page views
- 76% of visitors were new users
- Safari was the top browser used to access the site followed by Chrome and Edge. IOS was the top operating system
- 82% of people came to the website via a search, 14% direct, 3% from social media (mainly Facebook) and 1.5% from other websites
- Most visited page: Grimsby hospital home page

The top three news releases viewed on the website were 'New triage number for medical concerns in pregnancy', 'Christmas arrangements for patients and visitors' and 'Trust ready to leave quality special measures.'

128
General enquiries dealt with

139
FOIs received

156k
Page views on our website

Social media

Social media overview

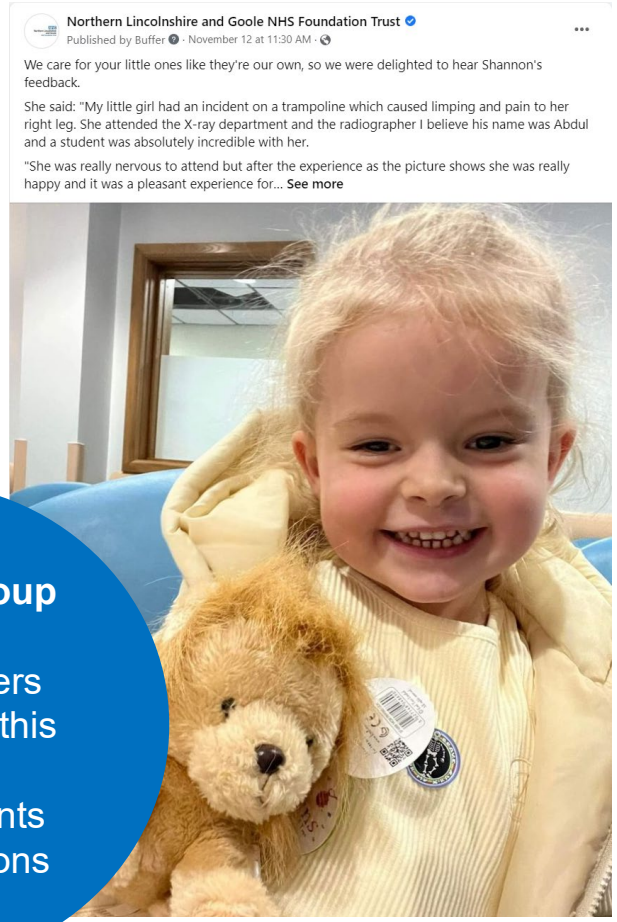
Followers update for the Trust's corporate accounts:

- 13,940 on the Trust's Facebook page
- 5,409 followers on Twitter
- 4,806 on LinkedIn

We shared 26 #ThankYouNHS posts and 24 #ThumbsUpFriday posts in this period. Since we started using #ThankYouNHS the campaign has been seen by more than 240,000 people, had more than 21,000 post engagements and 400 comments (mainly compliments)

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.



Facebook group stats
3,955 members
1003 posts in this period
4814 comments
22,177 reactions

Social media

Facebook page
Two of our more light-hearted posts were among the most popular in this period: a plea to return a lost bunny to it's rightful owner and a santa caption competition.

Top posts November

November 18, 2022 04:00pm

Congratulations to all our areas that have recently received their Outstanding and Good 15 Steps certificates to celebrate the high standard of they're delivering to our patients! The 15 Steps programme is a continuous audit cycle that allows us to observe the environments from which we deliver care, review our da

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
1,356	115	10,835	8,108	13.62%	—

November 4, 2022 02:01pm

What a fantastic achievement! #ThumbsUpFriday and congratulations to Dr Gazala Layas, Registrar in Acute Medicine, who has recently completed a PHD in the development of new liposome form of secukinumab in the treatment of psoriasis.

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
1,292	277	8,833	8,431	18.63%	—

November 22, 2022 10:00am

When your child comes into our hospital, we want them to receive the best care. As a parent, we also want to reassure you that your child is in safe hands. Dettie recently shared a great experience she had: "I would like to say a massive thank you to the nurses at Grimsby A&E. My little boy severed his finger and was in

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
455	111	8,092	7,883	7.08%	—

Tope posts December

December 16, 2022 04:00pm

Help! We desperately want this lost little bunny to be home in time for Christmas 🎅 Our staff are doing regular obs and looking after it in Scunthorpe A&E while we look for their owner. Please share to get this bunny home! 🐰

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
3,648	112	92,412	82,537	5.56%	—

December 15, 2022 12:15pm

The best caption wins...GO! 🎅

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
5,445	99	42,814	42,814	13.56%	—

December 12, 2022 12:37pm

Babies with tongue-tie are benefitting from the expertise skills of two of our midwives. Tongue-tie ankyloglossia is where a membrane under the tongue connecting the baby's tongue to the bottom of their mouth is shorter than usual. A tongue-tie division involves cutting the short, tight piece of membrane connecting

Post Clicks	Reactions	Impressions	Reach	Eng. Rate	Spend
1,614	231	12,839	12,194	14.88%	—

Social media

Twitter
Our Twitter feed is now available on the home page of the staff intranet (The Hub) to ensure more staff see our celebrating staff content. Our top tweet, (by impressions) was a post celebrating our latest CQC report and our top mention was from our former People Director.

NOV 2022 SUMMARY

Tweets	Tweet impressions
54	22K
Profile visits	**Mentions**
5,192	236
New followers	
36	

DEC 2022 SUMMARY

Tweets	Tweet impressions
70	39.6K
Profile visits	**Mentions**
3,987	170
New followers	
26	

Nov 2022 • 30 days

TWEET HIGHLIGHTS

Top Tweet earned 998 impressions

It's an exciting week for our teams as we head to the **#HSJawards** this week. The awards take place on Thursday and we're finalists in two categories alongside partners: 'Integrated Care Partnership of the Year' and 'Covid Vaccination Programme' Wish us luck! pic.twitter.com/RrVIyba5S7

3 3 13

Top mention earned 202 engagements

Claire Shipley
@ClaireShipley83 · Nov 11

Day 5 of the Accelerated Home First Event, No ambulances waiting at scunthorpe **#teamwork #homefirst @NHSNLaG @ECISTNetwork** pic.twitter.com/6CZ9mMaH1f

2 6 68

Top media Tweet earned 1,863 impressions

Is it an emergency? Our hospitals are experiencing very high levels of demand and are extremely busy. Those attending A&E who do not require urgent emergency treatment may have a long wait to be seen as we prioritise the patients most in need. (1/3) pic.twitter.com/Xw4q908FBf

1 6 2

Dec 2022 • 31 days

TWEET HIGHLIGHTS

Top Tweet earned 1,876 impressions

Here's some of the key headlines from our CQC inspection report:
Our Safe rating went up ⬆️
We're rated GOOD for caring across all services ✅
Outpatients went up 2 ratings to GOOD ⬆️⬆️
Goole hospital is rated GOOD ✅
Diagnostics was recognised for 'Outstanding Practice'

1 2 19

Top mention earned 321 engagements

Christine Brereton
@ChristineBrere3 · Dec 29

Well that's it from me, after 2 years at **@NHSNLaG** it's time to say goodbye. Thanks to all my wonderful colleagues good luck for the future **@NLaG4Inclusion @NLaG4Wellbeing @NhsnlagQ**

12 35

View Tweet

Social media

LinkedIn

Stats

1,416 page views
545 unique visitors
451 reactions
26 comments
49 reposts

Content

NLaG Christmas Stars, Building Our Future review of 2022 provided the top content.

You Tube

Stats

November	December
25 NEW SUBSCRIBERS	8 NEW SUBSCRIBERS
4,318 TOTAL VIEWS	2,697 TOTAL VIEWS
8,551 MINUTES WATCHED	4,225 MINUTES WATCHED

Content

Our top video was the ‘bottle feeding video’ produced in 2018 which had 1,071 views in Nov and 966 views in December

Other work

We are working with the Governors to **reinvigorate member engagement.** Our latest Members' Update – Winter edition - had 1,708 opens

The team has plans in place to increase the use of **video** as a corporate comms channel. During December 7 videos and 15 animations were produced.

North Lincolnshire Overview and Scrutiny Committee – we supported the preparation for this which covered: CQC, Group developments, maternity and HAS. We also helped with the **COVID-19 Inquiry submission**.

Health Tree Foundation:

Scunny Bikers visited SGH on 11 December and donated toys to the children on Disney Ward. We had coverage before the event and Gav, organiser, was interviewed on BBC Radio Humberside and That's TV Humber. ITV Calendar also attended on the day.

We sent out a news release about Cleethorpes Golf Club raising more than £8,000 for a new RITA machine for Grimsby hospital. This will benefit our dementia patients. The story was picked up by various media organisations.

THE HEALTH TREE FOUNDATION
Your hospital charity

NLG(23)034

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	7 February 2023	
Director Lead	Dr Peter Reading, Chief Executive	
Contact Officer/Author	As Above	
Title of the Report	**Documents Signed Under Seal**	
Purpose of the Report and Executive Summary (to include recommendations)	The report below provides details of documents signed under Seal since the date of the last report (December 2022 – NLG(22)243).	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

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

Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal has been used on the following occasions:

Seal Register Ref No.	**Description of Document Sealed**	**Date of Sealing**
-	----	-

Action Required

The Trust Board is asked to note the report.